## INITIAL COMMENTS

During the annual Recertification survey and complaint investigation of #28481 conducted on August 1 to 3, 2011, at Imperial Gardens Health and Rehabilitation, deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.

F 157
483.10(b)(11) NOTIFICATION OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update

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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 patient. (See instructions.) Except for nursing homes, the findings stated above are discoverable to the Patient Advocate (PA) and other staff members 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 discoverable 15 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.
**IMPERIAL GARDENS HEALTH AND REHABILITATION**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR NRC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 157</td>
<td>Continued From page 1 the address and phone number of the resident's legal representative or interested family member.</td>
<td>F 157</td>
<td>Residents with any changes in condition have a potential to be affected.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Beginning on August 16, 2011, all team leader nurses were in-service by IDON, an LPN, and Nurse Educator regarding notification to appropriate parties when a resident has a change in condition. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on notification to appropriate parties when a resident has a change in condition prior to working on the unit by the Nurse Educator, IDON or designee. The IDON or designee reviews the 24 hour report daily. This report identifies residents who have a change in condition or treatment based on physician orders. The IDON or designee will review daily to assure appropriate parties are notified in a timely manner when such notification is warranted. The 24 hour report is automatically generated from the Electronic Charting System (ECS). Additionally, the IDON or designee reviews changes in resident condition or treatment in stand up meetings with the Team Leaders and other members of the IDT (i.e., therapy, social service, wound nurse). These daily meetings discuss residents with changes in</td>
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<td>Based on medical record review and interview, the facility failed to notify a family of a change in resident condition for one (#29) of twenty-nine residents reviewed.</td>
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<td>The findings included:</td>
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<td>Medical record review revealed resident #29 was admitted to the facility on December 19, 2008, with diagnoses to include Diabetes Mellitus, Hypertension, Congestive Heart Failure, Dementia, Atrial Fibrillation, and Pacemaker insertion.</td>
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<td>Review of the Minimum Data Set dated July 3, 2011, revealed the resident required total assistance with transfers, dressing, bathing, had to be fed by staff; was incontinent of bowel; had a urinary catheter in place; and had a stage II pressure ulcer.</td>
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<td>Medical record review of nursing notes dated May 14, 2011, revealed &quot;In House Acquired Pressure Ulcer stage 2 coccyx; healed, treatment discontinued&quot;. Continued medical record review of nursing notes dated May 21, 2011, revealed &quot;Informed Wound Care Nurse resident has skin breakdown on lower back/coccyx area. It is in the area of prior wound&quot;. Review of nursing notes dated June 2, 2011, revealed the pressure ulcer on the coccyx was ... stage II and measured 2 cm (centimeters) x 1 cm x &lt; (less than) 1/8 cm</td>
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with serosanguinous (bloody) drainage and irregular wound edges... 

Medical record review of physician's telephone orders dated May 30, 2011, revealed "Cleanse wound to coccyx with wound cleanser, pat dry with 4x4 gauze, cover with hydrocolloid dressing; change every 5 days and as needed until resolved". Continued review of physician's orders dated June 2, 2011, revealed "Cleanse wound to coccyx with wound cleanser; apply transparent film or thin foam dressing; change every 3 days and as needed for 14 days then reassess".

Medical record review of nursing notes dated June 15, 2011, revealed the pressure ulcer on the coccyx measured 6.5 cm x 4 cm x <1/8 cm and had serous drainage. Continued medical record review of nursing notes dated June 22, 2011, revealed the pressure ulcer on the coccyx measures 4.5 cm x 6 cm x <1/8 cm with serous drainage. Continued medical record review of nursing notes dated July 5, 2011, revealed the pressure ulcer on the coccyx measured 2 cm x 6 cm x 1/8 cm with serosanguinous drainage; had 5% slough, 5% epithelization, and 90% granulation.

Medical record review of physician's orders dated July 5, 2011, revealed "Cleanse wound with wound cleanser; apply Solosite gel to wound bed and cover with foam dressing. Change daily and as needed".

Medical record review of nursing notes dated July 26, 2011, revealed "Call Placed To Attending physician regarding increased wound drainage. New orders received and noted". Further medical...
Continued From page 3
record review of nursing notes dated July 26, 2011, revealed "... dressing removed due to saturation. Area cleansed and wound treatment done per order."

