STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	06/27/2014

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AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

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F000000	This visit was for a Recertification and State Licensure Survey. Survey Dates: June 23, 24,25,26 & 27, 2014 Facility number: 002657 Provider number: 155681 AIM number: 200308930 Survey team: Gwen Pumphrey RN,TC Trudy Lytle, RN Jennifer Sartell, RN Tammy Forthofer, RN Rita Bittner, RN Census bed type: SNF: 46 SNF/NF:41 Total: 87 Census payor type: Medicare: 22 Medicaid: 35 Other: 30 Total: 87 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F000000		

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

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	Quality Review completed on July 8, 2014, by Brenda Meredith, R.N.			
F000221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview and record review, the facility failed to attempt restraint reduction on 1 of 2 resident's reviewed for restraints. (Resident #131) Findings include: The clinical record for Resident #131 was reviewed on 6/26/14 at 10 a.m. Diagnoses included, but were not limited to, Anemia, Hypertension, Dementia and Anxiety disorder. During the initial tour on 6/23/14 at 9:35 a.m., Resident #131 was observed in the hallway of the special care unit. She was sitting in a wheelchair with a lap buddy (a device in a chair that the resident	F000221	Resident #131's restraint was reviewed and evaluated for a reduction on 7/16/2014 by the physical therapist. On 7/21/14 a 72 hour device reduction tracking log was initiated by nursing per the therapy recommendation. Resident has been reduced from a lap buddy to an alarming self releasing seat belt. Resident is able to release the seat belt easily. Resident continues on a restorative program for ambulation and active range of motion of bilateral lower extremities. Resident #131's MDS and plan of care have been updated and coded to reflect current status. 2. All eleven remaining residents with a restraint have had an individualized nursing re-assessment completed to address the need for	07/27/2014

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	cannot easily remove) and chair alarm attached to the chair. On 6/25/14 at 10 :25 a.m., Resident #131 was observed in an activity in the activity/living area on the special care unit. The lap buddy was in place. On 6/26/14 at 2:17 p.m., Resident #131 was observed in an activity in the activity/living area on the special care unit. The lap buddy was in place. On 6/25/14 at 2:20 p.m., the Dementia Care Unit Director indicated the diagnosis for the use of Resident #131's lap buddy was Alzheimer's. He also indicated it was more of a restraint and a restraint reduction had not been attempted. On 6/25/14 at 2:42 p.m., the Director of Health Services (DHS), indicated that the Interdisciplinary Team reviews restraints as a team to determine whether they are safe to remove. She indicated they do restraint reductions, but had not tried one for Resident #131 because she would fall. On 6/25/14 at 9:10 a.m., the Minimum Data Set (MDS) assessment Quarterly Review, dated 4/2/14, was reviewed. The MDS indicated no restraints were		the safety device and medical reason for use of the device. Based on the assessment results 8 of the 11 residents have had a restraint reduction and one is in the process of being reduced. The two remaining residents with a restraint have been determined to be inappropriate for restraint reduction at this time. One of the two residents has a non healing cervical neck fracture, and from a medical standpoint cannot have the lap tray removed due to risk of further major injury. This resident is mobile throughout the facility and continues on a restorative program for ambulation and AROM. The one remaining resident has a documented reduction failure on 6/11/14, and will be reevaluated quarterly and prn for any further possible reduction. The MDS and care plans of these residents have been updated to reflect current status. 3. All licensed nursing staff will be re-educated by the DHS or ADHS on the policy and procedure guidelines for physical restraint/enabler reduction. Included as part of the education was the risks of restraint utilization and a list of alternative interventions were provided to all staff, including therapy, to be implemented prior to initiation of a restraint. 4. The DHS/ADHS or LLD will conduct an audit for residents with restraints for 11 residents/week for 4 weeks	

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	used for this resident. Resident #131's clinical record was reviewed on 6/25/14, at 2:45 p.m. The document tilted, "First Conference Notes," dated 4/3/14, indicated the resident had a lap buddy to wheelchair for fall risk and no changes were made. Interview with DHS indicated this was the Quarterly Assessment. The Policy and Procedure titled Guidelines for Restraint/Enabler Use was provided by the DHS on 6/26/14 at 1:00 p.m. The purpose of the policy indicated, "To ensure completion of assessment and evaluation for appropriate and safe use of restraints." The policy also indicated, "...The interdisciplinary team shall investigate alternatives to restraints and determine that all alternative measures have been exhausted and found to be unsuccessful...If restraints are used there must be a systematic gradual restraint reduction program in place...." 3.1-26(r)		then 5 residents/week for 8 weeks to verify ongoing compliance with appropriate reductions. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.	

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F000272 SS=D	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. 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; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; 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			

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	Documentation of participation in assessment. Based on observation, interview and record review, facility failed to accurately assess residents with a restraint. This deficient practice affected 1 of 2 resident's reviewed for restraints. (Resident #131) Findings include: The clinical record for Resident #131 was reviewed on 6/26/14 at 10 a.m. She had diagnoses including, but not limited to, Anemia, Hypertension, Dementia and Anxiety disorder. During the initial tour on 6/23/14 at 9:35 a.m., Resident #131 was observed in the hallway of the special care unit. She was sitting in a wheelchair with a lap buddy (a device in a chair that the resident cannot easily remove) and chair alarm attached to the chair. On 6/25/14 at 10 :25 a.m., Resident #131 was observed in an activity in the activity/living area on the special care unit. The lap buddy was in place. On 6/26/14 at 2:17 p.m., Resident #131 was observed in an activity in the activity/living area on the special care unit. The lap buddy was in place.	F000272	1. Resident #131 MDS has been reviewed and revised by the MDS Coordinator to reflect accurate assessment information on 6/26/2014. 2. All residents with a restraint will be reviewed to ensure MDS assessment is coded accurately by the MDS team. 3. MDS coordinators were re-educated by Administrative Clinical MDS Clinical Support on accurate coding of residents with a restraint on 7/8/2014. 4. The DHS/ADHS will conduct an audit of MDS assessments for 10 residents per week for 4 weeks then 5 residents per week for 8 weeks to verify ongoing compliance. Results of these audits will be presented by the DHS to the QA committee for review and further recommendations to continue until the Quality Assurance team determines that substantial compliance has been achieved.	07/27/2014

