STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155356	A. BUILDING 00 B. WING	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 29, 30, 31, February 1 and 2, 2018 Facility number: 000247 Provider number: 155356 AIM number: 100268500 Census Bed Type: SNF/NF: 17 Total: 17 Census Payor Type: Medicare: 17 Total: 17 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 6, 2018.	F 0000	The facility is requesting paper compliance	
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure physician orders were followed for 2 of 5 residents observed during the medication pass. (Resident 2 and 205)	F 0659	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	03/04/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings include: 1. During an observation of the administration of an intravenous antibiotic for Resident 2 by Nurse 1 on 1-30-2018 at 11:10 a.m., the nurse was observed to mix the powder in the medication container of ampicillin-sulbactam sod 1.5 gram with the solution of 50 ml (milliliters) normal saline in the IV bag. Nurse 1 then to attached the tubing to the IV bag and prime the tubing, then flushed the power PICC (Peripherally inserted central catheter) with 10 - 20 ml of normal saline. The nurse then flushed the PICC line with heparin 25 units (2.5 ml). She then started to connect the IV tubing to the PICC line port. Nurse 1 was questioned prior to attaching the IV line with the antibiotic to the PICC line port if this was the next step. The nurse indicated it was hospital policy to flush power PICC lines with normal saline and heparin before and after infusing the IV antibiotic due to the nature of the power PICC lines clogging. Nurse 1 indicated she had been taught this way at a previous facility. She connected the IV tubing with the ampicillin-sulbactam solution to Resident 2's power PICC. The last flush of the line was with Heparin 25 units (2.5 ml.). The nurse was then observed to program the IV pump and the antibiotic medication began to flow. An interview with the DON (Director of Nursing), on 1-30-2018 at 2:25 p.m., indicated the administration of the heparin flush just prior to infusing the antibiotic was an error. The DON indicated the facility used the SASH (saline, antibiotic, saline, heparin) method when infusing IV (intravenous) antibiotics. A copy of the physician orders for Resident 2 was provided by the DON on 1-30-2018 at 2:25 p.m.		1.Resident # 2 affected by Administration of Intravenous Antibiotic 1.The deficient practice was immediately addressed and corrected. The nurse involved was re-educated and competency completed on 01/30/2018 (the day of the occurrence and prior to administering any further intravenous medication) to ensure the correct method is followed per physician order. In addition, the referring physician of the involved resident was immediately called and informed about the additional heparin flush that took place without physician order on this patient and no new orders received. The family was also notified immediately on the same day. There was no negative patient outcome as a result of the deficient practice. No additional actions were required. 2.All nursing staff present on that day (01/30/2018) were re-educated by the Director of Nursing immediately to ensure that physician orders are followed. 3.The remainder of the staff are being currently re-educated by the Director of Nursing or designee during unit meeting and one on one education which will be completed by 02/26/2018. 1.Resident # 205 affected by Administration of inhaler by	

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	The orders indicated "...power catheter...flush each lumen with 10-20 ml (milliliters) N/S (normal saline) before and after each use...then flush each lumen with heparin 25 units after each use or every 12 hrs (hours) when not in use...." The current MAR (Medication Administration Record) for Resident 2 was also provided at this time by the DON. The MAR scheduled medications instructions for the ampicillin-sulbactam indicated "...compatible with nor; mal (sic) saline only; **do not infuse with other solutions**...." An interview with the DON on 1-31-2018 at 9:25 a.m., indicated the facility did not have a policy on the use of the normal saline and heparin flushes prior to or after the use of an IV antibiotic due to the many kinds of IV devices in place in the facility. The DON indicated the physician orders were what the nurse was supposed to follow when administering the normal saline, heparin and IV antibiotics. An interview with IV Nurse 3 on 2-1-2018 at 1:50 p.m., indicated the facility had either used the SASH method or the SAS (Saline, Antibiotic, Saline), depending on the type of IV line. IV Nurse 3 indicated an antibiotic should have never been given after flushing the power PICC line with heparin for fear of precipitation or crystallization of the line, thus making the line unusable. IV Nurse 3 checked with the other facility Nurse 1 had referred, for their policy on flushing IV lines. IV Nurse 3 indicated the other facility also used the SASH method and did not use a heparin flush just prior to infusing an IV antibiotic. 2. An observation of an administration of an inhaler by Respiratory Therapist (RT) 2 for Resident 205 on 1-31-2018 at 8:55 a.m., indicated the Dulera 200 mcg/5mcg (micrograms) with a blue		Respiratory Therapist 1.The deficient practice was addressed and corrected immediately by the Lead Respiratory Therapist and Administrative Director of Therapy who re-educated the Respiratory Therapist on 01/31/2018. The referring physician was informed and the resident/family was notified on 01/31/2018 that the patient was not offered water to rinse the mouth per physician order. 2.All respiratory staff present on that day (01/31/2018) were re-educated by the Administrative Director of Therapy Services and Lead Respiratory Therapist to ensure that physician orders are followed. 3.The remainder of the staff are being currently re-educated by the Administrative Director of Therapy Services and Lead Respiratory Therapist to follow physician orders and ensure oral rinse completed after use of Dulera during unit meeting and one on one education which will be completed by 02/26/2018. **II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** 1.Administration of Intravenous	

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	adapter was connected to a spacer by RT 2. Resident 205 was then observed to administer 2 puffs of the inhaler. RT 2 then replaced the spacer in the box and returned it to the resident's room. RT 2 was not observed to offer water for Resident 205 for her to rinse her mouth after the administration of the Dulera. The physician's orders for Resident 205 were provided by the DON on 1-31-2018 at 10:50 a.m. The order indicated "...fluticasone-salmeterol (Advair Diskus) 500-50 1 puff inhalation...common canister...rinse mouth after use...Substitution Instructions (Advair 500-50 is non-formulary, substitution is to Dulera only)...." The current MAR for Resident 205 was provided by the DON on 1-31-2018 at 10:50 a.m. The date of the MAR documentation was 1-27-2018. The MAR for the Dulera indicated "...2 puff HFAA (hydrofluoroalkane aerosol) inhalatn (inhalation) every 12 hours per RT...indication: allow sub per P and T policy; common canister rinse mouth after use**bag and return to pharmacy**; This therapy was substituted for fluticasone-salmeterol 500-50 (Advair Diskus)...." An interview with RT 2 on 2-1-2018 at 2:50 p.m, indicated after administration of the Dulera inhaler, she should have had the resident rinse their mouth with water. She was unable to recall if she had Resident 205 rinsed her mouth after the 1-31-2018 8:55 a.m. administration. RT 2 indicated there was a lot going on at the time with the resident and RT 2 was unable to recall. A copy of the respiratory flowsheet for 1-30-2018 was provided on 2-2-2018 at 1:25 p.m. The flowsheet indicated for 1-30-2018 after 8:58 a.m., the MDI (metered dose inhaler) was administered		Antibiotic 1.Physician orders for 100% of active residents were reviewed. Physician orders were followed for all patients. There was no deficient practice noted. No additional actions were required. 2.All new hires will be educated by the Director of Nursing or designee during department orientation and all staff who administer medications will be reeducated annually. 1.Administration of inhaler by Respiratory Therapist 1.Physician orders for 100% of active residents were reviewed. Only one additional patient had orders for Dulera. Physician orders of rinsing the mouth after administration were followed for this patient as evidenced by the medical record notes and interviewing the therapist. The resident was also interviewed on 01/31/2018 by Administrative Director of Therapy Services and he indicated correct procedure was followed. 2.All new hires will be educated by the Administrative Director of Therapy Services or designee during department orientation and all Respiratory staff will be reeducated annually. **III. What measures will be put into place or what systemic changes will be made to**	

