

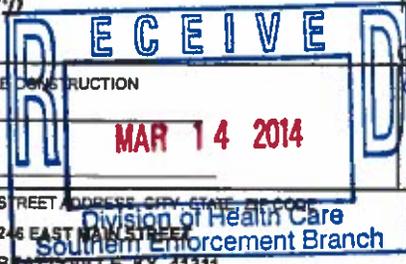
Addendum to F281

#2. The Director of Nursing and Unit Mangers reviewed all residents care plans and newly admitted residents care plans from Jan 1, 2014 to present to ensure an initial care plan had been completed, care plan interventions were implemented, and communication had occurred to the C.N.A. Any concerns identified during the audit were addressed upon identification.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

3rd SCD

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 02/06/2014
NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311 Division of Health Care Southern Enforcement Branch		
(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	
F 000	INITIAL COMMENTS A standard health survey was conducted on 02/04-06/14. An abbreviated survey (KY21273, KY21275, KY21277, KY21298) was also conducted at this time. KY21273, KY21275, and KY21277 were unsubstantiated. KY21298 was substantiated with deficient practice identified at "G" level. The facility failed to ensure services provided for one (1) of nineteen (19) sampled residents (Resident #19) met professional standards of care and failed to ensure the environment remained as free of accident hazards as possible. The facility admitted Resident #19 on 01/15/14, at approximately 12:00 PM, from an acute care facility. Review of the History and Physical from the acute care facility, dated 01/11/14, revealed the resident required the assistance of two people to ambulate. However, review of an Accident/Incident Report dated 01/16/14, revealed on 01/15/14 at approximately 1:45 PM to 2:00 PM, (approximately two hours after the resident's admission to the facility) two staff persons assisted the resident to the bathroom, left him/her alone in the bathroom, and the resident sustained a fall while in the bathroom alone. The facility transferred Resident #19 to the Emergency Department (ED) on 01/15/14 at 2:30 PM, and documentation by the Emergency Department physician on 01/15/14 revealed Resident #19 sustained a hematoma and contusion to the head as a result of the fall.	F 000	Lee County Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves the right to contest the survey findings through informal dispute, resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Susan Bush

TITLE

NHA

(X6) DATE

8/14/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: lea co-g level</p> <p>Based on observations, interviews, record reviews, and review of the facility's policies, the National Federation of Licensed Practical Nurses publication entitled "Nursing Practice Standards for the Licensed Practical/Vocational Nurse," a Fall Risk Evaluation, an Accident/Incident Report, and the Emergency Room Physician's assessment, it was determined the facility failed to ensure services provided for one (1) of nineteen (19) sampled residents (Resident #19) met professional standards of care.</p> <p>The facility admitted Resident #19 on 01/15/14, at approximately 12:00 PM, from an acute care facility. Review of the History and Physical from the acute care facility, dated 01/11/14, revealed the resident required the assistance of two people to ambulate. However, review of an Accident/Incident Report dated 01/16/14, revealed on 01/15/14 at approximately 1:45 PM to 2:00 PM (approximately two hours after the resident's admission to the facility) two staff persons assisted the resident to the bathroom and left him/her alone in the bathroom. The resident sustained a fall while in the bathroom alone. Review of the Emergency Department Physician's Report dated 01/15/14, revealed Resident #19 sustained a contusion and hematoma to the head as a result of the fall. Interview with Licensed Practical Nurse (LPN) #2 revealed even though she was made aware Resident #19 required the assistance of two for ambulation, she failed to develop an initial care plan to address the resident's needs until after the resident sustained the fall.</p>	F 281	<p><u>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u></p> <p><u>F281</u></p> <ol style="list-style-type: none"> Resident # 19's primary physician was notified at the time of the fall on 1/15/14 by the charge nurse. Resident #19's family was present at the facility at the time of the fall on 1/15/14. An order was obtained immediately following the fall, after a physical assessment on 1/15/14 by the charge nurse to send the resident to the ER to be evaluated. The resident was not kept at the hospital after evaluation by the resident's primary physician on 1/15/14. An admission assessment, fall risk assessment, and initial care plan were completed by the Charge Nurse on 1/15/14. <p><u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</u></p>		

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F 281	<p>Continued From page 2</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Admission Assessment and Follow Up: Role of the Nurse," with a revision date of December 2012, revealed the purpose of the assessment was to identify the resident's needs and to initiate a care plan based on the assessment. The policy revealed the nurse would also conduct a fall risk assessment at the time the admission assessment was conducted.</p> <p>Review of the facility's policy titled, "Fall Policy," dated April 2012, revealed the facility would conduct a fall risk assessment at the time of the resident's admission to the facility and appropriate care plan interventions would be implemented as indicated by the assessment.</p> <p>Review of the National Federation of Licensed Practical Nurses publication, dated October 2003, entitled "Nursing Practice Standards for the Licensed Practical/Vocational Nurse," section "Practice," revealed "The Licensed Practical/Vocational Nurse" ..."4. Shall know and utilize the nursing process in planning, implementing and evaluating health services and nursing care for the individual patient or group," and "Planning: The planning of nursing includes: 1) assessment/data collection of health status of the individual patient, the family and community groups. 2) reporting information gained from assessment/data collection."</p> <p>Review of the closed record for Resident #19 revealed Licensed Practical Nurse (LPN) #2 admitted the resident on 01/15/14, at approximately 12:00 PM, with diagnoses including Fracture of Nasal Septum, Previous</p>	F 281	<p>2. All residents that reside in the facility have the potential to be affected by this practice.</p> <p>All resident care plans will be reviewed by 3/14/14 by the Director of Nursing or Unit Managers to ensure care plan interventions have been implemented and revisions completed for any change in condition per physician order. The review of care plans will include interventions required for residents with a fall risk score of 10 or greater to ensure interventions were implemented and updated to the c.n.a. care plans.</p> <p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</u></p> <p>3. Education will be provided by the Director of Nursing and Unit Managers for licensed nurse's by March 14, 2014 to complete the initial assessment and initial care plans upon admission to ensure newly admitted residents have all care needs addressed before direct resident care is provided. Care plans will be updated quarterly, and as needed to ensure care plans are implemented, revised, and communicated to the c.n.a and placed on the c.n.a care plan.</p>		

