| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155029 | A. BUILDING 00<br>B. WING | 04/02/2019 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: March 26, 27, 28, April 1 and 2, 2019.<br><br>Facility number: 000012<br>Provider number: 155029<br>AIM number: 100274900<br><br>Census Bed Type:<br>SNF/NF: 80<br>SNF: 0<br>Total: 80<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 67<br>Other: 4<br>Total: 80<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on April 10, 2019 | F 0000 | Community Nursing and Rehab humbly request paper compliance for cited deficiencies. | |
| F 0558<br>SS=D<br>Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>Based on observation, interview, and record review, the facility failed to ensure a call light was in reach for 1 of 2 residents reviewed for call lights. | F 0558 | **What corrective action(s) will be accomplished for those residents found to have been** | 05/01/2019 |

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

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| | (Resident 55)<br><br>Findings include:<br><br>The clinical record for Resident 55 was reviewed on 3/27/19 at 10:00 a.m. The diagnosis for Resident 55 included, but was not limited to, contracture's of muscle.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 2/22/2019, indicated Resident 55 had impairments on upper extremities.<br><br>An observation was made of Resident 55 on 3/26/19 at 10:46 a.m. Resident 55 was in bed and his call light cord was attached to the wall mount on the wall next to the bed. The cord dangled down the length of wall and disappeared under the bed. There was no observation of a call light button in reach to Resident 55.<br><br>An observation was made of Resident 55 on 3/27/19 at 10:21 a.m. Resident was in bed and his call light cord was observed dangled down the length of the wall. There was no observation of call light button in reach to Resident 55.<br><br>An observation was made of Resident 55 with Registered Nurse (RN) 5 on 4/2/19 at 12:36 p.m. Resident 55 was observed awake and in bed. The call light was attached to a wall mount and dangled down the length of the wall. There was no observation of call light button in reach to Resident 55. RN 5 grabbed the call light cord from the wall and indicated at that time she was unable to pull the cord, because she had noticed the cord was tied to the left side rail of the bed. She then went on the other side of the bed and was able to locate Resident 55's call light button after digging under his pillow. Resident 55 reached over to the left bed rail using his right hand and was unable to reach the call | | **affected by the deficient practice?**<br><br>· Resident #55 call light in reach with touch-pad call light and call-light cord clipped to bedframe.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>· An audit of all call lights have been completed using the Call-Light Audit Tool to ensure they are within reach and have a clip attached to the cord; if the resident prefers elsewhere a care plan will be initiated<br><br>· The DNS/designee will in-service the IDT and nursing staff to ensure call-lights are in reach.<br><br>· The DNS/Designee will conduct daily rounds to ensure all call lights are within reach using the Nurse Rounds Tool by May 1, 2019.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br><br>· An audit of all call lights have been completed to ensure they are within reach and have a clip attached to the cord; if the resident | |

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| | light. There was no observation of Resident 55 moving his left arm.<br><br>An interview was conducted with the Clinical Education Coordinator in Resident 55's room on 4/2/19 at 12:45 p.m. She indicated she had educated staff to tie the call light on the rail, because Resident 55 would knock it on the floor.<br><br>An interview was conducted with Occupational Therapist 4 on 4/2/19 at 1:07 p.m. She indicated Resident 55's contracture on his upper extremity was located on his left hand.<br><br>3.1-3(v)(1) | | prefers elsewhere a care plan will be initiated.<br><br>· The DNS/designee will in-service the IDT and nursing staff to ensure call-lights are in reach.<br><br>· The DNS/Designee will conduct daily rounds to ensure all call lights are within reach using the Nurse Rounds Tool by May 1, 2019.<br><br>**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?**<br>·Nurse Audit Tool will be utilized weekly x 4 weeks, monthly x 2 months, with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |
| F 0561 SS=D Bldg. 00 | 483.10(f)(1)-(3)(8)<br>Self-Determination<br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. | | | |

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| | §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>Based on interview and record review, the facility failed to honor a resident's preference, regarding her bathing frequency, for 1 of 2 residents reviewed for choices. (Resident 12)<br><br>Findings include:<br><br>The clinical record for Resident 12 was reviewed on 3/26/19 at 2:00 p.m. The diagnoses for Resident 12 included, but were not limited to: hypertension, diabetes, and obesity.<br><br>The 12/26/18 Quarterly MDS (Minimum Data Set) assessment indicated Resident 12 had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. It indicated she required physical help in part of bathing, and the support provided for bathing was one person physical assistance. | F 0561 | **F-561 Self- Determination**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident #12 shower preference and care plan updated<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>· All residents have the potential to be affected by deficient practice.<br>· All resident shower preferences will be reviewed and updated using the Preference for | 05/01/2019 |