Medical record review of physician's orders dated July 27, 2011, revealed "Cleanse wound to coccyx with wound cleanser. Apply calcium alginate to wound bed. Apply foam dressing. Change three times a day at 9:00 a.m., 5:00 p.m., and 1:00 a.m.". Continued review of physician's orders dated July 28, 2011, revealed "Cleanse wound to coccyx with wound cleanser. Apply calcium alginate to wound bed. Apply foam dressing. Change twice a day at 7:00 a.m., and 3:00 p.m."

Medical record review of nursing notes dated August 1, 2011, revealed pressure ulcer to coccyx measured 3.5 cm x 4 cm x 1/2 cm; had serous drainage; deep purple to area surrounding ulcer; and had slough in the base of the wound.

Medical record review of nursing notes revealed no documentation the family was notified of the deterioration in the pressure ulcer on the resident's coccyx.

Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on June 3, 2011, at 9:15 a.m., in the DON's office revealed the ADON is a Certified Wound Care Nurse. Continued interview revealed the ADON saw the wound on July 25, 2011, which had no drainage and was not deep. Further interview revealed the resident had "... pools of exudate under the skin which leaked out overnight so the wound became a crater by the next morning."

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Further interview with the DON revealed the daughter was told the only thing the facility failed to do was notify the family when the wound because worse. Continued interview confirmed the family was not notified of the deterioration in the status of the pressure ulcer on the resident's coccyx.

COMPLAINT #28481
483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(a)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, observation, facility policy review, and interview, the facility failed to assess for self-administration of medications for one (#28) of twenty-nine residents reviewed.

The findings included:

- Resident #28 was admitted to the facility on September 8, 2008, with diagnoses including Chronic Obstructive Pulmonary Disease, Vascular Dementia, and Congestive Heart Failure.

Medical record review of the Minimum Data Set (MDS) dated May 11, 2011, revealed the resident had moderately impaired cognitive skills.

Imperial Gardens Health and Rehabilitation will assess residents for self-administration of medications and only those who are assessed as able to self-administer medications will be permitted to do so.

The IDON spoke with the attending physician on August 3, 2011 regarding resident #28 being left unattended with his nebulizer treatment running. A medication error report was inititated by the IDON immediately on August 3, 2011. The physician determined the resident needed no further intervention, and stated to continue the medication with the next scheduled treatment. No adverse outcomes were noted by the staff or the physician.

Immediately thereafter the IDON gave verbal education and training to the LPN who administered the nebulizer treatment to resident #28 regarding administering respiratory treatments and staying with the resident until respiratory treatments are completed. The written instruction was provided to the LPN by the IDON on August 16, 2011.
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Medical record review of the physician's orders dated August 2011, revealed "...DuoNeob\nIpratropium-Atosuclor (bronchodilators) 0.5 mg (milligrams)/3ml (milliliter) 0.25(3):mg/3 ml\nsolution inhalation via nebulizer bid (two times a\nday)..." for chronic bronchitis...

Medical record review revealed no documentation the resident had been assessed for self-administration of medications.

Observation on August 3, 2011, from 9:06 a.m., until 9:18 a.m., revealed the resident asleep in a\nrecliner, with the feet elevated. Continued\nobervation revealed a nebulizer mask was\nlocated on the resident's face. Continued\nobervation revealed the top of the nebulizer\nmask was approximately one inch above the\neyebrows, and the bottom of the mask was in the\nresident's mouth. Continued observation revealed no staff member was present on the\nhallway of the resident's room.

Observation on August 3, 2011, at 9:18 a.m.,\nrevealed Licensed Practical Nurse (LPN) #\n7 entered the resident's room, and removed the
nebulizer mask. Interview with LPN #7, at the\ntime of the observation revealed LPN #7 had not\napplied the nebulizer mask on the resident.\nContinued interview revealed LPN #8 was responsible for applying the nebulizer treatment and mask to the resident.

Interview on August 3, 2011, at 9:20 a.m., with\nLPN #8, on a different hallway, revealed the nebulizer treatment had been placed on the\nresident approximately 20-25 minutes earlier.

Resident # 28 is has his medication administered by the nurse.

Beginning August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding appropriate medication passage including respiratory treatments. This in-service included policy and procedures related to self-administration of medications. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on medication pass including respiratory treatments prior to working on the units by the Nurse Educator, IDON or designee.