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	On 6/25/14 at 2:20 p.m., the Dementia Care Unit Director indicated the diagnosis for the use of Resident #131's lap buddy was Alzheimer's. He also indicated it was more of a restraint. On 6/25/14 at 2:42 p.m., the Director of Health Services (DHS), she indicated that the Interdisciplinary Team reviews restraints as a team to determine whether they are safe to remove. She indicated they do restraint reductions, but had not tried one Resident #131 because she would fall. On 6/25/14 at 9:00 a.m., review of the Physical Restraint Information and Consent, dated 9/10/13, indicated restraint will be used to treat decreased safety awareness, impaired mobility and behavior issues. On 6/25/14 at 9:10 a.m., the Minimum Data Set (MDS) assessment Quarterly Review, dated 4/2/14, was reviewed. The MDS indicated no restraints were used for this resident. On 6/25/14 at 9:30 a.m., the Minimum Data Set (MDS) assessment, dated 9/17/13, indicated trunk restraint used in bed. There were no restraints listed for use in chair or out of bed.			

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	On 6/26/14 at 2:00 p.m., review of the careplan dated 6/4/14 indicated "I have a lap buddy restraint related to dx (diagnosis) of dementia w/ (with) dist (disturbance) of mood and behavior and decreased safety awareness and my attempts to get up unassisted r/t (related to) dementia." 3.1-31(d)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			

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	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to develop and update comprehensive care plans for residents. This deficient practice affected 1 of 5 residents reviewed for psychotropic medications, 1 of 3 residents reviewed for urinary catheters, and 1 of 2 residents reviewed for nutrition.(Resident #79, Resident #20, Resident #148). Findings include: 1. Resident #79's clinical record was reviewed on 6/25/13 at 10:05 a.m. She was admitted with diagnoses, including but not limited to, dementia, high blood pressure, and depressive disorder. The physicians orders was reviewed and indicated the following: -On 3/28/14 buspirone (an antidepressant medication) 10 milligrams by mouth three times a day -On 3/28/14 lexapro (an antidepressant	F000279	1. Resident's #79 and #20 comprehensive care plans have been reviewed and revised by the MDS staff to reflect an accurate and current plan of care on 7/8/2014. Correction cannot be completed on Resident #148 as this resident is no longer residing at our campus. 2. All residents receiving psychotropic medication, residents with an indwelling urinary catheter and significant weight loss have had the comprehensive care plans reviewed and revised as indicated by the MDS staff to reflect an accurate and thorough plan of care. 3. The MDS coordinators were re-educated by Administrative Clinical MDS Support on developing and updating comprehensive care plans as applicable on 7/8/2014. 4. The DHS/ADHS will conduct an audit of comprehensive care plans for 10 residents/week for 12 weeks to verify ongoing compliance. Results of these audits will be presented by the DHS to the QA committee for further recommendations and	07/27/2014

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	medication) 10 milligrams by mouth every day -On 3/28/14 trazodone (an antidepressant medication) 25 milligrams by mouth at bedtime depression/dementia -On 4/5/14 seroquel (an antipsychotic medication) 12.5 milligrams every morning and 25 milligrams by mouth at bedtime -On 4/27/14 seroquel 25 milligrams by mouth at bedtime and 12.5 milligrams by mouth twice a day -On 5/31/14 seroquel 25 milligrams by mouth every morning and at bedtime -On 5/31/14 seroquel 12.5 milligrams by mouth at 2:00 p.m. -On 6/15/14 discontinue trazodone 25 milligrams by mouth at bedtime The care plan, dated 6/6/14, was reviewed. The care plan lacked documentation of the need for psychotropic medications, the interventions, or the side effects of the medications. On 6/26/14 at 11:40 a.m., LPN #24 indicated Resident # 79 can get "antsy" and "will swat at you when providing care." On 6/26/14 at 2:30 p.m., the Director of Health Services (DHS) indicated the		continue until the Quality Assurance team determines substantial compliance has been achieved.	

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	MDS (assessment) Coordinator was responsible for updating the care plans. She indicated Resident #79's psychotropic medications should have been added to the care plan. 2. On 6/24/14 at 10:30 a.m., LPN#4 indicated Resident #20 had an indwelling Foley catheter for urinary retention. On 6/24/14 at 11:00 a.m., Resident #20 was observed in his room with a Foley catheter. Resident #20 indicated he had the catheter placed during a inpatient hospital stay in December 2013 and the catheter has not been removed. The resident indicated he needed to have the catheter but was unable to provide a reason why. The clinical record for Resident #20 was reviewed on 6/25/14 at 3:00 p.m. He had diagnoses, including but not limited to, dehydration, renal failure, high blood pressure and anemia. Review of the [named] hospital transfer documentation, dated 12/21/13, indicated the resident entered the facility with a Foley catheter. The care plan, dated 6/24/14, was reviewed. The care plan lacked documentation of the residents Foley catheter. 3. The Resident #148's clinical record			

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	was reviewed 6/26/14 at 2:30 p.m. Diagnoses included, but were not limited to, Obesity, Dementia, Hypertension and Diabetes. Resident #148 was admitted on 3/17/14 with an admission wt (weight) of 230 lbs (pounds). The Vital Signs and Weight Record indicated resident wt as follows: 4/6/14 at 217.8 lbs, 4/13/14 at 215 lbs, 4/20/14 at 213.6 lbs and 4/26/14 at 215.2 lbs. Resident #148 was discharged home on 4/29/14. During an interview on 6/26/14 at 11:58 a.m., LPN #19 indicated she remembered the resident was wanting to lose weight because his wife was going to have to take care of him when he discharged home. . During an interview on 6/26/14 at 11:59 a.m., the Director of Health Services (DHS) indicated she remembered the resident and he was wanting to lose weight. Review of the Clinically at Risk Individual Monitoring Sheet, on 6/26/14 at 2:40 p.m., indicated the admission wt on 3/17/14 was 230 lbs. On 4/6/14, wt was 217.8 lbs with intervention of weekly weights. On 4/15/14, no intervention for 4/13/14 wt of 215 lbs which indicated resident continues with weight instability. On 4/22/14, no			