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| | An interview was conducted with Resident 12 on 3/26/19 at 2:26 p.m. She indicated she would like to take a shower every other day, but only received one on Saturdays. She indicated the facility previously set up a schedule for her to take showers every other day, but it was never followed.<br><br>The 12/26/18 Preferences for Customary Routine and Activities assessment for Resident 12 indicated it was very important for her choose between a tub bath, shower, and bed bath. It indicated she preferred to bathe more than twice per week after 12:00 p.m.<br><br>The shower schedule provided by the Administrator on 3/28/19 at 11:57 a.m. indicated Resident 12 was scheduled for showers on Wednesdays and Saturdays only.<br><br>The resident profile provided by the Administrator on 3/28/19 at 11:57 a.m. indicated she preferred to shower herself twice weekly in the mornings.<br><br>The February, 2019 and March, 2019 Shower Reports were provided by Unit Manager 4 on 3/28/19 at 9:57 a.m. UM 4 indicated these reports were the only verification of showers for Resident 12. The reports indicated Resident 12 refused showers and provided care for herself on the following days: 3/27/19, 3/20/19, 3/6/19, 2/27/19, 2/20/19, 2/13/19, and 2/6/19. The 3/13/19 shower report indicated Resident 12 refused the shower, and a complete bed bath was completed, and Resident 12 provided care for herself.<br><br>The March, 2019 Point of Care bathing logs indicated Resident 12 had showers on 3/9/19 and 3/23/19.<br><br>An interview was conducted with Resident 12 on 3/28/19 at 11:00 a.m. She indicated she needed | | Daily Customary Routines by May 1, 2019<br>· Nursing staff will be in-serviced by the DNS or designee on honoring resident Preference for Daily Customary Routines tool by May 1, 2019.<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>· Staff will be in-serviced by the DNS or designee on honoring resident shower preferences<br>· All resident shower preferences will be reviewed and updated per Preference for Daily Customary Routines audit tool by May 1, 2019.f<br>· Director of Nursing or designee will conduct rounds on all shifts to ensure that staff are showered per preferences by using Nursing Rounding Tool.<br>**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?**<br>·Nursing Rounding QA tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter for with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |

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| | assistance to get to the shower room down the hall and for someone to stay with her, in case she fell. She washed her body herself.<br>She indicated she did not refuse showers, but preferred a particular staff member to assist her with showers. She indicated she was supposed to receive a shower the previous day (Wednesday, 3/27/19), but no one came to assist her. Resident 12 indicated she thought it was in December, 2018 that nursing set up a plan for her to have showers every other day, but never followed through with the plan.<br><br>An interview was conducted with CNA (Certified Nursing Assistant) 5 on 3/28/19 at 11:12 a.m. She indicated Resident 12 could wash her body herself. Nursing just needed to take her to the shower room and stay with her in case she fell.<br><br>The Preferences for Daily Routine policy was provided by the Administrator on 3/28/19 at 12:18 p.m. It read, "The Preferences for Daily Customary Routines is a tool that can be used to gather information about a resident and incorporate this into the interdisciplinary plan of care....The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences."<br><br>3.1-3(u) | | | |
| F 0578 SS=A Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or | | | |

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| | medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>Based on observation, interview and record review the facility failed to assure the accuracy of a POST (Physicians Orders for Scope of Treatment) Form for 1 of 22 residents reviewed (Resident 7).<br><br>Findings include:<br><br>The clinical record for Resident 7 was reviewed on 3/27/2019 at 11:10 a.m. The diagnosis for Resident 7 included, but were not limited to, personal history | F 0578 | No plan of correction needed for this Level I NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM was found. no remedies necessary from facility. | 05/01/2019 |

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| | of urinary tract infections.<br><br>A physician's order dated 7/25/2017 indicating that Resident 7's code status was Full Code ( CPR was to be initiated in the case of cardiac arrest).<br><br>A POST (Physicians Order for Scope of Treatment) form dated 6/27/2018, indicating Resident 7 did not wish to have CPR initiated if she experienced a cardiac arrest.<br><br>During an interview on 3/28/2019 at 3:54 p.m., the Director of Nursing indicated that the POST form and physician's order for code status should match.<br><br>During an interview on 3/29/2019 at 2:59 p.m., the Social Service Director indicated she had discussed Resident 7's code status with her upon her return from the hospital in July of 2018. She indicated that Resident 7 expressed the desired to be a Full Code. She indicated the current physician's order was accurate.<br><br>On 3/29/2019 at 3:24 p.m., the Social Service Director and the Administrator were observed speaking with Resident 7 about her code status. Resident 7 indicated that she wished to have CPR done in the case of a cardiac arrest.<br><br>During an interview on 3/29/2019 at 3:30 p.m., the Administrator indicated that the POST form should have been removed from the medical record since it did not reflect the current code status.<br><br>3.1-50(a) | | | |
| F 0641<br>SS=D<br>Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status. | | | |

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| | Based on interview and record review the facility failed to accurately reflect a resident's ability to perform transfers on a Minimum Data Set Assessment for 1 of 22 residents reviewed. (Resident 5)<br><br>Findings include:<br><br>The clinical record for Resident 5 was reviewed on 3/26/2019 at 2:53 p.m. The diagnosis for Resident 5 included, but were not limited to, muscle weakness.<br><br>During an interview on 3/26/2019 at 2:53 p.m., Resident 5 indicated he could not stand and had not gotten out of bed for at least 2 to 3 weeks.<br><br>The clinical record contained a Quarterly MDS (Minimum Data Set) assessment which was completed 3/19/2019, indicating that he was cognitively intact and that he required extensive assistance of 2 staff members for transfers from his bed to a wheel chair.<br><br>The clinical record contained a Physical Therapy Evaluation dated 3/29/2019, indicating that Resident 5 utilized a Hoyer (mechanical full body) lift for transfers out of bed and that he had not tried to stand in greater than 2 years.<br><br>During an interview on 4/1/2019 at 4:01 p.m., CNA (Certified Nursing Assistant) 9 indicated that Resident 5 used a Hoyer lift for all transfers and that he was unable to transfer from bed without the use of a Hoyer lift.<br><br>During an interview on 4/1/2019 at 3:35 p.m., the MDS Coordinator 2 indicated that residents who use a Hoyer lift for transfers should be coded as total assistance. | F 0641 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>Resident #5 MDS updated to reflect total assistance<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>· All residents who require total assistance has the potential to affected by deficient practice.<br><br>MDS nurse or designee will audit all residents MDS coded as a extensive assist of transfers to ensure coding is accurate by May 1, 2019<br><br>· A facility audit of MDS assessments within the last 90 days will be conducted by MDS nurse to ensure transfers were coded correctly on the MDS<br><br>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?<br>· MDS nurse or designee will audit all residents MDS coded as a extensive assist of transfers to ensure coding is accurate by May 1, 2019<br><br>· A facility audit of MDS assessments within the last 90 days will be conducted by MDS nurse to ensure transfers were coded correctly on the MDS | 05/01/2019 |