Additionally, medication pass audits are being conducted weekly on licensed nursing staff including licensed nursing agency staff by the IDON Nurse Educator and RN Team Leaders. This audit tool was revised in April, 2011 and weekly audits began on August 8, 2011. These audits check to ensure residents receive their medications appropriately. If an error is found it is corrected immediately by the person completing the audit. (Attachment 3)

The results of medication pass audits are given to the IDON. The IDON or designee then tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining
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<td>F176</td>
<td>Continued From page 6</td>
<td>Continued interview revealed LPN #8 was unaware if the resident had been assessed for self-administration of medications. Review of the facility's policy Self-Administration of Medications revealed &quot;Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team had assessed the resident and determined that this practice is safe for the resident and other residents of the facility.&quot; Interview on August 3, 2011, at 9:25 a.m., with the Quality Improvement Coordinator, in the Admissions office, confirmed the resident had not been assessed for self-administration of medications.</td>
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<td>F221</td>
<td>483.13(a) RIGHT TO BE FREE FROM PHYSICALRAINTS</td>
<td>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to assess for the use of a restraint for one (#12) resident of twenty-nine residents reviewed. The findings included: Resident #12 was admitted to the facility on January 15, 2010, with diagnoses including Major</td>
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<td>F221</td>
<td>Stated as necessary</td>
<td>Residents will be assessed for restraints prior to use by the licensed nurse. A restraint assessment on resident #12 was completed by the licensed nurse on August 13, 2011 to determine the need for the wheelchair self-release seat belt. (Attachment 4) Beginning August 8, 2011 prior to a restraint being placed on a resident the IDON or designee must be notified. The IDON or designee will review information to assure a pre-restraint assessment is conducted, is warranted and a physician order is written prior to giving permission for a restraint to be placed on a resident. Beginning on August 16, 2011 all team leader nurses were in-services by the IDON and LPN and the Nurse Educator regarding pre-restraint assessments prior to</td>
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Depressive Disorder, Hypertension, Arteriosclerotic Dementia, and Cerebrovascular Accident.

Medical record review of a physician's order dated February 16, 2011, revealed "...Self Release wheelchair belt with alarm..."

Medical record review of a Rehab Screen dated February 16, 2011, revealed, "Type of Screen...Fail observed for transitions, transfers, and belt buckle detachment. Pt. (patient) was unable to push the unlocking mechanism on the belt in order to release self from w/c (wheelchair) after multiple tries. Pt. could not follow verbal instruction and was unable to place finger on appropriate area in order to release the belt...The application of a belt buckle currently meets the definition of a restraint due to pt cognitive status...Therapy not recommended at this time..."

Review of the facility policy, Physical Restraints, revealed, "...a Pre-Restraint Assessment will be completed to determine the least restrictive measures..."

Medical record review revealed no pre-restraint assessment had been completed for the self release wheelchair belt with alarm.

Observation on August 1, 2011, at 1:15 p.m., revealed the resident seated in a wheelchair, in the resident's room, with a self release belt alarm in place.

Interview on August 3, 2011, at 9:50 a.m., with the Assistant Director of Nursing, in the Director of Nursing office, confirmed a pre-restraint using a restraint. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on pre-restraint assessments.

Residents with existing restraints are identified by the Restraints/Physical forms generated from ECS. This form shows all residents using physical restraints or assistive devices. The Team Leader Nurse pulls this report form daily and conducts visual checks throughout the day to assure appropriate restraints or assistive devices are on and in working order. Additionally, the Team Leader Nurse reviews all residents visually on a daily basis to assure restraints are not used on a resident without a physician order. This Restraint/Physical form is given to the IDON or designate daily by the RN/LPN.

Additionally, the IDON or designate reviews the 24 hour report, which pulls all new physician orders regarding restraints from the ECS to the report. The IDON or designate reviews all new physician orders for restraints. This is a double check to assure they have been called prior to the restraint being placed on the resident.

The results of the restraint audits are given to the IDON or designate. The IDON or designate then tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team.
### IMPERIAL GARDENS HEALTH AND REHABILITATION

