F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to revise the comprehensive care plan to address emergency bleeding for 2 of 3 (Residents #18 and 20) sampled residents receiving dialysis.

The findings included:
1. Medical record review for Resident #18 documented an admission date of 12/19/08 with diagnoses of Diabetes Mellitus, End Stage Renal Disease, Hypertension and Chest Pain. Review of

Any deficiency statement ending with an asterisk (*) requires 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.
F 280 Continued From page 1

a physician's order dated 2/1/12 documented, "HEMODIALYSIS TUES [Tuesday], THURS [Thursday], and SAT [Saturday] @ [at] 1045 AM @ [named dialysis facility]..." Review of the "Comprehensive Care Plan" dated 1/2/12 contained no documentation to address emergency bleeding procedures.

During an interview in the activities office on 2/8/12 at 2:30 PM, the Director of Nursing (DON) was asked to review Resident #18's comprehensive care plan. The DON confirmed there was no documentation on the care plan related to emergency bleeding precautions.

2. Medical record review for Resident #20 documented an admission date of 2/16/11 with diagnoses of Congestive Heart Failure, End Stage Renal Disease, Diabetes Mellitus II, Atrial Fibrillation and Anxiety. Review of the "Care Plan" dated 8/26/11 revealed no documentation to address emergency bleeding procedures for the dialysis shunt.

During an interview in the activities office on 2/8/11 at 2:40 PM, the DON confirmed the correct measures for emergency bleeding were not on the care plan.

F 282

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...
<table>
<thead>
<tr>
<th><strong>F 282</strong></th>
<th>Continued From page 2 by:</th>
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<tbody>
<tr>
<td>Based on medical record review, observation and interview, it was determined the facility failed to develop a care plan for oxygen therapy for 1 of 8 (Resident #16) sampled residents.</td>
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The findings included:

Medical record review for Resident #16 revealed an admission date of 5/10/10 with a readmission date of 11/14/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Osteoarthritis, Hernia, Scoliosis and Osteoporosis. Review of the recertification orders dated 1/28/12 documented: "...O2 [oxygen] @ [at] BNC [bilateral nasal cannula] as needed to keep sats [saturations] above 92% [percent]..."

Observations made during initial tour in Resident #16's room on 1/6/12 at 8:44 AM, revealed Resident #16 was on oxygen at a setting between 0 and 1 liter per minute.

During an interview in the activities office on 1/8/12 at 2:40 PM, the Director of Nursing confirmed that there was no care plan for oxygen therapy for Resident #16.

<table>
<thead>
<tr>
<th><strong>F 315</strong></th>
<th>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</th>
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<tbody>
<tr>
<td>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incompetent to bladder receives appropriate treatment and services to prevent urinary tract infections.</td>
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<th><strong>F 282</strong></th>
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<tbody>
<tr>
<td>3. Licensed nurses were in-serviced on updating care plans to include the use of oxygen on 2/13/12 by the Director of Nursing and/or Staff Development.</td>
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<tr>
<td>4. An audit of new oxygen orders will be completed to ensure accuracy of care plans 5 times a week for 4 weeks then 2 times a week for 2 months and/or until 100% compliance is obtained by the Director of Nursing. The findings will be reported to the Quality Assurance Committee by the Director of Nursing x 3 months or until 100% compliance is achieved. Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Dir., Dietary Manager, Minimum Data Set Nurse, Staff Development Coordinator, Medical Records, Rehab Manager, Maintenance Director and Environmental Services.</td>
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</tr>
</tbody>
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Continued From page 3

F 315 infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide valid medical justification for the use of an indwelling catheter for 1 of 6 (Resident #13) sampled residents with a catheter.

The findings included:

Review of the facility's "Foley Catheters, Care of, Infection Control and Insertion Guidelines" policy documented, "...Purpose... To prevent and control Foley catheter associated urinary tract infection... Urinary catheters should be inserted only when necessary and left in place only for as long as necessary. They should not be used for the convenience of resident care personnel."