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| | | | · The MDSC will be in-serviced by the RAI Specialist on proper transfer coding of the MDS by May 1, 2019<br><br>Each week the DNS or designee will review all assessments transmitted to ensure accuracy of MDS assessments in regard to coding of transfers<br><br>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?<br>· Nurse Round Audit QA tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the | | | |

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| | resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>Based on interview and record review, the facility failed to revise a dental care plan for 1 of 1 residents reviewed for dental. (Resident 4)<br><br>Findings include:<br><br>The clinical record for Resident 4 was reviewed on 3/26/19 at 11:40 a.m. The diagnosis for Resident 4 included, but was not limited to, chronic obstructive pulmonary disease.<br><br>A care plan for Resident 4 dated 3/26/19, indicated "...Resident has some or all of natural teeth lost. Does not have or use dentures or partials related to pain when using...."<br><br>An interview was conducted with Resident 4 on 3/26/19 at 11:42 a.m. He indicated the dentist had ordered him some dentures, but he never has received.<br><br>An interview was conducted with the Social Services Director on 4/1/19 at 11:11 a.m. She indicated Resident 4 did not want to pay for his new | F 0657 | F 657 Care Plan and Timing and Revision<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident #4 dental care plan was reviewed and revised<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>· All residents who have natural teeth lost have the potential to be affected by deficient practice.<br>· Social Services or designee will conduct audit using new dental consents and care plans will be updated to reflect preference including residents' refusals.<br>· Social Services or designee will be inserviced on Ancillary | 05/01/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155029 | A. BUILDING 00<br>B. WING | 04/02/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| | dentures. She could not locate any dentures or documentation indicating Resident 4 had dentures in the facility in the past. The dental care plan was incorrect. Resident 4 did not refuse to wear dentures, because of pain. She would update Resident 4's dental care plan.<br><br>3.1-35(d)(2)(B) | | Services and consent by Social Services Consult or Designee by May 1, 2019<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>· All residents who have natural teeth lost have the potential to be affected by deficient practice.<br>· Social Services or designee will conduct audit using new dental consents and care plans will be updated to reflect preference including residents' refusals.<br>· Social Services or designee will be inserviced on Ancillary Services and consent by Social Services Consult or Designee by May 1, 2019<br><br>**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?**<br>·Dental Services will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to | | | |

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| | facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, interview, and record review, the facility failed to address a resident's dry skin on her hands for 1 of 3 residents reviewed for ADLs (activities of daily living.) (Resident 13)<br><br>Findings include:<br><br>The clinical record for Resident 13 was reviewed on 3/26/19 at 11:00 a.m. The diagnoses for Resident 13 included, but were not limited to: multiple sclerosis and depression.<br><br>The 12/27/18 Quarterly MDS (Minimum Data Set) assessment indicated a staff assessment for mental status was completed as Resident 13 was unable to complete the BIMS (brief interview for mental status.) The staff assessment indicated Resident 13's cognitive skills for daily decision making was severely impaired, as she never/rarely made decisions. The MDS assessment indicated Resident 13 required total dependence of 2 persons for bed mobility, transfers, and personal hygiene.<br><br>An observation of Resident 13 was made on 3/26/19 at 11:55 a.m. She was lying in bed, wearing palm protectors on both hands. The tops and sides of her hands were very dry, with white chafing skin to the tops of both hands, the tops of her fingers, and up both arms between her hands and elbows.<br><br>An observation of Resident 13 was made on 3/28/19 at 9:27 a.m. She was lying in bed, wearing palm protectors on both hands. The tops and sides her hands were very dry, with chafing skin on both | F 0684 | F 684 Quality of Care<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident #13 skin integrity checked to bilateral hands for skin breakdown and lotion applied to both hands per physician orders<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by the alleged deficient practice<br>·Licensed nurses will be in-serviced by Director of Nursing Services or designee by May 1, 2019 on bilateral skin integrity checks including application of lotion to extremities.<br>·Director of Nursing or designee will audit all residents skin integrity conducting a complete skin sweep of facility will be completed by nurse management to ensure lotion is applied to dry, scaly skin by May 1, 2019<br>·New admission/readmission audit of skin integrity will be checked upon admission and reviewed by Director of Nursing Service or designee to ensure dry, | 05/01/2019 |