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	intervention indicated for 4/20/14 wt of 213.6 lbs which indicated resident continues with wt instability. On 6/26/14 at 2:24 p.m., review of the Registered Dietician (RD) note, dated 3/24/14, indicated resident weight at 230 lbs and was on a regular, consistent carbohydrate diet with no added salt. Average % (percent) consumed of food served was 91.1%. Restrictions indicated zero (the number zero with line through it) desserts per resident request. On 6/26/14 at 3:00 p.m., the Minimum Data Set (MDS) assessment dated 3/24/14 indicated resident weight was 270 lbs. Vital Signs and Weight Record indicated resident wt as follows: 4/6/14 at 217.8 lbs, 4/13/14 at 215 lbs, 4/20/14 at 213.6 lbs and 4/26/14 at 215.2 lbs. Resident discharged home on 4/29/10. The meal consumption record for Resident #148 was reviewed 6/27/14 at 9:00 a.m. Between 3/31/14 through 4/29/14, the record indicated the average meal consumption's as follows: Breakfast 89.2%,Lunch 91%, and Dinner 93.8% On 6/27/14 at 9:10 a.m., review of the careplan, dated 3/24/14, indicated, "My weight is obtained monthly and prn (as needed). Please review my overall weight			

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	trends at least once monthly and make any necessary recommendations to my physician for approval should I experience any undesired weight change. My weight for my height is above normal. My weight should remain at a healthy range for me and be without any unwarranted significant change." A copy of the policy titled, "Guidelines for Care Plan Development," was provided by the DoN on 6/26/14 at 1:00 p.m. The policy indicated, " A care plan shall be developed no later than 21 days after admission, and no later than 7 days after the date in V0200B2 (care area assessment process completion date) ,addressing the resident preferences, MDS (minimum data set assessment) triggers, diagnoses, risk factors, and other applicable care needs....The care plan shall be updated as preferences and needs change...." 3.1-35(a)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed ensure physician orders	F000282	1. Resident #6 was reassessed by DHS on 7/17/2014 no adverse	07/27/2014

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	were adequately followed and failed to ensure the implementation of the care plan interventions for medication requiring blood pressure monitoring for 1 of 1 residents reviewed for intravenous therapy. (Resident #6) Findings include: 1. The clinical record for Resident #6 was reviewed on 06/26/14 at 10:10 a.m. A physician's order, dated 06/05/14, was written for placement of a midline (4 French single lumen catheter placed in the basilic vein, externally measuring 20 cm [centimeters] at the axillary junction of the left arm) to administer Merrem (antibiotic) 500 mg iv (intravenous) every 12 hours for 10 days. The midline was to be flushed with 5 cc (cubic centimeters) saline before and after antibiotic followed by 3 cc heparin (anticoagulant). A physician's order, dated 06/20/14 at 2:00 p.m., was written for removal of a midline. There was no documentation in the nurse's notes that indicated the removal of the midline. On 06/26/14 at 10:45 a.m., LPN # 4 indicated "registered nurses remove the midlines and it should have been		affects were identified and MD was notified of the lack of documentation of heart rate. Resident #6's heart rate is being obtained and documented per the physician orders on the MAR. Resident #6 midline's removal has been documented and is reflected in the nurse's notes. 2. The medication records of all residents requiring blood pressure and heart rate monitoring per physician orders, will be reviewed by DHS/ADHS to verify appropriate documentation. In addition, the plan of care for these residents will be reviewed and revised as indicated to verify physician's orders are accurately reflected in the plan of care. All residents receiving intravenous therapy will be reviewed by the DHS/ADHS to verify that physicians orders are being followed and documented accordingly. 3. All licensed staff will be re-educated by the DHS on the policy and procedure for following physician orders documentation. Emphasis will be placed on proper documentation of blood pressures and heart rate. QMA's will be re-educated on documentation guidelines per the physician orders. In addition, all licensed nurses will be re-educated on following physician's order for IV removal and proper documentation of the procedure. This will be conducted by the DHS. 4. The DHS/ADHS will conduct an audit	

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	documented." LPN # 4 searched and documentation was not found for removal of the midline. On 06/26/14 at 11:09 a.m., RN # 8 stated she removed the midline on 06/23/14 at 7:00 a.m. for Resident # 6 and forgot to document it. She stated the site was fine with no problems. She just forgot to document because it got busy. 6/27/2014 10:33 a.m., RN # 8 indicated the reason she waited to remove the midline was she didn't receive the order to remove the midline until 06/23/14. 2. On 6/27/14 at 9:00 a.m., record review of current MAR (Medication Administration Record) for Resident # 6 indicated to administer hydralazine 25 mg orally 3 times daily for hypertension. The resident also received digoxin 125 mcg orally on Monday, Wednesday and Friday at noon for atrial fibrillation and to hold for heart rate below 60. No documentation was noted on the MAR for blood pressure or heart rate. On 6/27/14 at 9:20 a.m., review of Resident # 6's care plan for vitals indicated, "I have HTN [hypertension]. Please help me to achieve and maintain normal heart rate 60-80 and blood		of residents requiring blood pressure monitoring and IV removal for 10 residents per week for 12 weeks. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.	