Observations in Resident #13's room on 2/6/12 at 9:50 AM, on 2/7/12 at 7:10 AM and 2:45 PM, and on 2/8/12 at 9:00 AM, revealed Resident #13 with an indwelling catheter.

3. Licensed nurses were in-serviced on 2/13/12 regarding valid medical justification for the use of indwelling catheters by the Director of Nursing and/or Staff Development.

4. Indwelling catheter orders will be audited for diagnosis 2 times per week for 1 month and 1 time a week for 2 months and/or until 100% compliance is obtained by the Director of Nursing/Nurse Supervisor. Results of the audits will be reported to the Quality Assurance Performance Improvement committee for 3 months by the Director of Nursing and/or until 100% compliance is obtained. Members of the committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activity Director, Dietary Manager, MDS-RN, Medical Records, Rehab Manager, Maintenance Director and Environmental Services.
Continued From page 4

During an interview in the activities office on 2/8/12 at 9:25 AM, the Director of Nursing (DON) was asked why Resident #13 had a catheter. The DON stated, "...because she has VRE...."

**F 328**

483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

The facility must ensure that residents receive proper treatment and care for the following special services:
- Injections;
- Parenteral and enteral fluids;
- Colostomy, urostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

This REQUIREMENT is not met as evidenced by:
- Based on medical record review, observation and interview, it was determined the facility failed to ensure oxygen (O₂) was administered at the rate prescribed by the physician for 1 of 8 (Resident #16) sampled residents receiving O₂ therapy.

The findings included:
- Medical record review for Resident #16 documented an admission date of 5/10/10 with a readmission date of 11/4/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Osteoarthritis and Osteoporosis. The physician's order dated 1/10/12 documented, "...O₂ [at]"
F 328: Continued from page 5

2L [liters] BNC [binaural cannula] as needed to keep Sats [saturations] above 92% [percent]...

Observations in Resident #16's room on 2/6/12 at 8:44 AM, revealed Resident #16's O2 rate was set between 0 and 1 liters per minute, instead of the physician's prescribed rate of 2 L/minute.

During an interview in the activities office on 2/8/12 at 2:40 PM, the Director of Nursing confirmed that Resident #16's O2 rate should be at 2L.

F 441 483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a
Continued From page 6

communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on review of “Material Safety Data Sheet” standards, policy review, medical record review, observation and interview, it was determined the facility failed to maintain infection control practices to prevent the potential spread of infection by not properly cleaning a graduated cylinder used to empty a Foley catheter and not following facility policy for contact precautions for 1 of 2 (Resident #13) sampled residents in contact isolation.

The findings included:

Review of the "Material Safety Data Sheet" documented, "...IDENTITY (As Used on Label and List) First Choice PrimaGuard No-Rinse Perineal Wash... Section VI - Health Hazard Data. Health Hazards (Acute and Chronic) No-Rinse Perineal Wash is a mild detergent solution intended for topical human use, and should be used as directed..."
Review of the facility's "Infection Control Recommendations for Long-Term Care Facilities" policy documented, "...II. RESIDENTS WITH URINARY CATHETERS... Use a separate container for collection of urine from each resident. Disinfect the container after each use...

Review of the facility's "Contact Precautions" policy documented, "Purpose... It is the intent of this facility to use contact precautions for residents known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient's environment... Gloves and Handwashing 1. Gloves should be worn when entering the room and while providing care for a resident... 3. Gloves should be removed before leaving the resident's room and hands should be washed immediately. 4. After glove removal and handwashing, hands should not touch potentially contaminated environmental surfaces or items... Gowns 1. A gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room... 3. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces... Contact precautions may be considered for (examples): a. Multi-resistant organisms... VRE (vancomycin-resistant enterococcus)..."

Medical record review for Resident #13 documented an admission date of 1/18/12 with diagnoses of Right Femoral Fracture Status/Post Open Reduction Internal Fixation, Hypertension, Suspected Urinary Tract Infection and Insomnia.
F 441: Continued From page 8


Observations in Resident #13's bathroom on 2/6/12 at 9:50 AM and on 2/7/12 at 7:10 AM and 2:45 PM, revealed a graduated cylinder upside down on a paper towel on the back of the toilet.