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| | hands, particularly the right hand.<br><br>An interview was conducted with CNA (Certified Nursing Assistant) 5 on 3/28/19 at 2:35 p.m. She indicated Resident 13 needed assistance with all of her activities of daily, including bathing. CNA 4 indicated she'd assisted bathing Resident 13 once before, and put lotion on her feet only, not her hands. CNA 4 indicated Resident 4 had a special lotion for her feet.<br><br>An observation of Resident 13 was made with CNA 5 on 3/29/19 at 2:43 p.m. Resident 13 was wearing her palm protectors. The tops and sides of her hands were very dry, scaly, with dried, chafing skin on the tops of both hands. CNA 5 indicated she'd notice Resident 13's dry skin on her hands before, but no one ever told her what to do about it.<br><br>An observation of Resident 13 was made with UM (Unit Manager) 4 on 3/28/19 at 2:45 p.m. UM 4 removed Resident 13's palm protector from her right hand. Resident 13 grimaced during removal of the palm protector. Resident 13's right hand was extremely dry, scaly, with peeling skin on the area that was covered by the palm protector. UM 4 indicated Resident 13 needed some lotion on her hands and stated, "It's kind of dry." UM 4 indicated when nursing got her up in morning, they needed to make sure lotion was applied to Resident 13's hands before placing her palm protectors. UM 4 stated, "It doesn't look like she's had any lotion on her hands for a while."<br><br>The physician's orders for Resident 13 indicated to check the skin integrity to bilateral hands for skin breakdown, effective 1/14/19.<br><br>The March, 2019 medication administration record indicated LPN (Licensed Practical Nurse) 6 completed the above task on 3/28/19, between 7:00 | | scaly skin has lotion applied per Nursing Round Audit Tool.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·All residents have the potential to be affected by the alleged deficient practice<br>·Licensed nurses will be in-serviced by Director of Nursing Services or designee by May 1, 2019 on bilateral skin integrity checks including application of lotion to extremities.<br>·Director of Nursing or designee will audit all residents skin integrity conducting a complete skin sweep of facility will be completed by nurse management to ensure lotion is applied to dry, scaly skin by May 1, 2019<br>·New admission/readmission audit of skin integrity will be checked upon admission and reviewed by Director of Nursing Service or designee to ensure dry, scaly skin has lotion applied per Nursing Round Audit Tool.<br><br>**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?**<br>·Nursing Rounds QA tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement | |

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|---|---|---|---|
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|---|---|---|---|---|
| | a.m. and 3:00 p.m.<br><br>An interview was conducted with LPN 6 on 3/28/19 at 3:19 p.m. She indicated she checked Resident 13's hands that morning, prior to her palm protectors being placed, and noticed her hands were dry and scaly. LPN 6 indicated she did not address Resident 13's dry, scaly hands or tell the CNAs Resident 13 needed lotion applied. LPN 6 indicated she saw lotion in the room, when the CNAs were getting her up that morning, but she did not see any lotion applied to Resident 13.<br><br>The shower and a.m. care skills validations were provided by the Administrator on 3/28/19 at 3:30 p.m. Neither included the application of lotion.<br><br>3.1 37(a) | | Committee overseen by the Executive Director<br>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |
| F 0685 SS=D Bldg. 00 | 483.25(a)(1)(2)<br>Treatment/Devices to Maintain Hearing/Vision<br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>Based on interview and record review, the facility failed to address a resident's change in vision for 1 of 1 resident reviewed for communication and sensory. (Resident 12)<br><br>Findings include: | F 0685 | F 685 Treatment/Device to Maintain Hearing/Vision<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>· Resident #12 new ancillary | 05/01/2019 |

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| | The clinical record for Resident 12 was reviewed on 3/26/19 at 2:00 p.m. The diagnoses for Resident 12 included, but were not limited to: hypertension, diabetes, and obesity.<br><br>The 6/26/18 Admission MDS (Minimum Data Set) assessment indicated Resident 12 had adequate vision, with no corrective lenses used.<br><br>The 6/26/18 ancillary consent form indicated Resident 12 refused eye care services in the facility.<br><br>The physician's orders for Resident 12 indicated she may be seen by the optometrist, effective 6/25/19.<br><br>The 10/2/18 Quarterly MDS assessment indicated Resident 12's vision was now impaired, with no corrective lenses used.<br><br>The 10/1/18 social services note indicated Resident 12's vision was inadequate without the use of corrective lenses. The note did not reference a plan to address Resident 12's inadequate vision.<br><br>The 12/26/18 Quarterly MDS (Minimum Data Set) assessment indicated Resident 12 had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact.<br><br>The 12/26/19 social services note indicated Resident 12's vision was impaired without the use of corrective lenses. The note did not reference a plan to address Resident 12's impaired vision.<br><br>Resident 12's care plans did not reference her impaired vision.<br><br>An interview was conducted with Resident 12 on 3/26/19 at 2:30 p.m. She indicated she was having vision problems, in that her eyes would get blurry sometimes, and thought it was from looking at her | | consent signed, and care plan updated to reflect new preference. Resident #12 has been seen by optometrist and eye glasses has been ordered.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>· All residents have the potential to be affected by the alleged deficient practice<br>· A completed audit will be conducted by the Social Services Director or Designee using Ancillary Services Audit tool by May 1, 2019 and new ancillary services preferences consents will be reviewed and care plans will be updated to reflect new ancillary preferences.<br>· Social Services or Designee will be in-serviced on Ancillary Services by the Executive Director or Designee by May 1, 2019<br><br>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?<br>· A completed audit will be conducted by the Social Services Director or Designee using Ancillary Services Audit tool by May 1, 2019 and new ancillary services preferences consents will be reviewed and care plans will be updated to reflect new ancillary preferences. | |