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	pressure 100/60-120/80. Monitor my vital signs at least weekly bp [blood pressure] and administer medication as ordered...." On 6/27/14 at 11:04 a.m., LPN # 7 indicated some of the blood pressures are on the MAR, but when she looked for the documentation she could not find it on the MAR. On 06/27/14 at 11:50 a.m. the DON (Director of Nursing) indicated if there is a weekly vital sign order, it would be documented on the MAR and it would be a care plan problem if it isn't. 3.1-35(g)(2)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as			

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	possible. Based on observation, interview, and record review the facility failed to ensure residents were properly assessed for Foley catheter use. This deficient practice affected 1 of 1 residents reviewed in a sample of 3 residents with catheters. (Resident #20) Findings include: On 6/24/14 at 10:30 a.m., LPN #4 indicated Resident #20 had an indwelling Foley catheter for urinary retention. On 6/24/14 at 11:00 a.m., Resident #20 was observed in his room with a Foley catheter. The clinical record was reviewed on 6/25/14 at 3:00 p.m. He had diagnoses, including but not limited, to dehydration, renal failure, high blood pressure and anemia. Review of the [named] hospital transfer documentation dated 12/21/13 indicated the resident entered the facility with a Foley catheter. The document titled, "Nursing Admission Assessment," dated 12/21/13, indicated the resident was always continent of bowel and bladder. The resident was transferred to the	F000315	1. Resident #20 was assessed by physician for removal of foley catheter. Physician felt it was in the best interest of the resident to be seen by an Urologist before attempted removal. Resident #20 will be seen by an Urologist on 7/24/2014. 2. All residents utilizing urinary catheters will be reviewed by the DHS. The physician's of the identified residents will be contacted to verify the resident's medical condition supports the use of a urinary catheter and the resident has the appropriate medical diagnosis. 3. All licensed nursing staff were re-educated by the DHS on properly assessing residents for indwelling catheter use and ensuring the resident's medical condition supports the use of the catheter. In addition, Administrative Clinical Support reviewed the federal regulation with the DHS on 7/8/2014 to include justification of use, reassessment and validation of ongoing need for the catheter and appropriate documentation of removal attempts and the results. 4. The DHS/ADHS will conduct an audit of residents with urinary catheters to verify ongoing compliance. Four residents per week for 12 weeks will be audited. Results of these audits will be presented by the DHS to the QA committee for further recommendations and will continue until the Quality	07/27/2014

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	hospital on 1/3/14, and returned to the facility on 2/5/14. The progress notes from [named] hospital indicated the resident had a Foley catheter during the hospitalization. The nursing admission assessment, dated 2/5/14, indicated the resident has Foley catheter. A physicians order for a 16 french Foley catheter was dated 2/5/14. The order indicated the catheter could be replaced as needed for dislodgement. Documentation was lacking of a diagnosis for the Foley catheter. A nurse's note, dated 5/7/14 at 11:30 p.m., indicated "Resident's catheter leaking and abdomen distended and painful. New 16-10F [size of catheter] cath inserted with immediate return of 600 cc [cubic centimeter]." A nurse's note, dated 5/23/14 at 10:00 a.m., indicated, "Cath [catheter] not draining- removed and reinserted 18 french with 10 cc balloon with some difficulty. very small amount return immediately;did pass a few clots will monitor." The clinical record lacked documentation of an assessment to determine bladder		Assurance that substantial compliance has been achieved.	

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	function or necessity of catheter. On 6/25/14 at 2:50 p.m., Resident #20 indicated, "The pain [with the catheter] is about the same, its uncomfortable but not to uncomfortable. They [nurses] changed it once but I forget what the reason was. I've had it [catheter] since December." On 6/26/14 at 10:37 a.m., Resident #20's Foley catheter was observed to be draining yellow sediment urine. LPN#4 was unable to determine the size of the catheter, and stated, "the lettering has wore off. It's either a 16 or a 18. I'm pretty sure it was a 18." On 6/25/14 at 9:50 a.m., CRCA #6 indicated Resident #20 has had a catheter since he's been at the facility. On 6/26/14 at 2:10 p.m., the Director of Nursing (DoN) indicated, " I know he has renal failure and weight fluctuations. I thought that he went to urology and they were monitoring it. I can have the physician write a statement that he wanted it in. On 6/26/14 at 2:10 p.m., the Assistant Director of Nursing (ADON) indicated, "I thought that was monitored by the doctor."			

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	On 6/26/14 at 3:30 p.m., the Director of Nursing (DoN) provided a physician order, dated 6/26/14, stating, "leave Foley catheter in place due to urinary retention and chronic renal failure." A copy of a policy related to bladder assessments was requested on 6/26/14 at 2:10 p.m. and 6/27/14 at 10:34 a.m. The policy was not provided by the facility. 3.1-41(a)(2)			
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, facility failed to properly assess and monitor residents for weight loss. This deficient practice affected 1 of 2 residents	F000325	1. Resident #108 was discharged home on 6-20-2014. 2. All residents weights will be reviewed to verify that any weight losses have been identified and	07/27/2014

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	reviewed for nutrition. (Resident #108) Findings include: Resident #108's record was reviewed on 6/26/14 at 3:00 p.m. Diagnoses included, but were not limited to, Dementia and Hypertension. Resident was on an implanted morphine pump for back pain. The Facility Vital and Weight Record indicated the resident was admitted on 5/20/14 with a weight of 170 lbs (pounds). On 6/1/14, weight was recorded 3 times as followed: 159.8 lbs, 160 lbs, and 160.2 lbs. No further weights were recorded for this resident. The Registered Dietician (RD) note, dated 5/27/14, indicated resident's weight was 170.2. Diet was regular with thin liquids. The Average consumed food served was 90.7% (percent). The Minimum Data Set (MDS) assessment, dated 5/27/14, indicated the resident's weight was 170 lbs. The Facility Vital and Weight Record indicated the resident was admitted on 5/20/14 with a weight of 170 lbs (pounds). On 6/1/14, weight was recorded 3 times as followed: 159.8 lbs, 160 lbs, and 160.2 lbs. No further weights were recorded for this resident.		appropriate interventions are in place. 3. All resident weight's will be reviewed at a minimum monthly and or weekly if indicated by the DHS. Any residents with identified weight loss will be reviewed by the IDT at the Clinically at Risk meeting and interventions implemented as indicated. All licensed nursing staff will be re-educated by the DHS on proper monitoring and interventions of residents with weight loss. 4. The DHS/ADHS will conduct an audit of residents with significant weight loss to verify ongoing compliance. Ten residents per week for 4 weeks then 5 residents per week for 8 weeks will be audited. The Registered Dietician will continue to review weight loss weekly to maintain compliance. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines that substantial compliance has been achieved.	