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<tr>
<td>F 221</td>
<td>Continued from page 8 assessment had not been completed for the use of the self-release wheelchair belt with alarm.</td>
<td>F 221</td>
<td>composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.</td>
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<td>F 280</td>
<td>483.10(k)(2) RIGHT TO 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.</td>
<td>F 260</td>
<td>Imperial Gardens will revise care plans when appropriate.</td>
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<td>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.</td>
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<td>The plan of care for resident # 9 was revised on August 2, 2011 by the LPN to reflect that Hospice was discontinued. (Attachment 6)</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two (#9, #29) of twenty-nine residents reviewed.</td>
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<td>A physician order for a trial of a self-release belt was written on July 11, 2011. The order did not include to remove the soft waist belt therefore the order was unclear. On July 20, 2011 there is a nurse's note stating a self-release belt in place, no attempts to get out of chair. On August 2, 2011 the self-release belt was replaced.</td>
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<td>The findings included: Resident #9 was admitted to the facility on September 11, 2008, with diagnoses including</td>
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<td>According to the nurses' notes, resident # 9 has not experienced a fall since the self-release belt was in place on August 2, 2011.</td>
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<td>The plan of care for resident # 29 was not revised and the LPN MDS nurse was counseled on August 6, 2011 by the IDON. The resident expired on August 7, 2011. (Attachment 7)</td>
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Urinary Tract Infection, Congestive Heart Failure, and Stage Dementia.

Medical record review of the fall risk assessment dated June 8, 2011, revealed the resident was at high risk for falls.

Medical record review of a physician's order dated February 14, 2011, revealed "D/C (discontinue) Hospice Care per family request."

Medical record review of a physician's order dated July 11, 2011, revealed "D/C soft waist belt. Trial of self-release belt when in W/C (wheelchair) D/T (due to) unsteadiness and unassisted transfer attempts..."

Medical record review of the Care Plan reviewed on July 13, 2011, revealed "Resident is a hospice patient collaborate with hospice staff with concerns and problems...Resident to have soft waist belt in place in W/C..."

Observation on August 2, 2011, at 8:16 a.m., revealed the resident seated in a wheelchair, in the resident's room, without the self-release wheelchair belt in place.

Interview on August 2, 2011, at 11:10 a.m., with Licensed Practical Nurse (LPN) #4, in the admissions office, confirmed the Care Plan was not revised to discontinue hospice and the soft waist belt, and to include the self-release wheelchair belt.

Medical record review revealed resident #28 was

Beginning August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding updating the plan of care to meet current resident needs. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on updating the plan of care to meet current resident needs prior to working on the units by the Nurse Educator, IDON or designee.

The MDS nurse will review all resident's plans of care and make changes to reflect the resident's current condition no later than August 18, 2011.

Thereafter, resident plans of care will be updated by the Team Leader Nurse and the MDS Nurse no less than quarterly and with any change that warrants a new change in their current plan of care.

The RN/LPN will visually monitor the resident daily for any changes in condition and report such changes to the IDON or designee daily. The MDS Nurse or designee will review the 24 hour report, which shows all new physician orders, for any resident changes daily. The RN/LPN and MDS Nurse will review these audits and update the resident plan of care accordingly.
Continued From page 10 admitted to the facility on December 19, 2008 with diagnoses to include Diabetes Mellitus, Hypertension, Congestive Heart Failure, Dementia, Atrial Fibrillation, and Pacemaker Insertion. Review of the Minimum Data Set dated July 3, 2011 revealed the resident required total assistance with transfers, dressing, bathing; had to be fed by staff; was incontinent of bowel; had a urinary catheter in place; and had a stage II pressure ulcer.

Medical record review of nursing notes dated May 14, 2011 revealed "In House Acquired Pressure Ulcer stage 2 coccyx; healed, treatment discontinued". Continued medical record review of nursing notes dated May 21, 2011 revealed "Informed Wound Care Nurse resident has skin breakdown on lower back/coccyx area. It is in the area of prior wound". Review of nursing notes dated June 2, 2011 revealed the pressure ulcer on the coccyx was "... stage II and measured 2 cm (centimeters) x 1 cm x < (less than) 1/8 cm with serosanguinous (bloody) drainage and irregular wound edges".

Review of the nursing care plan dated May 4, 2011 revealed the problem of "Impairment of Skin Integrity" manifested by "Protective care - occasional excoriated buttocks and peri area" with the nursing approaches of "Assess skin condition daily and note any changes. Treat as ordered. Monitor diet intake. Ensure adequate hydration". The nursing care plan had not been updated to reflect the reappearance of the pressure ulcer on the coccyx; the treatment; the need to turn the resident every two hours to keep off the coccyx area; and to keep the resident off the back except for meals.
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Interview with the Director of Nursing (DON) on August 3, 2011, at 9:15 a.m. in the DON's office, confirmed the nursing care plan had not been updated.