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|---|---|---|---|
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|---|---|---|---|---|
| | electronic reader. She indicated someone at the facility asked her about seeing the eye doctor a couple months ago, and she agreed, but never did. Resident 12 indicated she would still like to see the eye doctor.<br><br>An interview was conducted with the SSD (Social Services Director) on 3/28/19 at 10:20 a.m. She indicated Resident 12 declined eye care services on admission, and they did not revisit her declination after her vision became impaired.<br><br>An interview was conducted with the SSD and Resident 12 on 3/28/19 at 10:28 a.m. The SSD asked Resident 12, if she wanted optometry services. Resident 12 indicated she did and signed a new consent to be seen.<br><br>An interview was conducted with the Administrator on 3/28/19 at 12:40 p.m. She indicated there was no follow up to address Resident 12's impaired vision after her 10/2/18 and 12/26/18 MDS assessments.<br><br>The Vision and Hearing Services policy was provided by the Administrator on 3/28/19 at 12:07 p.m. It read, "It is the policy of this facility to ensure that residents are provided with vision and hearing services as needed."<br><br>3.1-39(a)(1) | | · Social Services will revisit preferences for ancillary services during significant and annual MDS interviews with residents then document necessary changes<br><br>· Social Services or Designee will be in-serviced on Ancillary Services by the Executive Director or Designee by May 1, 2019<br><br>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?<br>· Ancillary Services QA tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |
| F 0812<br>SS=F<br>Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to | | | |

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|---|---|---|---|---|
| | applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. | | | |
| | Based on observation, interview, and record review, the facility failed to ensure the dishwasher reached the appropriate temperature, and store clean dishes, refrigerated foods, and bread properly in the kitchen. This had the potential to affect 80 of 80 residents in the facility.<br><br>Findings include:<br><br>A tour of the kitchen was conducted on 3/26/19 at 10:47 a.m. Upon entrance to the kitchen, DA (Dietary Aide) 7 was observed running the dish machine. DA 7 ran a cycle of the dishwasher. The wash reached 134 degrees Fahrenheit. The label on the front of the dishwasher indicated the wash was to reach 150 degrees Fahrenheit, and the rinse was to reach 180 degrees Fahrenheit for hot water sanitization. Five loads of dishes were observed to go through the dishwasher, which never reached a wash temperature of 150 degrees Fahrenheit. The highest temperature reached on the wash cycle was 142 degrees Fahrenheit. One of the five loads observed to go through the dishwasher was a container of silverware. DA 8 was observed wrapping the silverware from the load into single serve napkins.<br><br>The March, 2019 dishwasher temperature log, located near the front of the kitchen, was reviewed | F 0812 | We would like to request review of this deficiency to lower the scope and severity from F level to D level. We have 2 resident who was not receiving food/equipment from the kitchen. The 2567 says 80 of 80 residents could be affected – it is actually 78 of 80.<br><br>**F812 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Pots and pans are stored in a way that protects them from potential contamination.<br>· Bread and ready to serve desserts are stored, labeled and dated in a way that protect them from potential contamination.<br>· The dish machine has been serviced and has appropriate temperatures logged.<br><br>**How will you identify other residents having the potential** | 05/01/2019 |

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|---|---|---|---|---|
| | with DA 7 after the above observation. The log indicated the wash temperature at breakfast on 3/26/19 was 135 degrees Fahrenheit. The log was blank for breakfast, lunch, and supper for the previous day, 3/25/19. DA 7 indicated he wrote the temperature of 135 degrees for breakfast 20 minutes earlier. He indicated he was not working the previous day, so was unsure about the blank temperatures for 3/25/19.<br><br>An observation of the walk in refrigerator was made during the tour. Five ready to eat, uncovered, broccoli salads were on a metal tray located on the 4th from the top rack of a multi rack rolling unit. Seven pieces of chocolate cake on small serving plates were on a metal tray located on the 2nd from the bottom rack of another multi rack rolling unit. One of the chocolate cake plates was tilted, not flat on the metal tray, cutting into the piece of chocolate cake next to it.<br><br>An observation of a clean pots and pans metal, multi rack unit, located just outside of the walk in refrigerator, was made during the tour. Two pans and 2 pots were not inverted, stored on the bottom rack. The racks of the multi rack unit were not solid racks. They had spaces within the racks.<br><br>An observation of the bread bins in the dry storage room was made during the tour. A packaged loaf of Texas toast and a package of hamburger buns were stored in the bins, not secured or tied.<br><br>An interview was conducted with the DM (Dietary Manager) on 3/26/19 at 11:10 a.m. She indicated the bread should be tied up. There should be a sheet over the broccoli salads, and the cake plates should be flat on the metal tray.<br><br>The Cleaning Dishes and Dish Machine policy was provided by the Administrator on 3/26/19 at 12:40 | | **to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by the alleged deficient practice<br>·The Dietary Manager will conduct a short sanitation review after every meal to ensure that pots, pans and ready to serve desserts are stored in a way that protects them from potential contamination by May 1, 2019. This will be overseen by the Executive Director.<br>·The Dietary Manager or Designee will audit dish machine daily to ensure the dish machine temperature and pressure are followed according to manufactures recommendations using Short Sanitation Review Tool.<br>·The Dietary Manager or designee will in-service all dietary staff on the Food Storage Policy and Handling Clean Equipment and Utensils policy including ensuring that pans and containers are stored in a way that protects them from contamination by May 1, 2019<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>·The Dietary Manager will conduct a short sanitation review after every meal to ensure that pots, pans and ready to serve desserts are stored in a way that protects them from potential | |