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	The clinical record indicated Resident #108 was sent to the ER (Emergency Room), on 6/2/14, with change in mental status. Resident returned to the facility on the same day where she remained in the facility until discharge on 6/20/14. Vital sign records and interview with the DHS (Director of Health Services) indicated there were no other weights or assessments of the residents dietary status . The meal record indicated average consumption between 5/20/14 and 6/20/14 was, breakfast at 75.8%, Lunch at 79.8%, and Dinner at 85%. Between 5/29 and 6/3/14, average consumption fluctuated. On 5/29/14, meal intake for breakfast was 10%, no lunch was recorded, and 75% for dinner. On 6/3/14 breakfast consumption was 30% and 50% for dinner. No lunch was recorded. Intake began going up to above 60% between 6/4/14 and 6/5/14. Between 6/5/14 through 6/20/14, meal intake averaged 80%. The careplan, dated 5/27/14, indicated, "My weight is obtained monthly and as needed. My weight for my height is above normal. Please review my overall weight trends at least once monthly and make any necessary recommendations to my physician for approval should I experience any undesired weight			

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	changes. My weight should remain at a healthy range for me and be without any unwarranted significant weight change." On 6/26/14 at 3:30 p.m., the Director of Health Services indicated she could not find anything in the chart on the resident's weight. 3.1-46(a)(1)			

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F000329 SS=D	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 consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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			

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	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. Based on observation, interview and record review, the facility failed to ensure medications were administered with adequate indications for use. This deficient practice affected 1 of 5 residents receiving a antianxiety medication for an acute pain episode. (Resident #6) Findings include: On 06/24/14 at 4:00 p.m., Resident # 6 was observed to be sitting in the activity area watching television. The resident asked LPN# 19 for her lunch. LPN#19 explained to the resident she had lunch and tried to redirect the resident to the movie on the television. On 06/25/14 at 8:43 a.m., Resident # 6 was observed sitting in the activity room asleep. The Activity Director # 23 and CRCA (Certified Resident Care Assistant) # 20 awakened the resident to eat breakfast. The resident awakened when she saw her breakfast tray. On 06/25/14 at 11:53 a.m., Resident # 6 was observed sitting in activity room	F000329	1. Resident #6 medications have been reviewed and resident is receiving antianxiety medication with adequate indications for use. 2. All residents receiving as needed antianxiety medications will be reviewed to verify that the medication is being administered and documented according to the indication for its use. 3. All licensed nurses and QMA's will be re-educated by the DHS on ensuring medications are administered in accordance with its specific indications for use and proper documentation of the identified need for its use in the residents medical record. 4. The DHS/ADHS will conduct an audit of residents receiving antianxiety medications to verify that antianxiety medications are being given appropriately. Ten residents per week for four weeks then five residents per week for eight weeks will be audited. The Pharmacy consultant will continue to review antianxiety medications monthly to maintain compliance. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines that substantial	07/27/2014

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	asleep. At 11:59 LPN # 8 awakened the resident and obtained a blood sugar reading. On 06/25/14 at 2:12 p.m., Resident # 6 was observed to be sitting in activity area chewing gum and alert to visitors walking by her. On 06/26/14 at 8:30 a.m., Resident # 6 was observed to be laying in bed awake. She had refused to get up to breakfast. The clinical record for Resident # 6 was reviewed on 06/26/14 at 10:00 a.m. The quarterly MDS for 06/12/14 indicated the cognition of Resident # 6 had a BIMS (Brief Interview of Mental Status) of 10 (Moderately Impaired). The resident had no delirium behavior present. Her total mood severity score was 000 (no symptoms present). Her behavior was marked as not existent. Resident # 6's diagnoses included, but were not limited to, dementia and occasional pain. Resident # 6's MAR (Medication Administration Record) indicated the resident has Tramadol HCL 50 mg (milligrams) PO (by mouth) twice daily for pain and Hydrocodone-APAP 5/325 mg PO every 6 hours PRN (as needed) for pain. Ativan 1 mg PO (orally) every		compliance has been achieved.	

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	6 hours as needed for anxiety was noted to be handwritten on MAR. Review of Resident # 6's PRN (as needed) MEDICATION TRACKING sheet indicated the resident received Ativan 1 mg on 06/25/14 at 10:30 p.m. with a pain location of the right shoulder. The pain scale was marked as a zero, with interventions of on on one time, reassurance and positioning for comfort. The effectiveness was marked as effective with a follow up pain rating of zero. Recent pain medication of Norco 5/325 mg was indicated as given on 06/15/14 at 8:00 p.m. with a pain rating of 7 and a follow up rating of zero and noted as effective. Norco 5/325 mg was again given on 06/24/14 at 7:00 p.m. with a pain rating of 6 and a follow up rating of zero and noted as effective. Interventions noted on these dates were bed rest, one on one time, reassurance and positioning for comfort. The BEHAVIOR MONITORING RECORD for Resident #6 had intervention suggestions circled for one on one time, engage in activities, offer food, positional changes, re-direction, removal of the source of agitation, toileting and validation of feelings, but were not noted as performed.			