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F 281	<p>Continued From page 3</p> <p>Head Injuries and Falls, Bilateral Knee Replacements, Dementia, and Parkinson's. Review of the History and Physical report from the acute care hospital dated 01/11/14, revealed two staff persons were to assist Resident #19 to ambulate. The facility assessed the resident to be alert.</p> <p>Review of a Fall Risk Evaluation dated 01/15/14, completed prior to the resident's fall, revealed the facility assessed Resident #19 to have a score of 17 (a score of greater than 10 indicated the resident was at risk for falls).</p> <p>Review of an Accident/Incident Report dated 01/15/14, revealed LPN #2 and Resident #19's family member entered the resident's bathroom at 2:00 PM and found the resident lying on his/her right side on the floor.</p> <p>Review of the Emergency Department physician's assessment dated 01/15/14, at 3:20 PM, revealed Resident #19 sustained a hematoma and contusion to the right side of the head as a result of the fall at the facility.</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #17 on 02/05/14, at 2:15 PM, revealed SRNA #18 had told her Resident #19 required the assistance of two to ambulate and had asked her assistance to take Resident #19 to the bathroom. SRNA #17 stated she and SRNA #18 assisted Resident #19 to the bathroom, the resident asked for privacy, and the SRNA closed the door and left the room. According to SRNA #17, she thought SRNA #18 remained outside the resident's bathroom door. SRNA #17 stated she should have also stayed outside the resident's door to assist SRNA #18 to take the resident</p>	F 281	<p>Any new admission that scores above a 10 on the fall risk assessment will have a picture of a star placed by their name on the door frame. They will be identified on the interim and c.n.a. care plan as being at risk for falling and the picture of a star by the residents name on the door frame will identify to all staff that this resident is at risk for falling.</p> <p>The interim care plan and the c.n.a care plan will state whether the resident is independent or requires supervision or assist of 1 or 2. The star will be left up for 72 hours while determining appropriate safety interventions to ensure that the resident remains as free of accident hazards as is possible. The residents chart and plan of care will be reviewed daily by a nursing manager for 72 hours to ensure that the plan of care should remain the same and that the safety interventions that were put in place are appropriate.</p>		

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F 281	<p>Continued From page 4</p> <p>back to bed from the bathroom, but she had been assigned to another unit in the facility and returned to the unit to complete her assignments.</p> <p>Interview conducted with SRNA #18 on 02/05/14, at 2:53 PM, revealed she had been assigned to provide direct care to Resident #19 on 01/15/14. SRNA #18 stated she had been told by LPN #2 that Resident #18 required the assistance of two persons to ambulate. The SRNA stated after they were inside the bathroom, the resident asked for privacy; she and SRNA #17 closed the bathroom door and left the room. The SRNA stated she should have stayed in the resident's room outside the bathroom door but had been in a "hurry" because it was near the end of her shift and she had been "busy" assisting other residents back to bed. In addition, SRNA #18 stated she had not looked for an initial Plan of Care for Resident #19 prior to assisting the resident to the bathroom.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/05/14, at 3:00 PM, revealed she had provided care to Resident #19 upon the resident's admission to the facility on 01/15/14. LPN #2 stated she had been informed by staff from the acute care facility that the resident had a history of falls and required the assistance of two for ambulation. In addition, LPN #2 stated that based on her initial assessment of Resident #19 she had determined the resident was a fall risk. She stated although she had not developed the resident's initial care plan until after the resident sustained the fall, she had informed SRNA #18 that Resident #19 required the assistance of two persons for ambulation. LPN #2 stated although Resident #19 had asked for privacy in the bathroom, SRNAs #17 and #18 should have remained</p>	F 281	<p>Education will be provided by the Director of Nursing and Unit Mangers for the SRNA by March 16, 2014 to ensure there is an initial plan of care before providing care to a newly admitted resident.</p> <p>Residents identified at high risk for falls as evidenced by the falls assessment will be reviewed at the At Risk Meeting by the Director of Nursing, Assistant Director of Nursing, and Unit Managers to ensure all current interventions are in place per physician orders.</p> <p>Physician orders will be reviewed daily (Mon-Friday) by the Director of Nursing, MDS Coordinator, and/or the Unit Managers to ensure care plan interventions have been implemented or revised with a change of condition.</p> <p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and</u></p> <p>4. Audits will be completed of new admission resident's admission assessment, fall risk assessment, and care plans by the Director of</p>		

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F 281	Continued From page 5 outside the resident's bathroom door. Interview with Resident #19 on 02/05/14, at 4:25 PM, revealed the resident could not remember anything about the fall. The resident stated it was just a "big blur." Interview conducted with the Director of Nursing (DON) on 02/06/14, at 2:35 PM, revealed staff should have developed an initial plan of care and should have put the plan into place upon the resident's admission to the facility. According to the DON, facility staff was aware Resident #19 was at risk for falls and should not have left the resident unattended in the bathroom.	F 281	Nursing and Unit Managers daily x4 weeks then weekly x4 weeks and then monthly x3 Months to ensure the Assessments were completed upon admission and care plans were implemented. Care plans will be reviewed during the clinical meeting by the Director of Nursing, Unit Manager or MDS person Daily (Mon-Friday) to ensure care plan interventions have been implemented and revised with change in condition to ensure resident care needs are met per physician orders. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager and Quality of Life Director.	
F 282 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and the facility's policy, it was determined the facility failed to implement care plan interventions for one (1) of nineteen (19) sampled residents (Resident #3). The facility failed to ensure staff utilized heel lift boots for heel protection for Resident #3 in accordance with the resident's written plan of care. The findings Include: Review of the facility's policy entitled Using the	F 282	5. Date of Compliance 3-19-14. <u>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;</u>	