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| | p.m. It read, "Check temperature and pressure. Follow manufacturers' recommendations....Check the dish machine gauges throughout the cycle to assure proper temperatures."<br><br>The Recording Dish Machine Temperature/Sanitizer policy was provided by the Administrator on 3/26/19 at 12:40 p.m. It read, "Staff will be trained to record dish machine temperatures for the wash and rinse cycles and the sanitizer concentration (if appropriate) at each meal. Dishwashing staff will be trained to report any problems with the dish machine to the Dietary Services Manager as soon as they occur."<br><br>The Food Storage policy was provided by the Administrator on 3/26/19 at 12:40 p.m. It read, "Refrigeration: ...All foods should be covered or wrapped tightly, labeled and dated."<br><br>The Handling Clean Equipment and Utensils policy was provided by the Administrator on 3/26/19 at 12:40 p.m. It read, "Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from contamination by splashes and dust."<br><br>3.1-21(i)(3) | | contamination by May 1, 2019. This will be overseen by the Executive Director.<br>·The Dietary Manager or designee will in-service all dietary staff on the Food Storage Policy and Handling Clean Equipment and Utensils policy including ensuring that pans and containers are stored in a way that protects them from contamination by May 1, 2019<br><br>**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?**<br>· A Kitchen Sanitation/Environmental Review QA tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>· In addition, a full sanitation audit will be conducted by the RD Consultant monthly<br>· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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 | | | |

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| | 155029 | A. BUILDING 00<br>B. WING | 04/02/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable 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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable | | | |

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| | disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, interview and record review, the facility failed to ensure isolation precautions were initiated timely and infection control was maintained with hand hygiene during medication administration for 1 of 3 residents reviewed for ADL (Activities of Daily Living) , 1 of 1 resident reviewed for infections, and 1 of 5 medication administrations observed. (Residents 7, 50 and 63)<br><br>Findings include:<br><br>1. The clinical record for Resident 63 was reviewed on 3/28/19 at 11:00 a.m. The diagnosis for Resident 63 included, but was not limited to, vitamin D deficiency.<br><br>A physician order dated 2/21/18 indicated Resident 63 was to receive 800 units of vitamin D3 once a day.<br><br>During a medication administration with License Practical Nurse (LPN) 2 on 3/28/19 at 8:51 a.m., Resident 63 was observed taking his medications. | F 0880 | **F 880 Infection Prevention/Control**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident 63 continues to receive medications in a sanitary manner<br>· LPN 2 was educated on medication pass and infection control practices<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>· All residents who reside in the facility have the potential to be affected by the alleged deficient practice | 05/01/2019 |

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|---|---|---|---|
| | 155029 | A. BUILDING 00<br>B. WING | 04/02/2019 |

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|---|---|---|---|---|
| | During that time, Resident 63 had dropped a pill on the ground. LPN 2 donned gloves and removed the pill off the floor and discarded it. LPN 2 indicated at that time Resident 63 had dropped his vitamin D3. She then removed her gloves and opened the medication cart drawer. There was no hand hygiene observed at that time. LPN 2 was observed pulling out a medication card and popped another vitamin D3 from the card into a medication cup. She then administered the vitamin D3 to Resident 63.<br><br>An interview was conducted with the Clinical Education Coordinator on 3/29/19 at 3:43 p.m. She indicated LPN 2 should have utilized hand hygiene after the removal of her gloves.<br><br>A "Hand Hygiene Policy" was provided by the Administrator on 3/29/19 at 4:00 p.m. It indicated "..Purpose: To provide a standardized approach to Hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees. Policy: [name of company] will follow the Centers for Disease and Prevention (CDC) hand hygiene and World Health Organization (WHO) guidelines for the stands of hand hygiene...5. Moments of hand hygiene - a term that describes the hand hygiene opportunities that prevent infection transmission linked to healthcare activities... Before touching a patient..Before Clean/Aseptic procedure..After body fluid exposure risk.. After touching a patient..After touching patient surroundings..."<br><br>2. The clinical record for Resident 50 was reviewed on 3/28/19 at 11:00 a.m. The diagnosis for Resident 50 included, but was not limited to, urinary tract infection.<br><br>A lab reported for Resident 50 date reported 2/16/19 at 2:31 p.m., indicated "...Escherichia coli ESBL greater than 100,000 ...confirmed ESBL | | · DNS/Designee will conduct an inservice with all nurses related to Hand Hygiene, including the Moments of Hand Hygiene by May 1, 2019<br>· DNS/Designee will conduct an inservice with all nurses related to Infection Control, including placing residents into Isolation Precautions timely by May 1, 2019<br>· An audit was completed to ensure all residents who needed to be under Isolation Precautions were in Isolation by DNS/Designee<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>· DNS/Designee will conduct an inservice with all nurses related to Hand Hygiene, including the Moments of Hand Hygiene by May 1, 2019<br>· DNS/Designee will conduct an inservice with all nurses related to Infection Control, including placing residents into Isolation Precautions timely by May 1, 2019<br>· DNS/Designee will review orders and lab results daily during Clinical Meeting to ensure all residents requiring Isolation Precautions are timely placed into Isolation per policy<br>**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?**<br>·Infection Control QAPI Tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly | |