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	During an interview on 06/26/14 at 10:45 a.m., LPN # 4 indicated "The Ativan for anxiety was ordered on the 25th [6/25/14]. The resident does her own intervention by lowering her head and ignoring staff." During an interview on 06/27/14 at 11:50 a.m., the DON (Director of Nursing) indicated "Ativan is given instead of pain medication if Resident # 6 showed behavioral issues. I would not recommend pain medication for an anxiety episode. The circumstance note stated the resident was having an anxiety issue. Should we have asked for whether she was having pain? The nurse did not note on the circumstance the admission of pain by the resident. Yes, she did check the pain box on the circumstance. The DON was not able to find the notation on the monitoring behavioral sheet." 3.1-48(a)(6)			
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or			

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	considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to serve food in a sanitary manner during 2 of 2 dining observations. This deficient practice had the potential to affect 93 residents currently in the facility. (Resident #177, Resident #89, Resident #55, Resident #43, Resident #61, Resident #72, Resident #81 and Resident #124). Findings include 1. On 6/23/14 at 9:15 a.m. during the initial kitchen tour, 2 fans were observed to be running on high speed with clumps of dust blowing back and forth. Both fans had the potential to release dust particles into food being prepared and served. 2. On 6/26/14 at 11:30 a.m., Food Service Aide #16 was observed serving food with chipped finger nail polish and wearing hoop earrings. 3. During an observation of the Main Dining Room on 6/23/14 at 12:14 p.m. the Activities Director (Life Enrichment Director), without washing her hands, patted Resident #89 on the back, adjusted the window blinds, served a drink to Resident #55, followed by hand gel use.	F000371	1. & 2. The two fans located in the kitchen were cleaned by the Assistant Director of Food Services on 6/25/2014. The food service aide no longer is wearing hoop earrings and finger nail polish. 3. All employees will be re-educated on the Guidelines for proper hand washing to include serving food in a sanitary manner while using proper handwashing techniques. Dining service staff will be re-educated on proper cleaning of fans and proper dress code by the Director of Dining Services. 4. The ED/Director of Food Service will audit the cleaning schedule of the fans 5x per week for 4 weeks then 3x per week for 8 weeks to verify the cleaning schedule is followed. Also, food service staff dress code and staff handwashing will be observed while serving food 5x per week for 4 weeks then 3x per week for 8 weeks. Results of these audits will be presented by the ED and the Director of Food Services to the QA committee for further recommendations and continue until the Quality Assurance team determines that substantial compliance has been achieved.	07/27/2014

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	Later in the dining observation, the Activities Director washed her hands for less than 10 seconds, picked up a napkin off the floor, put it with the dirty dishes, then assists a resident with their wheelchair. 4. During an observation of the Main Dining Room on 6/25/14 at 11:48 a.m., the Activities Director provided a glass of chocolate milk for Resident #43, patted him on the back, picked up a glass from another table, and filled it with milk for Resident #61. She proceeded to provide a drink for Resident #95, donned an apron, and provided a drink to Resident # 93, then used hand sanitizer. During an interview with the Activities Director, on 6/26/14 at 9:42 a.m., she indicated the policy and procedure for hand washing included washing hands after touching a resident, after touching dirty dishes, or touching yourself. Hand sanitizer use is acceptable for 2 washings followed by washing with soap and water for 20 seconds. 5. During an observation of the Restorative Dinning Room on 6/23/14 at 12:35., the Director of Health Services (DHS) was observed not washing hands after touching resident #124 and the charting screen on the wall, in the dinning area. DHS continued without			

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	washing her hands and went to the supply counter picking up several straws. The DHS opened one straw and placed the straw in the glass of Resident #72. The DHS touched Resident #72 on the right shoulder and offered her a drink from the straw. The DHS handed the remaining straws to Certified Residential Medication Aide (CRMA) #5. 6. During an observation of the Restorative Dinning Room on 6/25/14 at 12:27., LPN #4 picked up the roll for Resident #177 and buttered the roll with her bear hands. After buttering the roll LPN #4 gave a piece of the roll to Resident #177. Certified Residential Medication Aide (CRMA) #5 picked up a roll with her bare hands and buttered the roll for Resident #124. Dinning Assistant #6 came into the Restorative Dinning Room and sat down at a third table. Dinning Assistant #6 picked up the roll off of Resident #81's plate and buttered the roll with his bear hands. The "Guidelines for Handwashing" provided by the Director of Health Services (DHS) on 6/26/14 at 1:00 p.m. indicated under item number 8. " Wash well for 20 seconds (ABC or Happy Birthday song.), using a rotary motion." Under item number 12., "Waterless hand cleaning products such as alcohol based			

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	gels, foams, rinses provide an acceptable alternative to handwashing in certain instances. Wash hands with soap and water after 4-5 uses of the waterless product." Under item number 13., "The waterless product is also not an adequate substitute for handwashing in a food service area." The Dietary Hair Restraint Policy and Procedures was provided by the Director of Health Services, on 6/26/14 at 1:00 p.m. The policy indicated,"Dining Service employees must keep their fingernails trimmed and maintained so the edges and surfaces are cleanable and not rough. No nail polish or artificial nails are allowed. While preparing food, food employees may only wear a wedding band on hand; Non dangling earrings are acceptable...." 3.1-21(i)(2)			
F000441 SS=F	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. (a) Infection Control Program The facility must establish an Infection Control Program under which it -			

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	(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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to follow infection control practices related to hand washing technique, glove use, and wound care. This deficient practice affected, 2 of 3 wound care observations, 1 of 3 personal care, and 1 of 1 transfers. (Resident #117, Resident #30, Resident #149, and Resident #6). Findings include:	F000441	1. Resident #117 supra pubic catheter infection has been re-assessed by the licensed nurse and the area continues to improve without any other signs of infection. Resident #30 could not be addressed as resident is no longer in the campus. Resident #149 was reassessed by the licensed nurse and showed no signs or symptoms of infection. Resident #6 was reassessed by the licensed nurse and has shown no signs or symptoms of UTI. 2. 3. All staff	07/27/2014