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	and after "...Rinsed mouth..." the word "...yes..." was entered. No flowsheet documentation was provided for the 1-31-2018 MDI dose administered at 8:55 a.m., that would have indicated whether the mouth was rinsed with water after the MDI administration. A current policy, "Medication Administration & Documentation in Admin-RX & Non-Admin-RX Units was last revised 9-2015 and provided by the Administrator on 2-2-2018 at 1:25 p.m. The policy indicated, "...Medications are only adminstered by physician order...the Patient Care Organizer Screen/Electric Medication Administration Record (MAR) is used for medication administration...the clinician must confirm each individual medication prior to administration...All medication administrations will be accomplished by asking/confirming patient name and birth date, scanning medications, patient bar code, and validating the 5 patient rights: Right Route, Right Medication, Right Patient, Right Time, Right Dose and assessing allergy to medication...." 3.1-35(g)(2)		**ensure that the deficient practice does not recur;** Administration of Intravenous Antibiotic 1.Starting 02/19/2018, Director of Nursing or designee will perform Two random audits per day X 14 days (28 audits), followed by 2 random audits 3 times a week X 2 weeks (12 audits), then 5 weekly random audits for 8 weeks will be done to ensure 100% compliance of Physician orders. 2.Findings will be reviewed weekly x 4 weeks, then monthly for 2 months, by the Director of Nursing/designee on TCU in morning QA leadership meeting until substantial regulatory compliance is met. 3.Reports will be presented quarterly by the Director of Nursing on TCU, at the Quality Assurance /QAPI Committee Meeting. Administration of inhaler by Respiratory Therapist 1.Starting 02/14/2018, Administrative Director of Therapies or designee will observe a minimum of 1 (up to 2) MDI inhalers per day X 14 days (14-28 audits), followed by 2 direct observations 3 times a week X 2 weeks (12 audits), then 5 weekly observations for 8 weeks will be done to ensure 100% compliance	

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			of Physician orders. 2.Findings will be reviewed weekly for four (4) weeks, then monthly for 2 months by the Administrator/designee on TCU in morning QA leadership meeting until substantial regulatory compliance is met. 3.Reports will be presented quarterly by the Administrative Director of Therapy, at the Quality Assurance /QAPI Committee Meeting. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Administration of Intravenous Antibiotic 1.The Director of Nursing or designee will address any deviations from the policy immediately with the concerned staff member. 1.The results of the audit will be shared with staff during Monthly Department Meeting. 2.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 3.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement	

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			Initiatives for the 1st and 2nd quarter of 2018 Administration of inhaler by Respiratory Therapist 1.The Administrative Director of Therapy Services or designee will address any deviations from the policy immediately with the concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement Initiatives for the 1st and 2nd quarter of 2018 **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 4 2018	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity			

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	§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure a pressure area was assessed weekly for 2 of 3 residents reviewed with a pressure area. (Resident 108, Resident 58) Findings include: 1. On 2/1/18 at 3:00 p.m., the clinical record of Resident 108 was reviewed. Diagnosis included diabetes mellitus and stage 4 pressure ulcer of sacral region. The admission MDS (Minimum Data Set) assessment, dated 1/16/18, indicated the following: extensive assistance required for bed mobility (resident involved in activity but staff provides weight bearing support); walking in room and corridor did not occur; 1, stage 4 pressure ulcer present on admission, length: 5.0 cm (centimeters); width: 7.0 cm and depth 3.0 cm. The Wound Nurse progress notes, dated 1/8/18 at 5:56 p.m., indicated the following: wound length: 4 cm, width 3 cm, depth 7 cm, periwound erythema	F 0686	**I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** 1.Resident # 108 and 58 affected by deficient practice. 1.The deficient practice is being addressed and corrected. A new policy on Pressure Injury/Wound Assessment and Care has been developed (TCU 750)specific to the Transitional Care Unit effective 02/08/2018. In addition, a new competency tool for Wound Measurement and Assessment/Documentation of Wound/Pressure Injury has been developed and implemented as of	03/04/2018

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	5 cm "tunneling: 5 cm at 3 o'clock; 6 cm at 12 o'clock; 5 cm at 9 o'clock, 8 cm at 6 o'clock..." The Wound Nurse progress notes, dated 1/10/18 at 1:34 p.m., indicated the following: wound length: 4 cm, width 3 cm, depth 7 cm; tunneling: "Tunneling did not measure this dressing change - see o'clock from 1/8 (sic)..." The next Wound nurse progress notes were dated 1/17/18 at 5:01 p.m., and indicated the following : wound length: 4 cm, width 3 cm, depth 2 cm; tunneling: 6 o'clock, 5 cm; 12 o'clock was 5 cm; 3 o'clock was 5 cm and 9 o'clock was 2.5 cm. A wound care progress note, dated 1/19/18, indicated the following: "...skin: sacral stage 4 ulcer with undermining (extensions into surrounding tissue) circumferentially...undermining 5-7 cm, especially near 12 o'clock and 6 o'clock..." A surgery report dated 1/22/18 included the following: "...a predebridement wound measurement of 4.5 x 3 cm at the area of the skin with significant undermining circumferentially and extending down towards the anus and extending into the right upper gluteal region...the post debridement dimensions were 11.3 cm in transverse direction, 13 cm in the superior to inferior direction and approximately 2 to 3 cm in depth. On 2/1/18 at 11:11 a.m., the DON (Director of Nursing) was interviewed. She indicated the wound areas were measured weekly and also had photos taken weekly. On 2/2/18 at 11:00 a.m., the wound nurse was interviewed. She indicated the resident had the		02/12/2018. The purpose of this competency is to ensure staff is re-educated regarding a standard and consistent method of measuring wounds and to outline the expectations of initial, daily and weekly assessment and documentation of wound/pressure injury. 1.The Enterostomal Therapy (ET) Nurse has completed the competency of two RN's on 02/12/2018 using this new tool. The competencies of the remaining nursing staff will be completed by the Director of Nursing and the 2 RN's using the "train the trainer" method by 02/26/2018. The nursing staff will also be educated on the new policy by the Director of Nursing during unit meeting and/or one on one education which will be completed by 02/26/2018. 2.The two residents who were affected by the deficient practice were assessed and measured by the Enterostomal Nurse using the standardized method as outlined in the policy and competency. This was completed on 02/07/2018 **II. How other residents having the potential to be affected by**	