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|---|---|---|---|
| | 155029 | A. BUILDING 00<br>B. WING | 04/02/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| | producing organism [infection]..."<br><br>A physician order dated 2/18/19, indicated Resident 50 was to be placed in contact isolation due to ESBL in his urine.<br><br>The February 2019 Medication Treatment Record (TAR) indicated Resident 50 was placed in contact isolation on Monday, 2/18/19.<br><br>An interview was conducted with the Director of Nursing on 3/28/19 at 3:53 p.m. She indicated she was unsure the delay of placing the residents in isolation after receiving the lab results on a weekend day.<br><br>An interview was conducted with Unit Manager 1 on 3/28/19 at 4:26 p.m. She indicated if a lab result indicated the need for isolation the physician should be contacted to get an order for an antibiotic and isolation. The resident should be placed in isolation that day. 3. The clinical record for Resident 7 was reviewed on 3/27/2019 at 11:10 a.m. The diagnosis for Resident 7 included, but were not limited to, personal history of urinary tract infections.<br><br>On 3/27/2019 at 11:27a.m., Resident 7 was observed in her room. There was a sign on the door indicating to see the nurse prior to entering the room.<br><br>During an interview on 11:27 a.m., LPN (Licensed Practical Nurse) 10 indicated that Resident 7 was in contact isolation for ESBL (a multi drug resistant bacteria) in her urine.<br><br>A urine culture, dated 3/24/2019, indicated that Resident 7's urine contained an ESBL producing bacteria. The culture results indicated that new orders to treat the urinary tract infection were obtained on 3/25/2019. | | thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |

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|---|---|---|---|---|

A physician's telephone order was written on 3/24/2019, indicating that Resident 7 was to be started on Macrobid ( an antibiotic) to be taken twice daily for 3 days.

The clinical record contained a physician's telephone order written 3/25/2019 indicating that contact isolation was to be used due to an ESBL infection and that Resident 7 was to receive Macrobid (an antibiotic) twice daily for a total of 5 days.

A progress note written 3/25/2019 at 2:39 p.m., indicated Resident 7 was transferred to the first floor that day, due to the need for contact isolation.

During an interview on 03/28/2019 at 4:36 p.m., the Unit Manager indicated lab results showing the need for isolation were to be called to the physician and orders should be received for isolation and treatment the day the result were obtained.

During an interview on 03/28/19 at 3:51 p.m., the Director of Nursing indicated she was unsure why it took 2 days for isolation precautions to be initiated.

On 3/29/2019 at 11:33 a.m., the Clinical Education Coordinator provided a policy titled Infection Prevention and Control Program, which was revised November 2017. The policy read as follows: "Policy: The facility shall establish and maintain infection prevention and control program [ICPC] designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections...Goals: The goals of the infection prevention and control program are to:...2. Monitor and identify occurrence of infections and implement appropriate control measures to prevent outbreaks and cross-contamination..."

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|---|---|---|---|
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| | 3.1-18(a) | | | |
| F 0881 SS=E Bldg. 00 | 483.80(a)(3)<br>Antibiotic Stewardship Program<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to prescribing antibiotics for not a true infections, for excessive duration and without adequate indication for use based on the McGeer Criteria for 2 of 2 residents. (Resident 37 and 74)<br><br>Findings include:<br><br>1. The record for Resident 37 was reviewed on 3/29/19 at 2:15 p.m. Diagnosis include, but not limited to, arthritis, asthma, congestive heart failure, coronary artery disease, hypertension, diabetes mellitus type 2, chronic obstructive pulmonary disease (COPD) and emphysema.<br><br>A nursing note written on 3/22/2019 at 1:08 p.m. indicated resident 37 was complaining of shortness of breath at 7:45 a.m., 10:45 a.m. and 1 p.m... The resident was given a breathing treatment from her duoneb inhaler (a medication to open up airway) which the resident indicated had seem to help. The nurse assessed resident's lung sounds and indicated she heard audible wheezing and rhonchi (coarse, rattling respiratory sounds) in the front and back of | F 0881 | **F 881 Antibiotic Stewardship Program**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>· Resident 37 is no longer receiving antibiotic therapy and has discharged from the facility<br>· Resident #74 has a stop date for the antibiotic and given an indication for use<br><br>· **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>· All residents who are prescribed an antibiotic have the potential to be affected by the alleged deficient practice<br>· DNS/Designee will conduct an in-service with all nurses related to Antibiotic Stewardship Program including the McGeers Criteria, indications for use, and obtaining | 05/01/2019 |

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|---|---|---|---|
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|---|---|---|---|---|
| | both lungs. The nurse indicated a phone call to the physician was made to report her findings and was waiting for a call back from the on-call physician.<br><br>The resident's physician orders reviewed on 3/29/19 at 2:20 p.m. indicated Ceftriaxone (an antibiotic), 1 gram, IM (in the muscle) injection to be given one time, was ordered on 3/22/19.<br><br>A physician's progress note on 3/22/19 indicated the resident had complained of a cough. The symptoms chronic dyspnea does worsen with exertion. The sputum is clear in small amounts and there has been no fever.<br><br>The Medication Administration Record (MAR) reviewed on 3/29/19 at 2:32 p.m. indicated the Ceftriaxone was administered once as an IM injection on 3/22/19.<br><br>Radiology reports reviewed on 3/29/19 at 3: 01p.m. indicated chest x-rays were completed on 2/15/19 and 3/23/19. The findings for both of the chest x-rays indicated there was "no lung consolidation; no effusion (abnormal accumulation of fluid); no acute cardiopulmonary process; the lung fields are clear, without mass, infiltrate (accumulation of pus, blood or protein), congestion or effusion". The radiology report dated 3/23/19 stated a comparison to the last chest x-ray, which was dated 2/15/19, indicated that a chest x-ray was not performed to identify a true infection.<br><br>In an interview with the Clinical Educator Coordinator (CEC), on 3/29/19 at 2:54 p.m., indicated the facility uses a surveillance tool to track and measure antibiotic use and completion of antibiotics; creates an infection control event report to monitor the length of time on antibiotics and when test results expected to back. The CEC indicated the basis for the facility's antibiotic stewardship | | orders for stop dates for antibiotics by May 1, 2019<br>· An audit was completed to ensure all residents who are receiving antibiotic therapy are meeting criteria for a true infection according to McGeers Criteria. Corrective action will be taken as needed<br>· An audit was completed to ensure all residents who are receiving antibiotic therapy have an appropriate indication for use and a stop date. Corrective action will be taken as needed<br>**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>· DNS/Designee will conduct an in-service with all nurses related to Antibiotic Stewardship Program including the McGeers Criteria by May 1, 2019<br>· DNS/Designee will review orders and Infection Control events daily during Clinical Meeting to ensure all residents receiving antibiotic therapy have an appropriate indication for use, a stop date, and are meeting McGeers Criteria for receiving an antibiotic. Corrective action will be taken as needed.<br>· IDT will review Antibiotic Stewardship Program with Medical Director at next QAPI meeting, including McGeers Criteria, appropriate indication for use and ensuring stop dates are ordered when an antibiotic is prescribed<br>**How the corrective action (s)** | |