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	1. During an observation on 6/25/14 at 10:15 a.m., LPN #14 provided supra pubic catheter care for Resident #117 with a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) who was under contact precautions. She washed her hands for less than 8 seconds then touched the door to the bathroom and a cabinet with supplies in it. She then donned a gown, closed the drapes, tied the gown, donned gloves, touched the bed controls, moved the table, and pulled the resident's pants and disposable brief down to expose the site. She cleaned the catheter tubing with wipes, opened the tube of ointment (Silvasorb Antibiotic ointment), applied it to a swab, opened the dry dressing (split gauze sponge), and applied the ointment, followed by the gauze around catheter tube at the skin's surface. She reached around to her back pocket, found she did not have a marker to date the dressing, but said she would get one. She removed her gown and gloves, place them in the trash can, bagged the trash, replace the can liner, stuck the resident's ointment in her pocket that had her cell phone sticking out of it, and exited the room with the bag in her hand. She walked down the hall to the soiled utility room, opened the door, disposed of the bag, washed her hands, and exited the room. She went into the med room and placed		will be re-educated on the facility infection control policy and procedure to include proper hand washing technique, glove use and wound care by DHS. 4. The DHS/ADHS will audit handwashing, glove use and wound care while performing resident care 10x per week for 4 weeks then 5x per week for 8 weeks. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines that substantial compliance has been achieved.	

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	the ointment in the top drawer of the treatment cart with other ointments for other residents. During an interview with LPN #14 on 6/27/14 at 11:41 a.m., she indicated the procedure for handwashing was to wash hands upon entering a resident's room and when leaving the room, also before and after resident care. She indicated one should wash long enough to sing the ABC song. 2. During an observation, on 6/25/14 at 10:33 a.m., LPN #7 went into Resident #30's bathroom to gathered paper towels and laid the paper towels on the Resident #30's bed side table. LPN #7 preceded to place the Q-tips on the edge of gauze package of 4 by 4 gauze pads with the same gloves which were touching the door and resident's bed rails. Then LPN #7 pulled the resident's bedding, moving the resident on her side. LPN #7 continued to remove the prior pressure ulcer dressing without changing gloves. During an observation, on 6/25/14 at 10:48 a.m., LPN #7 had a scissors and took it out of her pocket and placed the scissors on a table without being cleaned. This scissors was borrowed from a co-work RN #8. RN #8 pulled the scissors out of her pocket without cleaning prior to giving them to LPN # 7.			

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	LPN #7 walked into the Resident #30's room without cleaning the scissors. LPN #7 used the scissors to cut a new dressing to be placed on the Resident # 30's pressure ulcer. Next LPN #7 used the same scissors to cut a second dressing. LPN #7 continued to use the scissors without washing or wiping off to cut the sponge to be placed in the pressure ulcer for the wound vac. LPN #7 picked us a Q-tip by touching the sponge top area with the same gloves and pushed the sponge into the opening of the pressure ulcer. The sponge fell out so the LPN # 7 cut another piece with same scissor without wiping or cleaning the scissors. LPN #7 used the Q-tip to push the second sponge into the pressure ulcer with touching the sponge tip with her gloved hand. The sponge continued to fall out onto the resident #30's bedding. LPN #7 used her finger tip with the same gloves and preceded to push the sponge and dressing into the open pressure ulcer. The finger tip of LPN #7 went into the wound bed up to the cuticle area of her pointer finger. LPN #7 then used the same scissors to scrap off the paper tape covering with the edge of the wound vac connector disc. LPN #7 was rubbing the scissors against the resident's bear skin with the non-sharp edge of the scissors. After attaching the vac, LPN #7 adjusted the settings on the wound vac without			

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	changing her gloves. Next LPN #7 changed her gloves and when back to the meter controls to readjust the settings without wiping the controls of the meter off. After LPN #7 readjusting the settings with the same gloves, LPN #7 went back to the dressing and started working with the edges to get a good seal. After the wound care was completed LPN #7 picked up the scissors and a pen light without wiping the equipment off and placed them in her pocket. During an observation on 6/25/14 at 10:33 a.m. to 11:20 a.m., LPN #7 performed a wound care procedure on Resident #30. LPN #7 washed her hands multiple times: one for 10 sec, second time for 7 sec, third time for 8 sec and forth time for 12 sec. The fifth time observed LPN #7 stopped the process and walked into the bathroom of the resident to blow her nose. After blowing her nose LPN #7 washed her hands for 5 seconds and continued with the wound care. 3. On 06/25/14 at 9:47 a.m. Resident # 149 was observed receiving care from CRCA (Certified Resident Care Assistant) # 20 who closed the door and performed handwashing for 6 seconds. She turned off the water then dried her hands with paper towels. She filled the tub with warm water and applied gloves,			

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	while communicating with the resident. CRCA # 20 removed her gloves and left the room. CRCA # 18 entered the room, closed the door, washed her hands, then left the room. CRCA # 18 returned to the room and applied gloves without handwashing. CRCA # 20 returned to the room with supplies. The bed was raised and the CRCA's gathered and opened trash bags. The CRCA's explained to the resident they were going to give her a bed bath. The bed was raised while wearing their gloves. The head of her bed was lowered to a flat position. The left bed rail was lowered and a hair tub was placed under the head of the resident. The CRCA's applied new gloves. A plastic glass was used to apply water to the residents hair. A wash cloth was placed on the resident's forehead while water and shampoo were applied. The right bed rail was lowered by CRCA # 18. The resident was asked if she was okay. New gloves were applied without handwashing and the residents hair was rinsed. A towel was applied to the back of her hair and the tub was removed from the bed. Her hair was dried and brushed. The water was emptied and fresh water was obtained. Fresh gloves were applied by both CRCA's without handwashing. CRCA # 20 asked the sitter her preference on which gown to place on the resident. The fleece heel protectors were			