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	tunneling of her wound measured on 1/8/18 and the next time the wound tunneling was measured was on 1/17/18. She indicated measurements were completed weekly on Wednesdays and was not sure why the wound tunneling was not measured on 1/10/18 (Wednesday). 2. Resident 108's Nurses notes, dated 1/6/18 at 11:31 a.m., indicated the resident had an open area to the left buttock, with small amount of drainage. There were no measurements completed. Nurses notes, dated 1/7/18 at 2:35 p.m., indicated the resident had an open area to the left buttock. There were no measurements or assessments completed. Wound nurse notes, dated 1/8/18 at 5:56 p.m., indicated the resident had an open area to the left buttock, length 1.5 cm, width 1.5 cm and depth 6 cm. Nurses notes, dated 1/10/18 at 9:48 p.m., indicated the resident had an open area to the right buttock. Documentation was lacking as to an open area to the left buttock. There were no measruements completed. Nurses notes, dated 1/11/18 at 12:18 a.m., indicated the resident had an open area to the right buttock. Documentation was lacking as to an open area to the left buttock. There were no measurements or assessments completed. Nurses notes, dated 1/17/18 at 10:08 a.m., indicated the resident had an open area to the left buttock. There were no measurements completed. On 2/2/18 at 11:16 a.m.,the DON was interviewed. She was made aware of the documentation of the		**the same deficient practice will be identified and what corrective action(s) will be taken;** 1. The remaining four residents who had the potential of being affected by the deficient practice were assessed and measured by the Enterostomal Nurse using the standardized method as outlined in the new policy (TCU 750) and competency. This was completed on 02/08/2018 2. The competencies of the all the remaining nursing staff will be completed by the Director of Nursing and the 2 RN's using the "train the trainer" method by 02/26/2018. The nursing staff will also be educated on the new policy by the Director of Nursing during unit meeting and/or one on one education which will be completed by 02/26/2018. 3.All new hires will be educated by the Director of Nursing or designee during department orientation and all staff will be reeducated annually on the new policy and competencies will be completed on an annual basis	

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	right buttock on 1/10/18 and 1/11/18. She indicated the reference to the open area on the right buttock on 1/10/18 and 1/11/18, was inaccurate and actually referenced the open area on the left buttock. The DON indicated the nurse "got her right and left mixed up." She also indicated documentation in the clinical record should be accurate and complete. 3. On 2/1/18 at 10:00 a.m. the clinical record of Resident 58 was reviewed. Diagnoses included acute exacerbation of chronic obstructive airway disease, respiratory failure and chronic kidney disease stage 3. On 1/24/18 at 5:04 p.m., a wound note indicated the following: site 2: right buttock; "stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister), type: open blister; length: 1 cm (centimeters); width: 1 cm; periwound (area surrounding the open wound) erythema radius: 2.5 cm. On 1/31/18 at 7:21 p.m., a wound note indicated the following: stage 2; type shallow; length: 4 cm; width 3 cm; periwound erythema radius: was blank. A wound note, dated 1/31/18 at 7:21 p.m., indicated "areas appear larger d/t (due to) peri-wound was so inflamed." On 2/2/18 at 10:45 a.m., the Wound Nurse was interviewed. She indicated the wound measurement on 1/31/18, length 4 cm and width of 3 cm, combined the measurements of the open area as well as the periwound erythema surrounding the wound. She indicated the reason		**III. What measures will be put into place or what systemic changes will be made to ensure that** **the deficient practice does not recur;** 1.Effective 02/19/2018, Director of Nursing or designee will perform daily audit on all patients with wound/pressure injury X 14 days , followed by 5 random audits 3 times a week X 2 weeks, then 6 weekly audits for 8 weeks to ensure 100% compliance with measuring and documentation of wound / pressure injury per policy and competency. 1. Findings will be reviewed weekly x 4 weeks, then monthly for 2 months, by the Director of Nursing/designee on TCU in morning leadership meeting until substantial regulatory compliance is met. 1.Reports will be presented quarterly by the Director of Nursing on TCU, at the Quality Assurance /QAPI Committee Meeting . **IV. How the corrective action(s) will be monitored to ensure the**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY TRANSITIONAL CARE UNIT FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the she didn't documented the "periwound erythema" for the site separately, was because she had already included the erythema in the measurement of the stage 2 pressure sore wound. The wound nurse indicated documentation was lacking the measurement on 1/31/18 of the open area portion of the pressure sore. On 2/2/18 at 8:53 a.m. the DON (Director of Nursing) was interviewed. She indicated the wound nurse should have measured the stage 2 wound. She further indicated the wound nurse should not have included the measurement of the stage 2 open area in the same measurement of the periwound erythema. On 2/2/18 at 9:31 a.m., the current policy and procedure, dated 3/2017, for "Wound Assessment and Care" was received from the DON. The policy included the following: "...purpose statement: To provide guidelines for a systemic approach to wound assessment and care in conjunction with policies...Policy...Documentation of wound assessment will be done at...each dressing change...All pressure injuries...will be measured by the E.T. (Wound Nurse) nurse on admission...weekly...Procedure:...Dimensions: measure and record the length, width, and depth of the wound...Undermining and sinus tract formation: inspect pressure injuries, especially stage 3 and 4, for undermining and/or sinus tract formation (beyond the wound base)...periwound skin: skin surrounding the wound is to be assessed with each dressing change..." 3.1-40		**deficient practice will not recur, i.e., what quality assurance program will be put into place;** 1.The Director of Nursing or designee will address any deviations from the policy immediately with the concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement Initiatives for the 1st and 2nd quarter of 2018 **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 4 2018	

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F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 2 of 5 residents (Residents 2 and 205) observed during medication pass. Two medication errors were observed during 33 opportunities for error in medication administration. This resulted in a medication error rate of 6.06%. Findings include: 1. During an observation of the administration of an intravenous antibiotic for Resident 2 by Nurse 1 on 1-30-2018 at 11:10 a.m., the nurse was observed to mix the powder in the medication container of ampicillin-sulbactam sod 1.5 gram with the solution of 50 ml (milliliters) normal saline in the IV bag. Nurse 1 was observed to attach the tubing to the IV bag and prime the tubing. Nurse 1 then flushed the power PICC (Peripherally inserted central catheter) with 10 - 20 ml of normal saline, then flushed the PICC line with heparin 25 units (2.5 ml). Nurse 1 was observed to start to connect the IV tubing to the PICC line port. Nurse 1 was questioned prior to attaching the IV line with the antibiotic to the PICC line port if administering the antibiotic was the next step. The nurse indicated it was hospital policy to flush	F 0759	**I What corrective action(s) will be accomplished for those residents found to have been affected** **by the deficient practice;** 1.Resident # 2 - Medication error- Intravenous Antibiotic 1.The deficient practice was immediately addressed and corrected. The nurse involved was re-educated and competency completed on 01/30/2018 (the day of the occurrence and prior to administering any further intravenous medication) to ensure the correct method is followed per physician order. In addition, the referring physician of the involved resident was immediately called and informed about the medication error that had taken place on this patient and no new orders were received. The family was also notified immediately on the same	03/04/2018