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|---|---|---|---|---|
| | program uses the Infection Criteria and Precaution Recommendation guide. The CEC provided a copy of the Infection Criteria and Precaution Recommendation (decision tree/ guide) which stated "based on McGeer" Criteria. CEC indicated understanding that prior to administration of antibiotics, McGeer Criteria must be met; if not met, the definition of a true infection is not met and fails to follow antibiotic stewardship. CEC indicated McGeer Criteria was not met for resident 37 and per the facilities Antibiotic Stewardship Program Policy, the facility must "take at least one action to improve the way antibiotics are used in the facility...". CEC indicated the prescriber was not asked to change the order, educated on definition of a true infection nor that the definition of a true infection had not been met. CEC indicated that if prescriber does not discontinue the antibiotic, the current order will continue.<br><br>The Infection Criteria and Precaution Recommendation guide categorizes respiratory tract conditions/infections in the following way...<br>"Pneumonia (all 3criteria must be present)<br>1. Interpretation of radiograph as demonstrating pneumonia or presence of new infiltrate<br>2. At least 1 of the following respiratory sub criteria<br>a. New or increased cough<br>b. New or increase sputum production<br>c....<br>Type of precaution: Droplet<br>Duration: 24 hours without symptoms<br>Comment: Rule out noninfectious causes of symptoms. In particular, congestive heart failure may produce signs and symptoms similar to those of respiratory infections"<br><br>McGeer's Criteria for Long Term Care Surveillance, provided on 4/2/19 via CDC website, | | **will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>·Infection Control QAPI Tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director<br>·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance | |

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|---|---|---|---|
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|---|---|
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| | indicated for an upper respiratory tract infection (RTI), "Pneumonia (all 3 criteria must be present) 1. Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate 2. At least 1 of the following respiratory sub criteria: new or increased cough, new or increased sputum production...For both pneumonia and lower RTI, the presence of underlying conditions that could mimic the presentation of a RTI (e.g., congestive heart failure or interstitial lung diseases, such as COPD) should be excluded ...".<br><br>Antibiotic Stewardship Program Policy received on 3/26/19 at 11:33 a.m. from CEC indicated, "The facility shall establish elements for antibiotic prescribing and a system to monitor and manage antibiotic use. Antibiotic stewardship refers to a set of commitments and activities to optimize the treatment of infections while reducing the adverse events associated with antibiotic use...antibiotic stewardship and antibiotic utilization will be reviewed to determine if any action is needed."<br><br>2. A record review on 4/1/19 at 9:43 a.m., for Resident 74 indicated a past medical history including, but not limited to, fracture of right patella (knee), pulmonary hypertension, atrial fibrillation, chronic congestive heart failure and lymphedema.<br><br>The Minimum Data Sheet (MDS) reviewed on 4/1/19 at 9:43 a.m., indicated resident had no signs or symptoms of delirium or depression. Resident had no indication of skin break down or any other wounds. Resident used a wheelchair for mobility.<br><br>A review of the resident's current medications on 4/1/19 at 9:43 a.m., indicated Resident 74 was taking the following medications, including but not limited to: Xanax, Coumadin, Paxil, Novolog, Metformin and Cephalexin (an antibiotic) | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| | The review of physician orders on 4/1/19 at 9:44 a.m., indicated a physician order on 2/6/19 for the medication Cephlaxin, 1000 mg, given orally at bedtime daily. There was no indication listed for this medication nor was there a stop date for this medication.<br><br>An interview with the Clinical Education Coordinator, on 4/02/19 at 10:26 a.m., indicated the resident continued to have Cephalexin, 1000mg given nightly, since admission to facility. CEC was unsure of indication for this medication at time of interview.<br><br>An interview on 4/02/19 at 11:51 a.m., with CEC indicated the continuation of Cephalexin from hospital discharge on 2/6/19 did not have indication for use, did not meet criteria the facility uses for definition of true infection, the duration of use was excessive as medication did not stop date and considered an unnecessary medication.<br>On the same day, at 12:17 p.m., the CEC indicated the indication for Cephalexin, per a conversation she had with a nurse, was for chronic lymphedema.<br><br>The Medication Administration Record, provided by CEC on 4/2/19 at 11:17 a.m., indicated resident #74 received Cephalexin daily on the following dates: 2/6/19 through 3/8/19. On 3/9/19 to present, resident #74 has refused to take Cephalexin.<br><br>3.1-18(b) (1) | | | |