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	removed and a blanket was draped over the resident to remove the gown. A tub of fresh water was obtained for rinsing, and no handwashing was observed. The CRCA # 18 soaped up a washcloth and started washing the resident. A dressing from a radiation wound was noted on the resident's right abdomen. The CRCA's observed 2 new 3/4 inch reddened circular areas new the dressing. The sitter left the room to let the RN # 8 know about the areas. New gloves were applied by the CRCA's and the resident was dried. The upper body was covered with a blanket. The lower body was washed by CRCA # 20, while CRCA # 18 applied deodorant. The LPN # 8 came in to check the dressing and red areas. Fresh water was obtained and the legs were rinsed and dried. Lotion was applied to the legs and arms. The CRCA # 18 washed her hands using the same 5 second count, turning off the water with wet hands, then drying with paper towels. The LPN # 19 applied gloves and looked at the red areas with RN # 8. She then washed her hands turning off the water with wet hands and dried them with paper towels. The CRCA's washed their hands in the same manner as before then applied clean gloves. The brief was removed, the resident's back and buttocks were washed. A clean wash cloth was used to rinse her. She was dried and the			

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	bedding was removed. A new brief and pad were placed under the resident and skin repair cream was applied to the buttocks and the back. The resident was rolled to her left side and clean sheets were applied. The resident had a watery bowel movement. The brief was removed and the resident was cleaned again in the same manner with no handwashing. The CRCA's applied new gloves and the resident was rinsed and dried. The CRCA's clothes and tags were touching the resident during the application of the clean brief. CRCA # 20 obtained a new brief because a spot of bowel was on the new brief. Lotion was again applied to the buttocks and groin area and the new brief was fastened. The clean gown was applied. A new 2 inch reddened area was noted on the resident's right upper, outer calf/near knee. The pillows which had been placed on the floor were cased and placed under the resident's head and knees. The fleece heel protectors were replaced. Fresh water was obtained, new gloves were applied and the face was washed. The air conditioner was turned back on and a sheet was re-applied on top of the resident. The CRCA's washed their hands and the water was turned off with wet hands before drying their hands. 4. On 06/26/14 at 9:45 a.m., CRCA # 22 and CRCA# 18 were observed			

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	transferring Resident # 6 into the wheelchair. They already had gloves on. They handed the catheter back and forth between each other, but it was kept below the resident's bladder and they transferred the resident into the chair. The back of the resident's pants was observed to be wet. The CRCA's did not observe the resident to be wet. The catheter was fastened to the wheelchair and inserted into the bag. Both CRCA's did 5 second hand washing, turned off the water with wet hands and dried their hands with paper towels. During an interview, on 06/26/14 at 9:55 a.m., CRCA # 22 quoted the procedure for proper hand washing correctly. During an interview, on 06/26/14 at 11:02 a.m., CRCA # 18 indicated "you turn the sink on with a paper towel, turn on the warm water, lather for 30 seconds or more getting the bed of nails. Rinse your hands and turn the water off with a paper towel." The facility's policy for handwashing procedure was provided by the Director of Nursing on 06/26/14 at 1:00 p.m. "The GUIDELINES FOR HANDWASHING states the purpose of handwashing is the single most important factor in preventing transmission of			

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	infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF (Long Term Care Facilities). Implementation of PROPER handwashing practices has interrupted outbreaks in many settings." Number 8 of the procedure indicated to "Wash well for 20 seconds (ABC or Happy Birthday song), using a rotary motion and friction." Number 9 indicated "Rinse hands well under running water, allowing water to flush from wrist to fingertips." Number 10 indicated "Dry hands with paper towels." Number 11 indicated "Turn off faucet with a dry towel to avoid recontaminating hands from the faucet." Record Review of the "General Wound and Skin Care Guidelines," provided by the DoN on 6/26/14 at 1:00 p.m., listed under item number 1. "Wash hands before and after resident contact. Observe standard precautions." Record Review of the "Guidelines Standard Precautions," provided by the DoN on 6/26/14 at 1:00 p.m., indicated under the sub-title "c. Gloves and Hand washing. Clean, non-sterile gloves should be worn when entering the room. Gloves should be changed after having contact with infective material that may contain high concentrations of			

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	155681	A. BUILDING 00 B. WING	06/27/2014

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	microorganisms (fecal material, wound drainage.) Remove and discard gloves within the room and wash hands immediately. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room." 3.1-18(l)			
F009999	3.1-18 INFECTION CONTROL PROGRAM (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. This state rule was not met as evidenced by: Based on observation and record review the facility failed to ensure infection control practices were followed related to tuberculin skin tests. This deficient practice 2 of 5 residents reviewed for immunizations. (Resident #6 and	F009999	1. Resident #6 and #20 have received a tuberculin skin test and normal results documented. 2. All resident's tuberculin skin tests will be audited to verify they are up to date and documented correctly. 3. All licensed nursing staff will be re-educated on the policy for administration on tuberculin skin testing requirements for giving and documenting tuberculin skin tests. 4. The DHS/ADHS will conduct an audit of resident's tuberculin skin tests to verify ongoing compliance with tuberculin skin testing. Ten residents per week for 4 weeks then 5 residents per week for 8 weeks will be audited. Results of these audits will be presented by the DHS to the QA committee for further recommendations and continue until the Quality Assurance team determines substantial compliance has been achieved.	07/27/2014

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	Resident #20). Findings include: 1. On 6/26/14 at 11:23 a.m., Resident #6's clinical record was reviewed. Review of the document titled, "Immunization Record" indicated the resident received an injection on 4/17/14. Documentation was lacking as to when the test was read. 2. On 6/26/14 at 1:00 p.m., Resident #20's clinical record was reviewed. He was admitted to the facility on 12/21/13. The document titled, "Immunization Record" was reviewed. He received a TB skin test on 1/9/14 and was read on 1/11/14. Documentation was lacking that he received a TB skin test on admission to the facility. On 6/27/14 at 10:34 p.m., the DHS indicated TB skin tests are monitored by the pharmacy. She indicated the physician order is faxed to pharmacy and added to the MAR. She indicated the nurses are responsible for administering the TB skin tests. She also indicated, she was not aware of any issues with residents not receiving their TB skin tests. 3.1-18(e)			

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