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F 282	<p>Continued From page 6</p> <p>Care Plan, revised August 2006, revealed staff should utilize the care plan to develop the resident's daily care routines. In addition, the policy review revealed the care plan would be available to staff personnel who had the responsibility to provide care or services to a resident.</p> <p>Record review revealed the facility admitted Resident #3 on 04/03/07, with diagnoses including Dementia, Anxiety, Altered Mental Status, Anorexia, Muscle/Ligament Disease, Difficulty in Walking, and Joint Contracture of the Arm.</p> <p>Review of a Quarterly Minimum Data Set Assessment dated 12/24/13, revealed Resident #3 was severely impaired and required total assistance of staff to complete Activities of Daily Living (ADL) and was at risk for the development of pressure sores.</p> <p>Review of physician orders, dated 01/29/14, revealed staff was to use heel lift boots for Resident #3 when he/she was in bed for heel protection.</p> <p>Review of a Comprehensive Skin Care Plan, dated 12/26/13, revealed staff had developed care plan interventions for the use of heel lift boots for Resident #3 when he/she was in bed or sitting up in Geri-chair.</p> <p>Review of a Nurse Aide Care Plan, dated November 2012, revealed facility staff was to use heel lift boots when Resident #3 was in bed or in a Geri-chair.</p> <p>Review of a skin assessment document dated</p>	F 282	<p><u>F282</u></p> <ol style="list-style-type: none"> The heel lift boots were re-applied by the Charge Nurse on 2/5/14 upon notification by the surveyor that they were not in place. The Licensed Nurse completed a skin assessment for resident #3 and no skin issues were identified. Resident #3's Primary Physician was notified by the Charge Nurse. An order was obtained on 2/5/14 by Dr. Noble to discontinue the use of the heel lift boots. <p><u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</u></p> <ol style="list-style-type: none"> The Director of Nursing and Unit managers reviewed all other resident's care plans by 3/14/14 to ensure that interventions identified are implemented and in place per the care plan and physician orders. Any care plan interventions not in place will be addressed upon identification. 		

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F 282	<p>Continued From page 7</p> <p>02/01/14, revealed Resident #3's skin was intact and there was very slight redness to the resident's buttocks and the resident's heels were "spongy."</p> <p>However, review of the Treatment Administration Records (TARs) for the month of February 2014 revealed staff failed to document the heel lift boots had been used for Resident #3.</p> <p>Observations during a skin assessment conducted by Licensed Practical Nurse (LPN) #3, Certified Nurse Aide (CNA) #4, and CNA #9 on 02/05/14 at 3:30 PM revealed staff failed to ensure the heel lift boots were in use for Resident #3.</p> <p>CNA #9 stated in an interview conducted on 02/05/14 at 3:46 PM and 3:50 PM that Resident #3 did not have heel lift boots in place. CNA #9 stated she obtained Resident #3's heel protectors from the chest of drawers at the resident's bedside and had informed CNA #4 the heel protectors needed to be put on Resident #3. CNA #9 further revealed Resident #3 should have had the heel lift boots on when he/she was in bed to prevent skin breakdown of the resident's heels.</p> <p>Interview on 02/05/14 at 4:16 PM with CNA #3 revealed Resident #3 should have had heel lift boots on but she had not put the heel protectors on Resident #3 because she could not find them. According to CNA #3, if they can't find the heel lift boots, they are to tell the nurse; however, the CNA stated she failed to inform the nurse that she could not locate the resident's heel lift boots.</p> <p>Interview on 02/05/14 at 4:00 PM with LPN #3 revealed Resident #3 should have had heel lift</p>	F 282	<p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</u></p> <p>3. All resident care plans will be reviewed by the Director of Nursing and Unit Managers by March 14, 2014 to ensure interventions are implemented. Treatment Records will be updated to ensure that the charge nurse is aware that they are in place and will be monitoring daily or as needed. All comprehensive care plans and c.n.a care plans will be compared to the physician orders by the Director of Nursing and the Unit Managers by March 14, 2014, to ensure care plan interventions were care planned. 100% audit will be completed by March 14, 2014 by the Director of Nursing and Unit Managers to ensure that interventions are available and in use as ordered by the physician.</p>		

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F 282	Continued From page 8 boots on in accordance with the Skin Care Plan. LPN #3 stated she "guessed" the resident's heels felt "a little soft." She stated she probably needed to measure the soft areas since she had not measured the areas during the skin assessment. Interview on 02/06/14 at 10:08 AM, with the facility's Staff Development Coordinator and the Unit Manager of the facility's B Wing revealed each resident's care plan should be developed and implemented in accordance with the physician orders. Interview on 02/06/14 at 4:01 PM with the facility's Administrator and on 02/06/14 at 4:24 PM with the facility's Director of Nursing revealed staff was expected to provide care in accordance with the interventions identified on each resident's care plan.	F 282	Education will be provided by the Director of Nursing and Unit Managers for Licensed Nurses and SRNA'S by March 16, 2014 by regarding following the physician's orders for care plan interventions. Education will be provided by the Director of Nursing and Unit Managers for Licensed Nurses and SRNA'S by March 16, 2014 regarding following the care plans to ensure interventions are utilized by the Licensed Nurses and the SRNA'S. <u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and</u>		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and the facility's policies it was determined the facility failed to ensure one (1) of	F 314	4. Care plans will be audited on 5 resident's daily, Mon-Friday, x4 weeks, weekly x4 weeks, then Monthly x3 months, during the clinical meeting by the Director of Nursing and Unit Managers to ensure a care plan intervention has been implemented per Physician Order. The Director of Nursing and Unit Managers will complete a room review of 5 resident's room to		

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F 314	<p>Continued From page 9</p> <p>nineteen (19) sampled residents (Resident #3) did not develop pressure sores and/or received the necessary care and services to promote healing of pressure sores. Resident #3's physician requested staff to utilize heel lift boots for Resident #3 when he/she was in bed for heel protection. In addition, facility staff assessed Resident #3 to be at risk for the development of pressure sores and developed interventions to prevent pressure sores that included the use of heel lift boots. However, staff failed to utilize the heel lift boots for Resident #3 and the resident's heels developed "soft" and "spongy" areas.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled Using the Care Plan, with a revision date of August 2006, revealed the care plan should be available to facility staff that provide care to residents and should be used in the development of the daily care routines of each resident.</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident on 04/03/07. Resident #3's diagnoses included Dementia, Anorexia, Muscle/Ligament Disease, Difficulty in Walking, and a Joint Contracture of the arm.</p> <p>Review of the Nurse Aide Care Plan dated November 2012 revealed staff was to use heel lift boots for Resident #3 when he/she was in bed and/or sitting up in a Geri-chair.</p> <p>Review of Resident #3's Quarterly Minimum Data Set dated 12/24/13, revealed the facility assessed the resident to be severely impaired and required total assistance from staff to complete Activities of Daily Living (ADL). In addition, the facility</p>	F 314	<p>ensure the care plan intervention the resident requires is available and in use per Physician Order daily, Mon-Friday, x4 weeks, weekly x4 weeks, then Monthly x3 months.</p> <p>Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager and Quality of Life Director.</p> <p>5. Date of Compliance 3-19-14.</p> <p><u>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;</u></p>		