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	power PICC lines with normal saline and heparin before and after infusing the IV antibiotic due to the nature of the power PICC lines clogging. Nurse 1 indicated she had been taught this way at a previous facility. The nurse was observed to connect the IV tubing with the ampicillin-sulbactam solution to Resident 1's power PICC after last flushing the line with the heparin 25 units (2.5 ml.). The nurse then programmed the IV pump and the antibiotic medication began to flow. An interview with the DON (Director of Nursing) on 1-30-2018 at 2:25 p.m., indicated the administration of the heparin flush just prior to infusing the antibiotic was an error. The DON indicated the facility used the SASH (saline, antibiotic, saline, heparin) method when infusing IV (intravenous) antibiotics. The admission diagnoses for Resident 2 included but were not limited to, abrasion and/or friction burn of multiple sites, motor vehicle accident, and adhesions due to foreign body accidentally left in operative wound and/or body cavity during a procedure. A copy of the physician orders for Resident 2 was provided by the DON on 1-30-2018 at 2:25 p.m. The orders indicated "...power catheter...flush each lumen with 10-20 ml (milliliters) N/S (normal saline) before and after each use...then flush each lumen with heparin 25 units after each use or every 12 hrs (hours) when not in use...." The current MAR (Medication Administration Record) for Resident 2 was also provided at this time by the DON. The MAR scheduled medications instructions for the ampicillin-sulbactam indicated "...compatible with nor; mal (sic) saline only;**do not infuse with other solutions**...."		day. There was no negative patient outcome as a result of the deficient practice. No additional actions were required. 2.All nursing staff present on that day (01/30/2018) were re-educated by the Director of Nursing immediately to ensure that physician orders are followed and to reduce future medication errors to less than 5%. 3.The remainder of the staff are being currently re-educated by the Director of Nursing to comply with physician orders and thus reduce medications errors to less than 5%. This will be accomplished during unit meeting and/or one on one education which will be completed by 02/26/2018. 1.Resident # 205 Medication error- Administration of inhaler by Respiratory Therapist 1.The deficient practice was addressed and corrected immediately by the Lead Respiratory Therapist and Administrative Director of Therapy who re-educated the Respiratory Therapist on 01/31/2018. The referring physician was informed and the resident/family was notified on 01/31/2018 that a medication error had occurred by not following physician order of rinsing the mouth. 2.All respiratory staff present on	

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	An interview with the DON on 1-31-2018 at 9:25 a.m., indicated the facility did not have a policy on the use of the normal saline and heparin flushes prior to or after the use of an IV antibiotic due to the many kinds of IV devices in place in the facility. The DON indicated the physician orders were what the nurse was supposed to follow when administering the normal saline, heparin and IV antibiotics. An interview with IV Nurse 3 on 2-1-2018 at 1:50 p.m., indicated the facility had either used the SASH method or the SAS (Saline, Antibiotic, Saline), depending on the type of IV line. IV Nurse 3 indicated an antibiotic should have never been given after flushing the power PICC line with heparin for fear of precipitation or crystallization of the line, thus making the line unusable. IV Nurse 3 checked with the other facility Nurse 1 had referred, for their policy on flushing IV lines. IV Nurse 3 indicated the other facility also used the SASH method and did not use a heparin flush just prior to infusing an IV antibiotic. 2. An observation of an administration of an inhaler by Respiratory Therapist (RT) 2 for Resident 205 on 1-31-2018 at 8:55 a.m., indicated the Dulera 200 mcg/5mcg (micrograms) with a blue adapter was connected to a spacer by RT 2. Resident 205 was then observed to administer 2 puffs of the inhaler. RT 2 then replaced the spacer in the box and returned it to the resident's room. RT 2 was not observed to offer water for Resident 205 to rinse her mouth after the administration of the Dulera. The admission diagnosis for Resident 205 included but was not limited to, acute exacerbation of chronic obstructive airway		that day (01/31/2018) were re-educated by the Administrative Director of Therapy Services and Lead Respiratory Therapist to ensure that physician orders are followed and to reduce future medication errors to less than 5%. 3.The remainder of the staff are being currently re-educated by the Administrative Director of Therapy Services and Lead Respiratory Therapist to follow physician orders (ensure oral rinse completed after use of Dulera or any steroid inhaler) . This will be accomplished during unit meeting and/or one on one education which will be completed by 02/26/2018 thus reducing medication error rate to less than 5% **II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Medication error- Intravenous Antibiotic	

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	disease. The physician's orders for Resident 205 were provided by the DON on 1-31-2018 at 10:50 a.m. The order indicated "...fluticasone-salmeterol (Advair Diskus) 500-50 1 puff inhalation...common canister...rinse mouth after use...Substitution Instructions (Advair 500-50 is non-formulary, substitution is to Dulera only)...." The current MAR for Resident 205 was provided by the DON on 1-31-2018 at 10:50 a.m. The MAR for the Dulera indicated "...2 puffs HFAA (hydrofluoroalkane aerosol) inhalatn (inhalation) every 12 hours per RT...indication: allow sub per P and T policy; common canister rinse mouth after use**bag and return to pharmacy**; This therapy was substituted for fluticasone-salmeterol 500-50 (Advair Diskus)...." An interview with RT 3 on 2-1-2018 at 2:50 p.m, indicated after administration of the Dulera inhaler, she should have had the resident rinse their mouth with water. She was unable to recall if she had Resident 205 rinse her mouth after the 1-31-2018 8:55 a.m. administration. RT 3 indicated there was a lot going on at the time with the resident and RT 3 was unable to remember. A copy of the respiratory flowsheet for 1-30-2018 was provided on 2-2-2018 at 1:25 p.m. The flowsheet indicated for 1-30-2018 after 8:58 a.m., the MDI (metered dose inhaler) was administered and after "...Rinsed mouth..." the word "...yes..." was entered. No flowsheet documentation was provided for the 1-31-2018 MDI dose administered at 8:55 a.m., that would have indicated whether the mouth was rinsed with water after the MDI administration.		1.Physician orders for 100% of active residents were reviewed. The Director of Nursing observed 2 medication passes of current residents receiving intravenous antibiotics on 01/31/2018 on the day shift. Physician orders were followed, and no medication errors identified. No other residents were noted to be affected. There was no deficient practice noted. No additional actions were required. 2.All new hires will be educated by the Director of Nursing or designee during department orientation and all staff who administer medications will be reeducated annually. <u>Medication error- Administration of inhaler by Respiratory Therapist</u> 1.Physician orders for 100% of active residents were reviewed on 01/31/2018. Only one additional patient had orders for Dulera. Physician orders of rinsing the mouth after administration were followed for this patient as evidenced by the medical record notes and interviewing the therapist. The resident was also interviewed on 01/31/2018 by Administrative Director of Therapy Services and he indicated correct procedure was followed. No deficient practice of medication	

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	A current policy, "Medication Administration & Documentation in Admin-RX & Non-Admin-RX Units was last revised 9-2015 and provided by the Administrator on 2-2-2018 at 1:25 p.m. The policy indicated, "...Medications are only adminstered by physician order...the Patient Care Organizer Screen/Electric Medication Administration Record (MAR) is used for medication administration...the clinician must confirm each individual medication prior to administration...All medication administrations will be accomplished by asking/confirming patient name and birth date, scanning medications, patient bar code, and validating the 5 patient rights: Right Route, Right Medication, Right Patient, Right Time, Right Dose and assessing allergy to medication...." Thirty-three medications were observed during the medication pass observations. Of the thirty-three opportunities, errors were observed for two medications. This resulted in a 6.06% error rate. 3.1-25(b)(9)		error was noted. 2.All new hires will be educated by the Administrative Director of Therapy Services or designee during department orientation and all respiratory staff will be reeducated annually. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Medication error- Intravenous Antibiotic 1.Director of Nursing or designee will perform Two random audits per day X 14 days (28 audits), followed by 2 random audits 3 times a week X 2 weeks (12 audits), then 5 weekly random audits for 8 weeks will be done to ensure 100% compliance of Physician orders. 2.Findings will be reviewed weekly x 4 weeks, then monthly for 2 months, by the Director of Nursing/designee on TCU in morning QA leadership meeting until substantial regulatory compliance is met. 3.Reports will be presented quarterly by the Director of Nursing on TCU, at the Quality Assurance /QAPI Committee Meeting.	