C/O TN 28481

**F 281**

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**F 280**

**483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

The services provided or arranged by the facility must meet professional standards of quality.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review, facility policy review, review of the Nursing Drug Handbook, observation, and interview, the facility failed to ensure licensed nursing staff appropriately administer medications for two (#14, #19), and failed to appropriately identify and check the heart rate for one (#6) of twenty-nine residents reviewed.

The findings included:

**Resident #14** was admitted to the facility on March 27, 2009, with diagnoses including Fractured Femur, Diabetes, Bronchitis, Hypertension, and Alzheimer's Disease.

Medical record review of the nursing notes dated May 5, 2011, at 8:04 a.m., revealed "Call placed to attending physician regarding medication error. This resident was given resident (resident #16's) medication. Result: no new orders."
IMPERIAL GARDENS HEALTH AND REHABILITATION

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Review of documentation provided by the facility, dated May 5, 2011, revealed Licensed Practical Nurse (LPN) #1 administered following medications in error to resident #14: Namenda (medication for treatment of dementia) 10 mg (milligrams); Seroquel (antipsychotic) 25 mg; Metamucil (laxative, no dosage indicated); Miralax (laxative, no dosage noted); Aspirin 81 mg; Calcium (no dosage noted); Colace (stool softener, no dosage noted); Estrace (estrogen, no dosage noted); Vitamin E (no dosage noted); and Decubivite (vitamin). Continued review of documentation provided by the facility revealed LPN #1 was being oriented/precepted by LPN #3, and LPN #3 had discovered the error by double checking behind LPN #1. Review of a statement dated May 5, 2011, signed by LPN #1 revealed “I thought I was giving meds to a pt (patient) just seen by my preceptor.”

Review of the facility’s policy Medication Administration revealed “…identification of the resident must be made prior to administering medication to the resident by checking the ID (identification) bracelet and/or photo identification card in the MAR (Medication Administration Record)...”

Interview on August 1, 2011, at 2:45 p.m., with LPN #3, in the conference room, revealed LPN #1 was no longer employed by the facility. Continued interview revealed on May 5, 2011, LPN #3 had instructed LPN #1 to administer resident #16’s medications. Continued interview revealed LPN #3 had exited resident #14’s room after checking the resident’s vital signs, when instructing LPN #1 to administer resident #16’s medications. Continued interview revealed LPN #1 administered the administration of medications. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on medication pass including resident identification and vitals prior to administering medications (where appropriate) prior to working on the units by the Nurse Educator, IDON, or designee.

The Nurse Educator, IDON or designee will conduct medication audits during normal medication pass times on RNL/PNs weekly or monthly X 3. If any errors are noted they will be corrected by the Nurse Educator, IDON or designee immediately to assure the resident does not get the incorrect medication. A medication error report will be initiated by the person conducting the audit and the IDON or designee will be notified.

The results of the these audits are given to the IDON or designee. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trends are presented to the QI Team composed of the Medical Director, IDON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.
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#3 had continued to check vital signs on additional residents while LPN #1 administered the medications. Continued interview revealed shortly after instructing LPN #1 to administer the medications to resident #16, LPN #3 had observed LPN #1 exit resident #14's room.

Continued interview revealed LPN #3 had spoken with LPN #1 as LPN #1 returned to the medication cart, and LPN #1 thought had administered the medications to resident #16. Continued interview revealed LPN #1 did not ask the resident's name prior to administering the medications, confirmed LPN #1 failed to correctly identify the resident prior to administering the medications, and confirmed resident #14 received resident #16's medications in error on May 5, 2011.

Observation on August 2, 2011, at 7:25 a.m., revealed LPN #6 preparing to administer medications. Observation revealed LPN #6 stated was going to administer resident #6's medications, who received tube feedings and was in the B bed (bed next to the window). Continued observation revealed LPN #6 stated had been pulled from another unit to administer medications and was unfamiliar with the residents. Continued observation revealed LPN #6 crushed the following medications to administer through the feeding tube: Ocular vitamin; Decubivite (vitamin) 1 tablet; Sertraline (antidepressant) 60 mg; Hydrocodone-Acetaminophen 5 mg-500 mg (narcotic pain medication); and Digoxin (heart medication) 0.125 mg. Continued observation revealed a computerized medication system and resident #6's picture was on the computer screen to identify the resident. Continued observation
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revealed LPN #6 entered the resident's room and
got to the bedside of resident #27 (roommate of
resident #6), located in the A bed, nearest to the
door. Continued observation revealed the
resident #27 had an identification band located on
the right wrist. Continued observation revealed
LPN #6 did not check resident #27's identification
band, located on the right wrist. Continued
observation revealed LPN #6 lifted resident #27's
gown, and resident #27 asked "What are you
doing?" and LPN #6 replied "I'm looking for your
feeding tube." Continued observation revealed
the resident did not have a feeding tube, and LPN
#6 returned to the medication cart and stated
would have to ask the Registered Nurse what had
happened to the resident's feeding tube.