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F 314	<p>Continued From page 10</p> <p>assessed Resident #3 to be at risk for the development of pressure sores.</p> <p>Review of the Comprehensive Skin Care Plan dated 12/26/13, revealed facility staff had developed interventions for the use of heel lift boots for Resident #3 when he/she was in bed or sitting up in a Geri-chair. However, review of the Treatment Administration Record for February 2014 revealed the facility failed to provide the use of the heel lift boots for Resident #3.</p> <p>Review of Physician Orders, dated 01/29/14, also revealed staff was to use heel lift boots for Resident #3 when the resident was in bed to aid in the protection of the resident's heels.</p> <p>Review of a skin assessment conducted by staff on 02/01/14 revealed Resident #3's skin was intact, had "very slight" redness to his/her buttocks, and the resident's heels were "spongy."</p> <p>Observation of a skin assessment conducted on 02/05/14, by Licensed Practical Nurse (LPN) #3, Certified Nurse Aide (CNA) #4, and CNA #9 revealed Resident #3 did not have the heel lift boots on his/her feet.</p> <p>Interview on 02/05/14 at 3:46 PM and 3:50 PM with CNA #9; and on 02/05/14 at 4:16 PM with CNA #4 revealed staff was to utilize the heel lift boots for Resident #3 when the resident was in bed. CNA #9 acknowledged Resident #3 did not have heel boots on at the time of the observation on 02/05/14 and stated the heel lift boots were to be used to help prevent heel breakdown. CNA #9 located the resident's heel lift boots in a drawer at the resident's bedside at the time of the observation on 02/05/14 at 3:46 PM. CNA #4</p>	F 314	<p>monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager and Quality of Life Director.</p> <p>5. Date of Compliance 3/19/14</p> <p><u>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u></p> <p>F314</p> <ol style="list-style-type: none"> The heel lift boots were re-applied by the Charge Nurse on 2/5/14 upon notification by the surveyor that they were not in place. The Licensed Nurse completed a skin assessment for resident #3 and no skin issues were identified. Resident #3's Primary Physician was notified by the Charge Nurse. An order was obtained on 2/5/14 by Dr. Noble to discontinue the use of the heel lift boots. 		

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F 314	Continued From page 11 applied the heel lift boots to the resident's feet. Interview on 02/05/14 at 4:16 PM with CNA #3 revealed she had assisted Resident #3 to bed on 02/05/14, prior to the skin assessment conducted on 02/05/14, and had not applied the heel lift boots to the resident's feet because she could not find them. According to CNA #3, staff was to inform the nurse if they were unable to locate the heel lift boots. However, CNA #3 acknowledged she failed to inform the nurse that she was unable to locate the resident's heel lift boots. Interview with Licensed Practical Nurse (LPN) #3 on 02/05/14 at 4:00 PM, revealed she "guessed" Resident #3's heels felt a "little soft." LPN #3 stated Resident #3 should have had the heel lift boots on while he/she was in bed. Interview on 02/06/14 at 10:08 AM, with the B Wing Unit Manager revealed staff should follow the individual care plan and physician orders when they provided care to residents. Interview on 02/06/14 at 4:24 PM, with the Director of Nursing revealed staff was to provide care in accordance with each resident's plan of care. Interview with the Administrator on 02/06/14 at 4:01 PM, revealed she expected staff to provide care based on the interventions on the care plans.	F 314	<u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</u> 2. The Director of Nursing and Unit managers reviewed residents who are at risk for breakdown, those with Pressure ulcers to ensure correct assessment, interventions and care plans reflected the current condition by 3/14/14. Residents who are at risk for breakdown, residents who are at risk for breakdown, those with Pressure ulcers to ensure correct assessment, interventions and care plans reflected the current condition by 3/14/14. All other resident's care plans will be reviewed by 3/14/14 by Director of Nursing and Unit Managers to ensure that Interventions identified are implemented and in place per the care plan and physician orders.		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --	F 322			

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F 322	<p>Continued From page 12</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy (Nasogastric/Gastronomy Tube Feedings), it was determined the facility failed to ensure one (1) of eight (8) residents selected for review that received enteral feeding through a gastrostomy tube (G-tube) received appropriate treatment and services to prevent aspiration pneumonia (unsampled Resident A). Observation during a medication pass revealed the nurse failed to check for placement of the resident's G-tube prior to flushing the G-tube with water. The resident's diagnoses included recurrent aspiration.</p> <p>The findings include: Review of the facility's policy titled</p>	F 322	<p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</u></p> <p>3. Residents who are at risk or will be identified upon admission or during the daily clinical meeting (Monday-Friday) by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and Therapy. Interventions and care plans will be developed at those times to ensure healing and further breakdown does not occur unless unavoidable. All resident care plans will be reviewed by the Director of Nursing and Unit Managers by March 14, 2014 to ensure interventions are implemented. Treatment Records will be updated to ensure that the charge nurse is aware that they are in place and will be monitoring daily or as needed. All comprehensive care plans and c.n.a care plans will be compared to the</p>		

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F 322	<p>Continued From page 13</p> <p>Nasogastric/Gastrostomy Feedings, effective date of December 2010, revealed staff should check placement of the gastrostomy tube prior to feeding. According to the policy, the tube is to be checked by injecting air and listening over the epigastric area with a stethoscope and by aspirating resident's stomach contents before each feeding. In addition, the policy revealed placement of the gastrostomy tube should be checked each shift and prior to giving medications.</p> <p>Review of the clinical record of Resident A revealed a diagnosis of Recurrent Aspiration with status post G-tube placement.</p> <p>Observation during a medication pass on 02/05/14 at 10:03 AM, revealed License Practical Nurse (LPN) #1 crushed the following medications: Phenobarbital 64.8 milligrams (mg) and Tegretol 200 mg and placed the medications into two separate medication cups. The nurse added water to the crushed medications and proceeded to flush Resident A's G-tube with 60 milliliters (ml) of water, and then poured the medications into the G-tube, flushing it with at least 30 ml of water between the medications. LPN #1 then administered a can (8 ounces) of Jevity (tube feeding) 1.5 Cal (calorie) bolus into the resident's G-tube. LPN #1 flushed the G-tube with at least 60 ml of water during the administration of the feeding. After emptying the can of tube feeding, LPN #1 flushed the G-tube with 240 ml of water. The nurse failed to bring a stethoscope into the room and failed to check for placement of the tube by injecting air and listening over the epigastric area with a stethoscope, and/or by aspirating the resident's stomach contents before administering the</p>	F 322	<p>physician orders by the Director of Nursing and the Unit Managers by March 14, 2014, to ensure care plan interventions were care planned. 100% audit will be completed by March 14, 2014 by the Director of Nursing and Unit Managers to ensure that interventions are available and in use as ordered by the physician.</p> <p>Education will be provided by the Director of Nursing and Unit Managers for Licensed Nurses and SRNA'S by March 16, 2014 by regarding following the physician's orders for care plan interventions. Education will be provided by the Director of Nursing and Unit Managers for Licensed Nurses and SRNA'S by March 16, 2014 regarding following the care plans to ensure interventions are utilized by the Licensed Nurses and the SRNA'S. All residents identified at risk or with breakdown will also be discussed weekly for appropriate intervention, progress, as well as care plan review weekly by the interdisciplinary team.</p>		