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			Medication error- inhaler by Respiratory Therapist 1.Administrative Director of Therapies or designee will observe a minimum of 1 (up to 2) MDI inhalers per day X 14 days (14-28 audits), followed by 2 direct observations 3 times a week X 2 weeks (12 audits), then 5 weekly observations for 8 weeks will be done to ensure 100% compliance of Physician orders and thus reducing the medication error rate to less than 5%. 2.Findings will be reviewed weekly for four (4) weeks, then monthly for 2 months by the Director of Nursing/designee on TCU in morning QA leadership meeting until substantial regulatory compliance is met. 3.Reports will be presented quarterly by the Administrative Director of Therapy, at the Quality Assurance /QAPI Committee Meeting. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Medication Error- Intravenous	

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			Antibiotic 1.The Director of Nursing or designee will address any deviations from the policy immediately with the concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement Initiatives for the 1st and 2nd quarter of 2018 Medication Error- Inhaler by Respiratory Therapist 1.The Administrative Director of Therapy Services or designee will address any deviations from the policy immediately with the concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement	

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			Initiatives for the 1st and 2nd quarter of 2018 **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 4 2018	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure resident medications were labeled and resident specific for 1 of 5 residents observed during medication administration. (Resident 205) Findings include: During an observation of the preparation of the administration of a Dulera inhaler by Respiratory Therapist (RT) 2 for Resident 205 on 1-31-2018 at 8:55 a.m., the Dulera medication was observed to be in a small, metal canister (an aerosol) which was placed in a blue plastic piece, the adapter. The Dulera HFA (hydrofluoroalkane propellant) Aerosol with adapter metal canister or the box was not identified with a specific resident name, physician name, resident specific administration instructions, or opened date of the inhaler. RT 2 was observed to return the Dulera HFA aerosol with adapter to the pyxis and placed it in a compartment in the pyxis. There was another Dulera HFA Aerosol with adapter observed in the pyxis and RT 2 indicated that was the 100 mcg/5mcg inhaler. An interview with RT (Respiratory Therapist) 2 on 1-31-2018 at 8:56 a.m., indicated the Dulera inhaler (200 mcg/5mcg) was a common use inhaler medication which was used for more than one resident except for those residents in isolation. The RT indicated residents in isolation were assigned their own inhalers. The RT indicated the Dulera 200 mcg/5mcg (micrograms) with a blue adapter was connected to a spacer prior to administration and the spacer was resident specific.	F 0761	1.Resident # 205 – Labeling of medication 1.The deficient practice was immediately addressed and corrected on 01/31/2018 by the Lead Respiratory Therapist , Pharmacy Director and Administrative Director of Therapy Services for the two patients that had orders for inhalers. The common canister program which is utilized hospital wide was discontinued immediately on 01/31/2018. Each resident was assigned their own specific inhaler which was labeled and in a locked drawer with Respiratory Therapists being the only personnel to have access to the keys. The label included the specific patient name, physician name, instructions and expiration date. 2.In addition, each resident was assigned their own labeled and dated spacer by the Lead Respiratory Therapist. This is to be replaced with a new one on a weekly basis. 3.The Pharmacy Director removed the Common Cannisters from the TCU Pyxis immediately on 01/31/2018 to ensure it is not dispensed incorrectly. **II. How other residents having the potential to be affected by**	03/04/2018

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	The physician's orders for Resident 205 were provided by the DON (Director of Nursing) on 1-31-2018 at 10:50 a.m. The order indicated "...fluticasone-salmeterol (Advair Diskus) 500-50 1 puff inhalation...common canister...rinse mouth after use...Substitution Instructions (Advair 500-50 is non-formulary, substitution is to Dulera only)...." The current MAR for Resident 205 was provided by the DON on 1-31-2018 at 10:50 a.m. The MAR for the Dulera indicated "...2 puffs HFAA (hydrofluoroalkane aerosol) inhalatn (inhalation) every 12 hours per RT...indication: allow sub per P and T policy; common canister rinse mouth after use**bag and return to pharmacy**; This therapy was substituted for fluticasone-salmeterol 500-50 (Advair Diskus)...." An interview with Pharmacist 4, the Administrator and the DON on 1-31-2018 at 10:50 a.m., indicated the facility had been using the common canister inhaler program since 2010 and were not aware the inhalers for residents in long term care were required to be specific for each resident. An interview with the Administrator on 1-31-2018 at 11:10 a.m., indicated there were 2 residents on the unit sharing the Dulera 200mcg/5mcg HFA Aerosol inhaler. A current policy, "Common Canister Inhaler Program" dated 8-27-2010 was provided by the Administrator on 1-31-2018 at 10:50 a.m. The policy indicated "...A common canister inhaler program is the practice of utilizing a metered dose inhaler for multiple patients who each retain their own one-way spacer device. The common canister inhaler program is an efficient, cost-effective method of providing respiratory		**the same deficient practice will be identified and what corrective action(s) will be taken;** 1.Out of the 17 residents on the unit, only 2 residents had orders for inhalers. The deficient practice was addressed and corrected immediately on 01/31/2018 by the Lead Respiratory Therapist, Director of Pharmacy and Administrative Director of Therapy Services 2.The policy and procedure has been revised by the Pharmacy Director to exclude TCU from the common canister program (see Policy attached). Each resident has their own specific inhaler which is labeled in a locked drawer with Respiratory Therapists being the only personnel to have access to the keys. The label includes the specific patient name, physician name, instructions and expiration date. 3.All Pharmacists have been educated by the Pharmacy Director to dispense an individual inhaler for each patient. This was accomplished on 02/01/2018. 4.The Administrative Director of Therapy services or designee will educate all TCU licensed staff and Respiratory therapist on the revised policy by 02/26/2018 5.All new hires will be educated by the Administrative Director of Therapy Services or designee	

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	care to patients. When performed correctly, studies have shown that the risk of contamination associated with the use of a common canister is minimal to none...Definitions...Common Canister--the mechanism for administering inhalers in which each patient is given their own one-way spacer device, and one common inhaler is shared among multiple patients...One Way Spacer Device--An aerochamber that is designed for single patient use, which is kept at the patient's bedside, and used to administer inhalers. The one-way design prevents any backwash onto the inhaler or cross contamination between patients...Procedure...orders for dry-powder inhalers or for patients in isolation, including neutropenic patients...will be excluded from the common canister program...." A current policy, "Dispensing Labels Policy" dated 5-1-2009 was provided by the Administrator on 2-1-2018 at 11:34 a.m. The policy indicated, "...all drugs stocked in the pharmacy, supplied to floor stock, or dispensed to patients shall be clearly, accurately, appropriately, and safely labeled using a standardized method...drug labeling must be consistent among all preparation areas throughout the facility and comply with the applicable laws and regulations of the state Board of Pharmacy...All labels shall include at a minimum...patient name and location (if applicable)...the proprietary and/or nonproprietary name of the drug...drug strength...dosage form...lot number or pharmacy control number...manufacturer...expiration date, when applicable...quantity of drug...appropriate accessory and cautionary statements or supplemental labels that address storage requirements, administration procedures, safety precautions, etc...."		during department orientation and all Respiratory staff will be reeducated annually. **III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 1.Starting 02/14/2018, The Administrative Director of Therapy Services or designee will perform a daily audit of all inhalers X 14 days, followed by 2 random audits 3 times a week x 2 weeks followed by 5 weekly random audits for 8 weeks will be done to ensure 100% compliance with labeling the inhalers and tracking expiration dates. 2.Findings will be reviewed weekly for four (4) weeks, then monthly for 2 months by the Administrator/designee on TCU in morning QA leadership meeting until substantial regulatory compliance is met. 3.Reports will be presented quarterly by the Administrative Director of Therapy, at the Quality Assurance /QAPI Committee Meeting. **IV. How the corrective action(s)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155356	A. BUILDING 00 B. WING	02/02/2018