During an interview in Resident #13's bathroom on 2/7/12 at 2:56 PM, Certified Nursing Assistant (CNA) #2 confirmed the graduated cylinder on the back of the toilet was used to empty Resident #13's foley catheter, and Resident #13 shared the bathroom with three other residents.

During an interview in Resident #13's bathroom on 2/8/12 at 9:10 AM, CNA #1 was asked to describe the procedure for cleaning the graduated cylinder used to empty Resident #13's foley catheter. CNA #1 stated, "...rinse it [graduated cylinder] out with Peri-wash, dry it out and put it on a paper towel on the back of the commode..." When asked to see what she used to disinfect the graduated cylinder with, CNA #1 produced first choice primaguard no-rinse perineal wash.

During an interview in the activities office on 2/8/12 at 9:23 AM, the Director of Nursing (DON) confirmed the CNAs used first choice primaguard no-rinse perineal wash to clean the graduated cylinder used to empty Resident #13's foley catheter.

Observations in Resident #13's room on 2/7/12 at 7:10 AM, CNA #2 brought linens out of Resident...
Continued From page 9

13's room and placed them in a gray linen barrel in the 500 hallway. CNA #2 did not remove her gloves or wash her hands before leaving Resident 13's room.

Observations in Resident 13's room on 2/7/12 at 7:42 AM, CNA #1 entered Resident 13's room and touched a bedside table while serving a breakfast tray without wearing gloves and without washing hands before leaving the room.

Observations in Resident 13's room on 2/7/12 at 2:47 PM, revealed Physical Therapy Worker #1 in Resident 13's room without wearing gloves or a gown. Physical Therapy Worker #1 touched Resident 13's bedside table, a Bible on the bedside table, Resident 13's closet and Resident 13's shoes without wearing gloves or a gown. Physical Therapy Worker #1 left Resident 13's room without washing her hands.

During an interview in the Activities Office on 2/8/12 at 9:25 AM, when asked what precautions should be taken when entering a contact isolation room the DON stated, "...you take the necessary precautions, such as gloves... if coming in contact with isolation contents, a gown..."

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it

1. Physician was notified on 2/7/12 of missing lipid panel on resident #10 by the Director of Nursing, note new order.

2. All residents who receive laboratory services have the potential to be affected.
Continued From page 10

was determined the facility failed to obtain laboratory tests as ordered by the physician for 1 of 24 (Resident #10) sampled residents.

The findings included:

Medical record review for Resident #10 documented an admission date of 2/17/11 and a readmission date of 3/1/11 with diagnoses of Atrial Fibrillation, Aspiration Pneumonia, Cerebral Vascular Accident, Vascular Dementia, Diabetes Mellitus and Anemia. Review of a physician's order dated 1/31/12 documented, "...LIPID PANEL EVERY 6 MONTHS..." The facility was unable to provide documentation that a lipid panel was done every 6 months as ordered.

During an interview in the activities office on 2/8/12 at 10:15 AM, the Assistant Director of Nursing confirmed the lipid panel was not done as ordered by the physician.

The Director of Nursing and the Assistant Director of Nursing completed an audit on 2/15/12 of resident charts to ensure laboratory tests have been obtained as ordered by the physician.

3. Licensed Nurses were in-serviced on 2/13/12 for obtaining labs by physician order by the Director of Nursing and/or Nursing Supervisor.

4. The Director of Nursing and/or Nursing Supervisor will audit physician order to blood draw to ensure lab was drawn as ordered 3 times a week for 2 weeks, 3 times a week for 2 weeks, 2 times a week for 1 month then 1 time a week for 1 month and/or until 100% compliance is obtained by the Director of Nursing. Results of the audits will be reported to the Quality Assurance Performance Improvement Committee for 3 months or until 100% compliance is obtained.

Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activity Director, Dietary Manager, Minimum Data Set Nurse, Medical Records, Rehab Manager, Maintenance Director and Environmental Services Director.