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F 322	<p>Continued From page 14</p> <p>medications or feeding in accordance with facility policy.</p> <p>Interview with LPN #1 on 02/05/14 at 10:17 AM, revealed the nurse thought placement of the G-tube could be determined by the injection of water through the G-tube and aspirating stomach contents. When asked if placement of the tube was checked by injecting air and listening with a stethoscope, the nurse replied that was not how they did it. The nurse then reviewed the Medication Administration Record (MAR) with the surveyor. The MAR revealed the G-tube placement should be checked before and after the administration of medications and feeding. When asked how this nurse conducted this, the nurse replied by flushing the G-tube with water and aspirating stomach content.</p> <p>Interview with the C Wing Unit Manager on 02/05/14 at 10:30 AM, revealed the nurses were supposed to check placement of a G-tube by injecting air and listening with a stethoscope to ensure the tube was in the resident's stomach and not the lungs. She stated stomach contents can be aspirated after the auscultation of the air.</p> <p>Interview with the Staff Development Nurse on 02/06/14 at 3:47 PM, revealed the facility had provided training on proper techniques during the administration of medications or feedings through a G-tube. She stated the training included checking placement of the tube prior to medication administration and feeding. The Staff Development Nurse provided training records that revealed LPN #1 received training on medication administration of G-tubes on 09/10/13.</p> <p>Interview with the Acting Director of Nursing on</p>	F 322	<p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and</u></p> <p>4. Residents identified at risk for breakdown or those with Pressure Ulcers will be audit weekly by the interdisciplinary team. Care plans will be audited on 5 resident's daily, Mon-Friday, x4 weeks, weekly x4 weeks, then Monthly x3 months, during the clinical meeting by the Director of Nursing and Unit Managers to ensure a care plan intervention has been implemented per Physician Order. The Director of Nursing and Unit Managers will complete a room review of 5 resident's room to ensure the care plan intervention the resident requires is available and in use per Physician Order daily, Mon-Friday, x4 weeks, weekly x4 weeks, then Monthly x3 months. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing, Unit Managers,</p>		

F322

1. Charge Nurse # 1 was in-serviced verbally on 2/5/14 by Unit Manager/Staff Development Nurse regarding checking placement of a G-tube prior to instilling medications. Please note that resident A did not have any adverse effect from the licensed nurse failing to bring a stethoscope into the room and failing to check for placement of the tube by injecting air and listening over the epigastric area.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

2. Residents requiring the use of G-tubes have the potential to be affected by Licensed nurses failing to bring a stethoscope into the room and failing to check for placement of the tube by injecting air and listening over the epigastric area prior to instilling medication. Charge Nurses will be re-educated by 3/14/14 by Unit Manager/SDC regarding the facility's policy and the procedure for Nasogastric/Gastrostomy Feedings.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;

3. Competencies will be completed by the Director of Nurses and Unit Managers for all Licensed Nurses by 3/17/14 to ensure all licensed nurses are competent to perform G-tube medications, feedings, and flushes per facility policy and procedure.

Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and

4. The Director of Nursing and Unit Managers will complete 5 observations daily (Monday-Friday) of Licensed Nurses administering medications thru G-tubes x4 weeks, then weekly x4 weeks and then Monthly x3 Months. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are:
Medical Director,
Administrator, Director of Nursing, Unit Managers,
Social Services Director,
Dietary Manager and Quality of Life Director.

5. Date of Compliance 3-19-14.

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F 322	Continued From page 15 02/06/14 at 3:49 PM, revealed she was aware of the incident when the nurse failed to check for placement prior to medication administration on 02/05/14. She stated she had spoken with LPN #1 and the nurse admitted they had not checked for placement prior to administering the medications. The nurse told her they had become nervous and forgot to check for placement. She stated it was facility policy and nursing standards of practice to always check for placement prior to medication administration or feeding. She stated the nurse should have checked placement with air and checked the stomach contents because it was important to ensure the tube was in the stomach.	F 322	<u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</u> <u>R323</u> 1. Resident # 19's primary physician was notified at the time of the fall on 1/15/14 by the charge nurse. Resident #19's family was present at the facility at the time of the fall on 1/15/14. An order was obtained immediately following the fall, after a physical assessment on 1/15/14 by the charge nurse to send the resident to the ER to be evaluated. The resident was not kept at the hospital after evaluation by the resident's primary physician on 1/15/14. An admission assessment, fall risk assessment, and initial care plan were completed by the Charge Nurse on 1/15/14. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</u>		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the environment remained as free of accident hazards as possible for one (1) of nineteen (19) sampled residents (Resident #19). The facility admitted Resident #19 on 01/15/14 from an acute care facility. Prior to the resident's arrival to the facility on 01/15/14, acute care staff informed facility staff Resident #19 required the assistance of two persons to ambulate. In addition, review of the Nurse Aide	F 323	2. All residents that reside in the facility have the potential to be affected by this practice. All resident care plans will be reviewed by 3/14/14 by the Director of Nursing or Unit		