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	3.1-25(j)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** 1.The Administrative Director of Therapy Services or designee will address any deviations from the policy immediately with the concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement Initiatives for the 1st and 2nd quarter of 2018 **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 4 2018	
F 0842 SS=E Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility			

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	itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-			

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	(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure clinical records were maintained in an accurate and complete manner for 4 of 13 residents reviewed for documentation. (Resident 108, Resident 58, Resident 104, and Resident 55) Findings include: 1. On 2/1/18 at 3:00 p.m., the clinical record of Resident 108 was reviewed. Diagnosis included Diabetes Mellitus; and pressure ulcer of sacral region. The admission MDS (Minimum Data Set) assessment, dated 1/16/18, indicated the following; extensive assistance required for bed mobility (resident involved in activity but staff provides weight bearing support); walking in room and corridor did not occur; one, stage 4	F 0842	**I What corrective action(s) will be accomplished for those residents found to have been affected** **by the deficient practice;** 1.Resident # 108, 58,104, 55– Clinical Records not maintained 1.The deficient practice is being addressed and corrected for residents affected by the practice. A new policy on Pressure Injury/Wound Assessment and Care has been developed (TCU	03/04/2018

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	pressure ulcer present on admission, length: 5.0 cm (centimeters); width: 7.0 cm and depth 3.0 cm. Nurses notes, dated 1/6/18 at 11:31 a.m., indicated the resident had an open area to the left buttock, with small amount of drainage. Nurses notes, dated 1/7/18 at 2:35 p.m., indicated the resident had an open area to the left buttock. Wound nurse notes, dated 1/8/18 at 5:56 p.m., indicated the resident had an open area to the left buttock, length 1.5 cm, width 1.5 cm and depth 6 cm. The Wound Nurse progress notes, dated 1/8/18 at 5:56 p.m., indicated the following: coccyx wound length: 4 cm, width 3 cm, depth 7 cm, periwound erythema 5 cm "tunneling (channels that extend from a wound into and through subcutaneous tissue or muscle) 5 cm at 3 o'clock; 6 cm at 12 o'clock; 5 cm at 9 o'clock, 8 cm at 6 o'clock..." The Wound Nurse progress notes, dated 1/10/18 at 1:34 p.m., indicated the following: coccyx wound length: 4 cm, width 3 cm, depth 7 cm; tunneling: "Tunneling did not measure this dressing change - see o'clock from 1/8 (sic)..." Wound nurse notes, dated 1/10/18 at 1:34 p.m., indicated the resident had an open area to the left buttock, length 1.0 cm, width 1.0 cm and depth 4 cm. Nurses notes, dated 1/10/18 at 9:48 p.m., indicated the resident had an open area to the right buttock. Documentation was lacking as to an open area to the left buttock. Nurses notes, dated 1/11/18 at 12:18 a.m., indicated the resident had an open area to the		750) specific to the Transitional Care Unit effective 02/08/2018. This policy outlines specifically the components of initial nursing assessment, how the risk of skin breakdown is assessed, when to call the Enterostomal (ET nurse), components of a weekly note by the ET nurse, daily and weekly assessment and documentation components by the bed side nurse, Event Reporting system expectation, and Prevention/Treatment Strategies including expectations of when photographs of the wound should be taken. In addition, a new competency tool for Wound Measurement and Assessment/Documentation of Wound/Pressure Injury has been developed and implemented as of 02/12/2018. The purpose of this competency is to ensure staff is re-educated regarding a standard and consistent method of measuring wounds, how often to measure and to outline the expectations of initial, daily and weekly assessment and documentation of wound/pressure injury. 1.The Enterostomal Therapy (ET) Nurse has completed the competency of two RN's on 02/12/2018 using this new tool. The competencies of the	

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	right buttock. Documentation was lacking as to an open area to the left buttock. Nurses notes, dated 1/17/18 at 10:08 a.m., indicated the resident had an open area to the left buttock. On 2/2/18 at 11:16 a.m.,the DON was interviewed. She was made aware of the documentation of the right buttock on 1/10/18 and 1/11/18. She indicated the reference to the open area on the right buttock on 1/10/18 and 1/11/18, was inaccurate and actually referenced the open area on the left buttock. The DON indicated the nurse "got her right and left mixed up." The DON also indicated documentation in the clinical record should be accurate and complete. 2. On 2/1/18 at 10:00 a.m. the clinical record of Resident 58 was reviewed. Diagnoses included acute exacerbation of chronic obstructive airway disease, respiratory failure and chronic kidney disease stage 3. On 1/24/18 at 5:04 p.m., a wound note indicated the following: site 2: right buttock; "stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister), type: open blister; length: 1 cm (centimeters); width: 1 cm; periwound (area surrounding the open wound) erythema radius: 2.5 cm. On 1/31/18 at 7:21 p.m., a wound note indicated the following: stage 2; type shallow; length: 4 cm; width 3 cm; periwound erythema radius: was blank. A wound note, dated 1/31/18 at 7:21 p.m.,		remaining nursing staff will be completed by the DON and the 2 RN's using the "train the trainer" method by 02/26/2018. 2.All nursing staff will also be educated on the new policy by the Director of Nursing during the unit meeting and/or one on one education which will be completed on 02/26/2018. 3.One out of the 17 residents did not have a completed Immunization section indicating if patient had accepted or declined the Influenza Vaccination. This was immediately corrected by the Director of Nursing on the same day 02/02/2018. <u>II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</u> a. The remaining four residents that were affected by the deficient practice were assessed and measured by the Enterostomal Nurse and designated RN's using the standardized method as outlined in the policy and competency. This was completed on 02/14/2018. b. Additionally, all new patients admitted after 02/01/2018 have been assessed, measured and treated using the standardized method of assessment and	