Interview on August 2, 2011, at 7:35 a.m., with
LPN #6, in the hallway, confirmed the resident's
roommate's identification band on the wrist was
not checked, the picture identification on the
computerized MAR had not been checked, and
confirmed the facility's policy for identifying
residents prior to medication administration had
not been followed.

Observation on August 2, 2011, at 7:52 a.m.,
revealed LPN #6 administering medications to
resident #6. Continued observation revealed LPN
#6 administered Digoxin (medication to treat
heart failure and irregular heart rhythms) 0.125
mg, through a feeding tube, to the resident,
without checking the resident's heart rate/pulse
prior to administration of the medication.
Continued observation revealed LPN #6, flushed
the resident's feeding tube after administering the
medication, applied antibiotic ointment to the
resident's feeding tube site, then checked the
F 281  Continued From page 15

resident's pulse. Interview with LPN #6, at the
time of the observation revealed resident #6's
pulse rate was seventy-eight.

Review of the Nursing 2008 Drug Handbook
revealed "...digoxin...before giving drug, take
apical-radial pulse for 1 minute. Record and
notify prescriber of significant
changes...Excessively slow pulse rate (60
beats/minute or less) may be a sign of
digitalis toxicity. Withhold drug and notify prescriber..."

Interview on August 2, 2011, at 8:15 a.m., with
LPN #8, in the resident's room, revealed the
pulse was to be checked prior to the
administration of Digoxin. Continued interview
revealed if the heart rate was below sixty the
Digoxin was not to be administered, and
confirmed the resident's pulse was not checked
prior to the administration of Digoxin.

Medical record review revealed resident #19 was
admitted to the facility on January 23, 2007 and
readmitted on November 26, 2010, with
diagnoses to include Atrial Fibrillation, Systolic
Heart Failure, Hypertension, Failure to Thrive,
Osteoporosis, Osteoarthritis, and Dementia.
Review of the Minimum Data Set (MDS) dated
June 9, 2011, revealed the resident scored 15 on
the BIMS (Brief Interview for Mental Status) with a
score of 15 signifying the resident was cognitively
intact.

Medical record review revealed resident #20 was
admitted to the facility on October 6, 2010, with
diagnoses to include Cerebrovascular Accident,
Patient Foramen Ovalis, Hypertension,
Osteoarthritis, Left Hemiplegia, and Dementia.
Continued From page 16

Review of the MDS dated July 12, 2011, revealed the resident scored a 14 on the BIMS.

Review of a facility investigation of an incident occurring May 15, 2011, revealed a medication error had occurred. Continued review revealed the incident occurred in the dining room where the LPN called the name of resident #20 but resident #19 answered. Further review revealed the LPN "showed the med (medication) cup with ... (named resident #20) name and room # (number) on it. (Resident #19) ... asked what the med was, I told ... and ... took it. Then ... (named Certified Nursing Assistant) told me that wasn't ... (named resident #20). I thought they looked similar."

Continued review of the investigation report revealed the medication administered was Verapamil (anti-hypertensive, control of angina).

Continued review of the investigation report revealed the Director of Nursing (DON) classified the medication incident as "Incorrect Patient" and the cause of the medication incident to be "Patient not identified".

Medical record review of nursing notes for resident #19 dated March 15, 2011, revealed "Call placed to Nursing Assistant regarding medication incident. New orders received and noted. Hold 1700 (5:00 p.m.) doses of Coreg (anti-hypertensive, congestive heart failure) and BID. Check bp (blood pressure) q2h (every two hours) until 7:00 a.m. May 16, 2011."

Interview with the Director of Nursing (DON) on August 2, 2011, at 2:30 p.m., in the conference room revealed the LPN involved in the incident was no longer employed by the facility. Continued
Continued from page 17

Interview revealed the DON confirmed medication intended for resident #20 was administered to resident #19.