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F 323	<p>Continued From page 16</p> <p>Care Plan for Resident #19 revealed upon admission the facility assessed the resident to require two staff persons to provide assistance to the resident for transfers and two staff persons were to assist the resident to reposition every two hours, or on a "PRN" (as needed) basis.</p> <p>However, on 01/15/14, two staff persons assisted Resident #19 to the bathroom at approximately 1:45 PM to 2:00 PM. They left the resident unattended in the bathroom, and at approximately 2:00 PM, observed the resident lying on the floor of the bathroom. The facility transferred Resident #19 to the Emergency Department on 01/15/14 at 2:30 PM. Resident #19 sustained a hematoma and contusion to the head as a result of the fall.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Fall Policy," dated April 2012, revealed the facility would conduct a fall risk assessment at the time of the resident's admission to the facility and appropriate care plan interventions would be implemented as indicated by the assessment.</p> <p>Review of Resident #19's closed medical record revealed the facility admitted Resident #19 from an acute care facility on 01/15/14 at approximately 12:00 PM. Further review revealed Resident #19's diagnoses included Parkinson's Disease and a history of falls and head injuries. Prior to the resident's arrival to the facility on 01/15/14, acute care staff informed facility staff that Resident #19 required the assistance of two persons to ambulate. The resident was assessed to be alert. Review of the acute care facility's History and Physical report, dated 01/11/14, revealed two staff persons were required to assist</p>	F 323	<p>Managers to ensure care plan interventions have been implemented and revisions completed for any change in condition to ensure residents remain as free as possible of accident hazards and alert the staff of any needed supervision. The review of care plans will include interventions required for residents with a fall risk score of 10 or greater to ensure interventions were implemented and updated to the c.n.a. care plans to keep the residents as free of accident hazards as possible and alert the staff of any needed supervision.</p> <p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</u></p> <p>3. Education will be provided by the Director of Nursing and Unit Managers for licensed nurse's by March 14, 2014 to complete the initial assessment and initial care plans upon admission to ensure newly admitted residents have all care needs addressed before direct resident care is provided. Care plans will be updated quarterly, and as needed to</p>	

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F 323	<p>Continued From page 17 Resident #19 to ambulate.</p> <p>Review of instructions on the facility's Fall Risk Evaluation tool revealed a score greater than 10 indicated a resident was at risk for falls. Review of the Fall Risk Evaluation, dated 01/15/14 (no time was documented), revealed the facility assessed Resident #19 to have a Fall Risk Evaluation score of 17.</p> <p>Review of an Accident/Incident Report, dated 01/15/14 at 2:00 PM, revealed LPN #2 and Resident #19's family member entered the resident's bathroom and observed the resident lying on his/her right side on the bathroom floor. The Accident/Incident Report revealed LPN #2 observed a large hematoma to the right side of the resident's head. The report stated the resident was transported by ambulance to an acute care hospital on 01/15/14, at 2:30 PM, for further evaluation and treatment.</p> <p>Review of the Emergency Department physician's documentation, dated 01/15/14, at 3:20 PM, revealed Resident #19 had a hematoma and contusion to the right side of the head which was a result of a fall the resident had at the facility.</p> <p>Interview with Resident #19 on 02/05/14, at 4:25 PM, revealed the resident could not remember anything about the fall. The resident stated he/she could not remember what happened and stated it was just a "big blur."</p> <p>Interview with State Registered Nurse Aide (SRNA) #17 on 02/05/14, at 2:15 PM, revealed SRNA #18 had requested her assistance to take Resident #19 to the bathroom. SRNA #17 stated SRNA #18 had told her Resident #19 required the</p>	F 323	<p>ensure care plans are implemented, revised, and communicated to the c.n.a and placed on the c.n.a care plan to keep the residents as free of accident hazards as possible and alert the staff of any needed supervision.</p> <p>Any new admission that scores above a 10 on the fall risk assessment will have a picture of a star placed by their name on the door frame. They will be identified on the interim and c.n.a care plan as being at risk for falling and the picture of a star by the residents name on the door frame will identify to all staff that this resident is at risk for falling. The interim care plan and the c.n.a care plan will state whether the resident is independent or requires supervision or assist of 1 or 2. The star will be left up for 72</p> <p>hours while determining appropriate safety</p> <p>interventions to ensure that the resident remains as free of accident hazards as is possible. The residents chart and plan of care will be reviewed daily by a nursing manager for 72 hours to ensure that the plan of care</p>		

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F 323	<p>Continued From page 18</p> <p>assistance of two to ambulate and both she and SRNA #18 assisted Resident #19 to the bathroom. Continued interview with SRNA #17 revealed after they reached the bathroom, Resident #19 asked for privacy, and she closed the door and left the resident's room. According to SRNA #17 she should have assisted SRNA #18 to take the resident back to the bed but she had been assigned to another unit in the facility and returned to the unit to complete her assignments.</p> <p>Interview with SRNA #18 on 02/05/14, at 2:53 PM, revealed she had been assigned to provide direct care to Resident #19 on 01/15/14. SRNA #18 stated she had been told by LPN #2 that Resident #18 required the assistance of two persons to ambulate. She asked SRNA #17 to assist her to walk Resident #19 to the bathroom. According to SRNA #18, after they were inside the bathroom, the resident asked for privacy and both she and SRNA #17 closed the bathroom door and left the room. The SRNA stated she should have stayed in the resident's room outside the bathroom door but had been in a "hurry" because it was near the end of her shift and she had been "busy" assisting other residents back to bed. SRNA #18 stated she felt Resident #19 would be all right alone in the bathroom.</p> <p>Licensed Practical Nurse (LPN) #2 stated in an interview conducted on 02/05/14, at 3:00 PM, that she had been assigned to provide care to Resident #19 at the time of the resident's admission to the facility on 01/15/14. LPN #2 stated she was informed by staff from the acute care facility that the resident had a history of falls and required the assistance of two for ambulation. In addition, LPN #2 stated that</p>	F 323	<p>should remain the same and that the safety interventions that were put in place are appropriate.</p> <p>Education will be provided by the Director of Nursing and Unit Mangers for the SRNA by March 16, 2014 to ensure there is an initial plan of care before providing care to a newly admitted resident.</p> <p>Residents identified at high risk for falls as evidenced by the falls assessment will be reviewed at the At Risk Meeting by the Director of Nursing, Assistant Director of Nursing, and Unit Managers to ensure all current interventions are in place per physician orders.</p> <p>Physician orders will be reviewed daily (Mon-Friday) by the Director of Nursing, MDS Coordinator, and/or the Unit Managers to ensure care plan interventions have been implemented or revised with a change of condition.</p> <p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and</u></p>	