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	indicated "areas appear larger d/t (due to) peri-wound was so inflamed." On 2/2/18 at 10:45 a.m., the Wound Nurse was interviewed. She indicated the wound measurement on 1/31/18, length 4 cm and width of 3 cm, combined the measurements of the open area as well as the periwound erythema surrounding the wound. She indicated the reason the she didn't documented the "periwound erythema" for the site separately, was because she had already included the erythema in the measurement of the stage 2 pressure sore wound. The wound nurse indicated documentation was lacking of the measurement on 1/31/18 of the open area portion of the pressure sore. On 2/2/18 at 8:53 a.m. the DON (Director of Nursing) was interviewed. She indicated the wound nurse should have measured the stage 2 wound. She further indicated the wound nurse should not have included the measurement of the stage 2 open area in the same measurement of the periwound erythema. On 2/2/18 at 9:31 a.m., the current policy and procedure, dated 3/2017, for "Wound Assessment and Care" was received from the DON. The policy included the following: "...purpose statement: To provide guidelines for a systemic approach to wound assessment and care in conjunction with policies...Policy...Documentation of wound assessment will be done at...each dressing change...All pressure injuries...will be measured by the E.T. (DEFINE) nurse on admission...weekly...Procedure:...Dimensions: measure and record the length, width, and depth of the wound...Undermining and sinus tract formation: inspect pressure injuries, especially		measurement as outlined in the policy. c. All nursing staff will be educated on the new policy (TCU 750) by 02/26/2018 by the Director of Nursing. In addition, competencies of all nursing staff will be completed by Director of Nursing or designee using the new competency tool. d. All new hires will be educated by the Director of Nursing or designee during department orientation and all staff will be reeducated annually on the new policy (TCU 750) and competencies will be completed on an annual basis e. The medical records of the remaining 16 patients that could have been affected by the deficient practice were reviewed on 02/03/2018 to ensure Immunization was addressed as outlined in the policy. No deficiencies were identified. f. All nursing staff will be educated by the Director of Nursing or designee on the Facility Policy regarding Immunization of Residents and applicable documentation by 02/26/2018. g. All new hires will be educated by the Director of Nursing or designee during department	

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	stage 3 and 4, for undermining and/or sinus tract formation (beyond the wound base)...periwound skin: skin surrounding the wound is to be assessed with each dressing change..." 3. A review of Resident 104's clinical record on 2/1/2018 at 10:35 a.m., indicated a BIMS (Brief Interview of Mental Status) of 15 out of 15, meaning the resident was cognitively intact. Diagnoses included but were not limited to: heart disease, and kidney disease. An External Transfer Report, dated 1/17/2018, no time, indicated Resident 104 had a Decubitus Ulcer (bed sore), Stage 1 (skin is discolored but not broken), and measured 1 cm (centimeter) in length and 1 cm in width. The report indicated the wound was being treated with Venelex Ointment (a combination medicine used to treat wounds) and a Mepilex (foam) Dressing. A review of forms titled "Wound Documentation Initial/Weekly" indicated the following: "...To be completed by patient care nurse on admission/discovery, weekly, and discharge. Site/Location of wound. Present on Admission, yes or no. .." The form contained sections for the following: wound bed, drainage, odor, pain scale, procedure performed and how the patient tolerated. Another section was to be completed by the WOCN (Wound, Ostomy and Continence Nurse)/ MD (Medical Doctor)/AHP (Advanced Health Professional). A Wound Documentation Initial/Weekly form for Resident 104 indicated a picture of a wound, labeled as Sacrum, and signed by the Physician on 1/19/2018. No documentation on the form was completed. Resident 104 was transferred from the 4th floor to the TCU (Transitional Care Unit) on 1/17/2018.		orientation and all staff will be reeducated annually on the Immunization policy on an annual basis III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; 1.Effective 02/19/2018, Director of Nursing or designee will perform daily audit on all patients with wound/pressure injury X 14 days , followed by 5 random audits 3 times a week X 2 weeks, then 6 weekly audits for 8 weeks to ensure 100% compliance with measuring and documentation of wound / pressure injury per policy and competency. 2.Director of Nursing or designee will perform audit of the Immunization section of the Admission Assessment of all patients to ensure that resident has accepted or declined the Influenza/Pneumococcal vaccine X 1 month followed by 5 random audits 3 times a week X 2 weeks, then 6 weekly audits for 8 weeks to ensure 100% compliance with documentation of Immunization section. 3. Findings will be reviewed	

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	A Wound Documentation Initial/Weekly form for Resident 104 indicated a picture of a wound, labeled as left buttock, and signed by the Physician on 1/19/2018. No documentation on the form was completed. A Wound Documentation Initial/Weekly form for Resident 104 indicated a picture of a wound, labeled as third toe of right foot, and signed by the Physician on 1/19/2018. No documentation on the form was completed. A Wound Documentation Initial/Weekly form for Resident 104 indicated a picture of a wound, labeled as right foot between great and 2nd toe, and was signed by the Physician on 1/19/2018. No documentation was completed. A Wound Documentation Initial/Weekly form for Resident 104 indicated a picture of a wound, labeled as left hip, and signed by the Physician on 1/18/2018. No documentation was completed. A review of Resident 104's electronic flowsheet for Skin Assessment indicated documentation and locations but no measurements for the following dates: 1/18/2018 at 01:15 (1:15 a.m.) on the following locations: right hand, sacrum, right buttocks, left hip, and the third toe of right foot. 1/18/2018 at 14:17 (2:17 p.m.) on the following locations: sacrum/coccyx, right buttock, left hip, and the third toe on right foot. 1/18/2018 at 17:46 (5:46 p.m.) on the following locations: coccyx, right buttock, left hip, and the left heel. 1/19/2018 at 06:00 (6 a.m.) on the following locations: coccyx and the right buttock.		weekly x 4 weeks, then monthly for 2 months, by the Director of Nursing/designee on TCU in morning leadership meeting until substantial regulatory compliance is met. 1.Reports will be presented quarterly by the Director of Nursing on TCU, at the Quality Assurance /QAPI Committee Meeting . **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** 1.The Director of Nursing or designee will address any deviations from the policy immediately with the concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement	

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	1/19/2018 at 08:45 (8:45 a.m.) on the following locations: coccyx and the right buttock. 1/20/2018 at 19:35 (7:35 p.m.) on the following locations: coccyx, right buttock, and the right third toe. 1/22/2018 at 01:30 (1:30 a.m.) on the following locations: coccyx, right buttock, left hip, and the right third toe. 1/22/2018 at 23:32 (11:32 p.m.) on the following locations: coccyx, left hip, right third toe, the right great toe, and second toe. 1/23/2018 at 04:21 (4:21 a.m.) on the following locations: coccyx, left hip, right third toe, and the right great toe. 1/23/2018 at 13:26 (1:26 p.m.) on the following locations: coccyx, left hip, and the right third toe. 1/23/2018 at 16:00 (4 p.m.) on the following locations: coccyx, left hip, and the right third toe. 1/24/2018 at 01:15 (1:15 a.m.) on the following locations: coccyx, left hip, right third toe, and the right great toe. 1/24/2018 at 08:46 (8:46 a.m.) on the following locations: coccyx, left hip, and the right third toe. 1/25/2018 at 06:00 (6 a.m.) on the following locations: coccyx, left hip, and the right third toe. 1/25/2018 at 11:46 (11:46 a.m.) on the following locations: coccyx, left hip, and the right third toe. 1/25/2018 at 17:48 (5:48 p.m.) on the following locations: coccyx, left hip, and the right third toe. 1/26/2018 at 15:59 (3:59 p.m.) on the following locations: coccyx, left hip, and the right third toe. 1/27/2018 at 06:00 (6 a.m.) on the following locations: buttocks, left hip, and the right third toe. 1/27/2018 at 09:51 (9:51 a.m.) on the following locations: buttocks, left hip, and the right third toe. 1/27/2018 at 15:48 (3:48 p.m.) on the following locations: buttock, and the left hip. 1/28/2018 at 01:26 (1:26 a.m.) on the following		Initiatives for the 1st and 2nd quarter of 2018 **V. By what date the systemic changes will be completed.** - Date Systemic Changes will be completed by March 4 2018	