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F 323	Continued From page 19 based on her initial assessment of Resident #19 she had determined the resident was a fall risk and had informed SRNA #18 that Resident #19 required the assistance of two persons for ambulation. LPN #2 stated although Resident #19 had asked for privacy in the bathroom, SRNAs #17 and #18 should have remained outside the resident's bathroom door to assist the resident back to his/her bed. The Director of Nursing (DON) stated in interview conducted on 02/06/14 at 2:35 PM that facility staff should have remained outside the resident's bathroom door after they had assisted Resident #19 to the bathroom. According to the DON, facility staff was aware Resident #19 was at risk for falls and should not have left the resident unattended in the bathroom.	F 323	1. Audits will be completed of new admission resident's admission assessment, fall risk assessment, and care plans by the Director of Nursing and Unit Managers daily x4 weeks then weekly x4 weeks and then monthly x3 Months to ensure the assessments were completed upon admission and care plans were implemented and revised as needed per physician order to keep the residents as free of accident hazards as possible and alert the staff of any needed supervision.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	Care plans will be reviewed during the clinical meeting by the Director of Nursing, Unit Manager or MDS person Daily (Mon-Friday) to ensure care plan interventions have been implemented and revised with change in condition per physician order to keep the residents as free of accident hazards as possible and alert the staff of any needed supervision. Observations will be conducted daily (Mon-Friday) of 5 residents x4 weeks, then weekly x4 weeks, and then monthly x3		

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F 431	<p>Continued From page 20</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and a review of the facility's policies, it was determined the facility failed to ensure drugs and biologicals were labeled with the date the medication was open. Six (6) multi-use vials of Insulin were observed to be opened and available for use. However, the vials of Insulin did not contain a date when staff had opened the vial as required by facility policy.</p> <p>The findings Include:</p> <p>Review of the facility's policy entitled Medication Administration-Injections, Insulin, with an effective date of December 2010, revealed staff was to mark the date the rubber seal on the bottle of insulin was first punctured on the side of the insulin bottle. In addition, the policy revealed staff was to discard the bottle not more than 28 days after it was first punctured, and refrigerate when</p>	F 431	<p>months by the Director of Nursing and Unit Managers of care givers providing care for residents identified as requiring interventions to keep the resident as free of accident hazards as possible to include identified needed supervision is being completed per care plan intervention.</p> <p>Findings of the above stated audits will be discussed in the Quality Assurance meeting</p> <p>Social Services Director, Dietary Manager and Quality of Life Director.</p> <p>5. Date of Compliance 3-19-14.</p> <p><u>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u></p> <p><u>F431</u></p> <p>1. The six bottles of insulin were discarded and replaced by the Unit Manager on 2/6/14. Please note that no residents were affected by the six bottles of insulin not having a date on the bottle.</p>		

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F 431	Continued From page 21 stored. Observation of the medication cart on 02/06/14 at 10:40 AM, revealed the rubber seal of six insulin bottles had been punctured. However, staff failed to document the date the seal on the bottles of insulin had been punctured on the side of the bottle. Interview on 02/06/14 at 10:37 AM, with Licensed Practical Nurse (LPN) #2 revealed the insulin bottles should have been dated. Interview on 02/06/14 at 11:10 AM, with the Unit Manager of C Wing also revealed the insulin bottles should have been dated. Interview on 02/06/14 at 4:24 PM, with the Director of Nursing revealed staff should follow the facility's policy and should have documented the date the seal on the insulin bottle was punctured. Interview on 02/06/14 at 4:01 PM with the Administrator revealed staff was expected to document the date medications, including insulin, were opened on the side of the bottle.	F 431	However, there was a date open and a discard date on each box the insulin was stored in <u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</u> 2. No further issues were identified. All medication carts and refrigerators were audited on 2/6/14 by the Unit Managers to ensure all medication requiring date open and discard dates were labeled correctly. No other issues were identified. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur</u> 3. An in-service will be completed for licensed nursing staff by the Director of Nursing or Unit Managers by 3-16-14 regarding the requirement to date all medication that require an open date and discard date ie: insulin vials and boxes with the date opened and a discarded date.	
F 441 SS=E	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	F 441		

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F 441	<p>Continued From page 22</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of documentation, it was determined the facility failed to establish and maintain an infection control program to help prevent the development and transmission of disease and infection for four (4) of nineteen (19) residents (Residents #3, #5, #14, and A). The facility failed to ensure staff changed gloves and washed their hands when</p>	F 441	<p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained: and</u></p> <p>4. The Unit Manager, DON, MDS Nurse's or Staff Development Coordinator will complete an audit of medication carts and fridges three times weekly for four weeks, then weekly for three months to ensure medications are stored and labeled according to Federal Guidelines. Findings will be forwarded to the DON weekly to ensure completion. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager and Quality of Life Director.</p> <p>5. Date of Compliance 3/19/2014</p>	

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F 441	<p>Continued From page 23</p> <p>they conducted a skin assessment of Residents #3 and #14; when they conducted a skin assessment and provided catheter care for Resident #5; and when they administered medications to Resident A through the resident's gastrostomy tube.</p> <p>The findings Include:</p> <p>Review of the facility's policy entitled Infection Control, revised in August 2012, revealed the policy was intended to facilitate a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of the facility's Infection Control policy included the prevention, detection, and investigation of infections in the facility.</p> <p>Review of the facility's policy entitled Hand Washing, effective December 2012, revealed staff was to wash their hands as necessary to prevent the spread of infections or germs. According to the policy, staff was to wash their hands before and after they provided resident care.</p> <p>Review of the facility's policy entitled Foley (indwelling catheter) Catheter Care, with an effective date of December 2010, revealed the purpose of catheter care was to prevent possible urinary tract infections from bacteria spreading from the perineal area and external catheter into the bladder. According to the policy, staff was to wash hands thoroughly before and after the provision of catheter care.</p> <p>1. Review of the medical record revealed the facility admitted Resident #3 on 04/03/07 with</p>	F 441	<p><u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</u></p> <p><u>F441</u></p> <ol style="list-style-type: none"> LPN #3, LPN #2, RN #1 and LPN #1 were re-educated verbally by the Unit Manager/Staff Development Coordinator on 2/5/14 and 2/6/14 regarding hand washing, changing of gloves, and following the infection control policy when providing care to residents in a n effort to prevent cross-contamination and /or the spread of infections. Please note resident #3, #5, #14 and A did not have any adverse effect from said practice. <p><u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</u></p> <ol style="list-style-type: none"> All resident's requiring staff to assist with direct contact have the potential for the spread of infection. Direct care staff will be observed 5x weekly x4 weeks then 5 observations monthly x3 months by the Director of Nursing or Unit Managers 		

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F 441	<p>Continued From page 24</p> <p>diagnoses including Dementia, Anxiety, Altered Mental Status, Anorexia, Muscle/Ligament Disease, Difficulty in Walking, and Joint Contracture of the Arm. Review of the Quarterly Minimum Data Set Assessment dated 12/24/13, revealed the facility assessed Resident #3's cognitive ability as severely impaired. The resident required total assistance of staff to complete Activities of Daily Living.</p> <p>Observation on 02/05/14 at 3:30 PM, during a skin assessment revealed Licensed Practical Nurse (LPN) #3 applied gloves and assessed Resident #3's perineum, legs, heels, and arms/arm pits. However, the LPN failed to change gloves and wash her hands after the assessment of the resident's perineum and before she continued to assess the resident's feet, legs, and arms.</p> <p>Interview on 02/06/14 at 3:50 PM with Licensed Practical Nurse (LPN) #3 revealed she should have changed her gloves after she assessed Resident #3's perineum and before she continued with the assessment.</p> <p>2. Record review revealed the facility admitted Resident #5 on 08/06/13 with diagnoses including Generalized Weakness, Mobility Impairment, Insulin Dependent Diabetes Mellitus (IDDM), Massive Morbid Obesity, Chronic Obstructive Pulmonary Disease (COPD) with Active Chronic Insufficiency, Chronic Edema, and Kidney Disease.</p> <p>Review of a Quarterly Minimum Data Set dated 11/01/13, revealed Resident #5's cognition was intact, he/she required assistance with activities of daily living, and had an indwelling urinary</p>	F 441	<p>providing care to residents to ensure the infection control policy is followed during care. Any issues identified will be addressed immediately.</p> <p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur</u></p> <p>3. The Director of Nursing and Unit Managers will provide re-education on the hand washing policy and changing of gloves and following the infection control policy for the direct care staff (Licensed Staff and SRNA'S) by 3/14/14 to ensure the facilities infection control program is being followed.</p> <p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and</u></p> <p>4. The Director of Nursing and Unit Managers will complete observations of Licensed Nurses and SRNA's completing direct care 5 observations weekly x4 weeks then 5 observations monthly x3 months.</p>		

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F 441	<p>Continued From page 25 catheter.</p> <p>Observation on 02/05/14 at 2:06 PM, revealed LPN #2 conducted a skin assessment and performed catheter care for Resident #5. LPN #2 was observed to apply gloves and begin the skin assessment; however, during the skin assessment, LPN #2 adjusted her hair, lanyard name badge, and pens with her gloved hands and continued to conduct the skin assessment without changing gloves and washing her hands. LPN #2 was also observed to pick up Resident #5's catheter bag from the floor with her gloved hands, place the catheter bag on the bed next to the resident, and continue to provide catheter care without changing gloves and/or washing her hands.</p> <p>Interview on 02/05/14 at 2:37 PM, with LPN #2 revealed she had tried to prevent her hair and lanyard name badge from touching Resident #5 during the skin assessment and acknowledged she should have changed her gloves after touching her hair and lanyard name badge. In addition, LPN #2 stated she should have changed her gloves after she picked the catheter bag up from the floor with her gloved hands and prior to the completion of the catheter care for Resident #5. LPN #2 stated her failure to change gloves and to wash her hands could have placed the resident at risk for infections.</p> <p>3. Record review revealed the facility admitted Resident #14 on 12/30/13, with diagnoses that included Hypertension, Alzheimer's Disease, Dementia, and Venous Stasis. Review of the Admission Minimum Data Set (MDS) Assessment revealed the resident needed extensive assistance with activities of daily living.</p>	F 441	<p>Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the quality assurance committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager and Quality of Life Director.</p> <p>5. Date of Compliance 3-19-14</p>		

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F 441	<p>Continued From page 26</p> <p>Observation on 02/06/14 at 1:55 PM, revealed Registered Nurse (RN) #1 conducted a skin assessment of Resident #14. RN #1 failed to change her gloves or wash her hands after she assessed Resident #14's feet or before she assessed the resident's perineum and buttocks.</p> <p>RN #1 acknowledged in an interview conducted on 02/06/14 at 3:18 PM, that she should have changed her gloves and washed her hands after she had assessed Resident #14's feet and before she assessed the resident's perineum and buttock area.</p> <p>Interview on 02/06/14 at 4:24 PM, with the facility's Director of Nursing revealed staff should follow the facility's infection control policy when they provided care to residents in an effort to prevent cross-contamination and/or the spread of infections.</p> <p>Interview with the Administrator on 02/06/14 at 4:01 PM, revealed staff needed to follow the facility's infection control policy. The Administrator further stated staff should have washed their hands and changed gloves in accordance with the facility's policy in an effort to help prevent and control the spread of infection.</p> <p>4. Observation during a medication pass for Resident A on 02/05/14 at 10:03 AM, revealed the nurse crushed the medications (tablets) and administered the medications through the resident's gastrostomy tube (G-tube). License Practical Nurse (LPN) #1 was observed to wash his hands prior to crushing the medications and taking the medications to the resident's room. However, the nurse forgot something outside of</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2014
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F 441	<p>Continued From page 27</p> <p>the room, removed the medication, and left the room. Continued observation revealed the nurse went to the supply room, obtained a syringe, touched the medication cart and the nurses' station counter, and then took the medications back into the resident's room to administer without performing hand hygiene. The nurse uncapped the resident's G-tube, placed his ungloved hand around the tube, and placed a syringe into the G-tube. After administering the medications, the nurse poured a can of Jevity 1.5 Cal (calorie) tube feeding into the G-tube with ungloved hands. The nurse flushed the tube with water and then recapped the G-tube with his bare hands. The nurse removed empty medication cups, the can of feeding, and other trash from the room. The nurse then used alcohol gel to cleanse his hands.</p> <p>Interview with LPN #1 on 02/05/04 at 10:17 AM, revealed he should have worn gloves during the medication and tube feeding administration. LPN #1 stated he had washed his hands prior to the preparation of the medications; however, the nurse acknowledged he had left the room and touched several environmental objects without performing hand hygiene again before the administration of the medications.</p> <p>Interview with the Director of Nursing (DON) on 02/06/04 at 3:49 PM, revealed staff was required to wash their hands prior to putting on gloves. In addition, the DON stated staff should wear gloves during the administration of medications and feedings through a resident's G-tube.</p>	F 441			