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	locations: buttock, and the left hip. 1/28/2018 at 09:27 (9:27 a.m.) on the following locations: buttocks, left hip, and the "right third great toe". 1/29/2018 at 09:14 (9:14 a.m.) on the following locations: buttocks, left hip, and the right third toe. 1/29/2018 at 16:32 (4:32 p.m.) on the following locations: buttocks, left hip, and the right third toe. 1/30/2018 at 09:06 (9:06 a.m.) on the following locations: right buttock, left hip, and the right third toe. 1/30/2018 at 16:00 (4 p.m.) on the following locations: right buttock, left hip, and the right third toe. 1/31/2018 at 14:53 (2: 53 p.m.) on the following locations: left hip, coccyx, and the "right". 1/31/2018 at 15:56 (3:56 p.m.) on the following locations: left hip, coccyx, right third toe, and the left great toe, and second toe. 2/1/2018 at 09:13 (9:13 a.m.) on the following locations: coccyx, left hip, and the right third toe. A review of the Wound Nurse documentation, dated on 1/25/2018 in the Electronic Record, under the Pressure Ulcer section of the Skin Assessment indicated the following: Site #1- Right buttock location, staged as a deep tissue injury, with an open, shallow blister and purple around the pressure spot. The measurements indicated 1 cm in length by 1 cm in width and 1.5 cm periwound (tissue surrounding the wound itself). Documentation included the following: a scant amount of dark red drainage, and the wounds edge was jagged. A tender sensation was documented in the pain section and Venelex Ointment with a Mepilex dressing was documented as the treatment. This site was referred to in the electroinc charting as the coccyx			

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	site. On this date, documentation by the Wound Nurse, in the Electronic Record, under the Trauma section of the Skin Assessment, indicated the following: Site #1- Left third toe, was dry and crusted with drainage, the wound bed color was black and had a jagged wound edge. A normal sensation was documented under the pain section and Xeroform (a petrolatum gauze) dressing with Kerlix (gauze bandage) was documented as the treatment. No measurements provided. Site #2- Left hip abrasion, measured 1 cm in length by 1 cm in width, with serous (thin, clear, watery) drainage and a pink wound bed. Normal sensation was documented in the pain section and wound to be cleansed with tap water and apply Mepilex dressing. This site was referred to in the electronic charting as the right third toe. During an interview with the DON (Director of Nursing) on 2/2/2018 at 2:30 p.m., indicated Resident 104's wounds were present on admission when moved from the 4th floor to the TCU. She further indicated the pictures of the wounds had a measuring device laying beside them. The DON indicated the documentation should have been accurate regarding the location of the wounds. 4. A review of Resident 55's clinical record on 2/2/2018 at 11:20 a.m., indicated the resident was interviewable. Diagnoses included, but were not limited to hypertension. A review of the Immunization section of the Admission Assessment section had not been completed regarding if Resident 55 had accepted or declined the Influenza Vaccination. A current facility policy, The Vaccination of			

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	Residents, dated 8/22/2017, provided by the ED (Executive Director) on 2/2/2018 at 10:30 a.m., indicated the following: "...All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. 5. If vaccines are refused, the refusal shall be documented in the resident's medical record..." A current facility policy, Nursing Documentation Procedure, dated 3/2015, provided by the ED on 2/2/2018 at 11:25 a.m., indicated the following: "...I. The following is charted on the flow sheet or PCP by the nurse or nursing personnel: 5. Reasons why medication or treatment were not given..." 3.1-3(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable			

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	diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP			

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	and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure staff washed their hands for the appropriate amount of time during 1 of 1 observations of hand washing. This had the potential to affect 3 residents residing in the facility receiving repiratory treatments. Findings include: During an observation of a respiratory treatment on 1-31-2018 at 8:50 a.m., RT (Respiratory Therapist) 2 was observed to don gloves and provided the respiratory treatment and an inhaler treatment to a resident. Once the treatments were completed, the RT removed her gloves and was observed to wash her hands for less than 5 seconds. During an interview with the Administrator, DON (Director of Nursing) and Pharmacist 4 on 1-31-2018 at 10:50 a.m., the concern for the hand washing was shared. The Administrator indicated the RT staff should have washed her hands for at least 15 seconds. The Administrator asked if RT 2's handwashing was timed and it was indicated the handwashing has been timeed at less than 5 seconds.	F 0880	**I What corrective action(s) will be accomplished for those residents found to have been affected** **by the deficient practice;** 1.Resident # 205 – Hand Hygiene - The deficient practice was immediately addressed and corrected by the Administrative Director of Therapy Services on 01/31/2018 by educating the Respiratory Therapist that was caring for the resident affected by the deficiency. There was no negative patient outcome as a result of the deficient practice. No additional actions were required. **II. How other residents having**	03/04/2018

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	A current policy "Hand Hygiene" revised on 05/2012, was provided by the Administrator on 1-31-2018 at 11:33 a.m. The policy indicated "...All associates must consistently practice appropriate hand hygiene. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids hands should be washed with antimicrobial soap and water. In addition to traditional handwashing, alcohol-based waterless antiseptic hand rubs (foam or gel) should be used for routinely decontaminating hands in all other clinical situations...Procedure for hand washing: wet hands with warm running water...dispense antimicrobial soap onto wet hands...rub hands together vigorously for at least 15 seconds, covering all surfaces of hands and fingers...rinse hands with warm water...dry hands thoroughly with a disposable towel...turn off the water using a paper towel to protect your hands from recontamination from the knobs...." 3.1-18(l)		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** 1.The Respiratory staff that were caring for the three patients on 01/31/2018 were re-educated on the Hand Hygiene Policy by the Lead Respiratory Therapist. 2.Re-education of all Respiratory Therapists by the Administrative Director of Therapy Services and Lead Respiratory Therapist has begun for the Infection Control Policy and Procedures of Hand Hygiene (IC 190), Standard Precautions (IC 100), Multi Drug Resistant Organism Guidelines (IC 110), and Transmission Based Precautions (IC 105B). This will be completed by 02/26/2018. 3.All new hires will be educated by the Administrative Director of Therapy Services or designee during department orientation and all Respiratory staff will be reeducated annually regarding infection control policies 4.There was no negative patient outcome as a result of the deficient practice. No additional actions were required.	

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			III. What measures will be put into place or what systemic changes will be made to ensure that **the deficient practice does not recur;** - Starting 02/14/2018, Two random audits per day X 14 days (28 audits), followed by 2 random audits 3 times a week X 2 weeks (12 audits), eventually 5 weekly random audits for 8 weeks will be done by the Administrative Director of Therapy services or designee to ensure 100% compliance of Respiratory staff with Hand Hygiene. **IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** 1.The Administrative Director of Therapy Services or designee will address any deviations from the policy immediately with the	

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			concerned staff member. 2.The results of the audit will be shared with staff during Monthly Department Meeting. 3.The audit results will be reviewed during the Quarterly Quality Assurance Meeting. 4.This deficient practice will be added to the Quality Assurance Performance Improvement program as one of the Performance Improvement Initiatives for the 1st and 2nd quarter of 2018 **V. By what date the systemic changes will be completed.** Date Systemic Changes will be completed by March 4 2018	