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 medical record review, review of the facility policy, and interview, the facility failed to implement the care plan for one (#15) resident of twenty-nine residents reviewed.

The findings included:

Resident #15 was admitted to the facility on November 16, 2010, with diagnoses including Diabetes, Bipolar Affective Disorder, and End Stage Renal Disease.

Medical record review of the care plan dated May 26, 2011, revealed, "...vs (vital signs) before and after dialysis Monitor venous access for bleeding immediately after patient returns from dialysis..."

Medical record review of the nurse's notes dated July 7, 12, 16, 21, 26, and 30, 2011, revealed no documentation of complete vital signs, or dialysis access site condition.

Review of the facility policy, Renal Dialysis Documentation, revealed, "...Documentation will
Continued from page 18:

Include: Vital Signs... Dialysis access site condition...

Interview on August 3, 2011, at 9:20 a.m., in the conference room, with Registered Nurses (RN) #3, confirmed there was no documentation that complete vital signs and assessment of the dialysis access site had been completed.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatments to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, facility policy review, and interview, the facility failed to assess bladder retraining for two (#3 and #9) of twenty-nine residents reviewed.

The findings included:

Resident #3 was admitted to the facility on April 21, 2011, with diagnoses including Syncope, Hypertension, Dementia, and a History of Falls.

Medical record review of the Minimum Data Set dated April 28, 2011, revealed the resident...
Continued From page 19

required moderate assistance with decision making, had short term memory problems, required moderate assistance with transfers, and was frequently incontinent of bladder.

Observation and interview on August 1, 2011, at 8:15 a.m. revealed the resident sitting in a wheel chair, in the resident's room, watching the television. Interview, at that time, revealed the resident was alert and oriented to the date and time.

Review of the facility's Incontinence Management Policy revealed, "...A Urinary Assessment will be performed on all residents at the time of admission or whenever there is a change in cognition."

Medical record review revealed no documentation the Bladder Assessment had been completed.

Interview with the Team Leader (Nurse Manager) on the West Hall, on August 2, 2011, at 11:00 a.m., at the nursing station, confirmed the resident had not been assessed for bladder retraining.

Resident #55 was admitted to the facility on May 16, 2011, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Osteoarthritis, and Cellulitis of the Leg.

Medical record review of the Minimum Data Set dated July 13, 2011, revealed the resident required no assistance with decision making, had no memory problems, required moderate assistance with transfers, and was occasionally incontinent of bladder.

On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding obtaining bladder assessments. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 30, 2011. New or returning licensed staff members including licensed agency staff will receive education on the bladder assessments prior to working on the units by the Nurse Educator, IDON or designee.

Residents will have a bladder assessment completed on admission and with a change in condition by a licensed nurse. The completion of bladder assessments will be monitored by the Nurse Educator, Team Leaders and/or IDON or designee when assessments are due (on new admissions, with a change in condition).

The RN/LPN also conducts visual checks on residents throughout the day and works with the nursing assistants reviewing their voiding patterns. The Team Leader oversees this process daily.

Results of bladder assessments are reviewed by the Team Leaders and appropriate interventions are implemented per physician orders or per facility protocol.

The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse,
Continued From page 20

Observation and interview on August 2, 2011, at 8:00 a.m., revealed the resident lying in bed, neatly dressed and watching television. Interview at that time revealed, "I can now ambulate with my walker in PT (Physical Therapy). I am so happy."

Interview with the resident on August 2, 2011, at 9:00 a.m., in the resident's room, revealed, "I know when I have to go (void), but sometimes I cannot hold it."

Medical record review revealed no documentation of a Bladder Assessment had been completed.

Interview with the Team Leader (Nurse Manager) on the West Hall on August 2, 2011, at 11:00 a.m., at the nursing station, confirmed the resident had not been assessed for bladder retraining.

F 323
483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains 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:
Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for five (#8, #14, #12, #13, #25).

F 323
MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.

F 323
Residents will receive adequate supervision and assistance devices to prevent accidents.

A self release seat belt was replaced for resident #9 the morning of August 2, 2011 by the Team Leader and the IDON verified its placement.

The pressure pad for resident #14 was immediately placed in the recliner on August 2, 2011 by the Team Leader. The nursing staff present were informed by the IDON that the pressure pad is to be in whatever chair the resident is using.

On August 1, 2011 resident #12 was immediately gotten out of bed by the Team Leader and a nurse aide and put in a wheelchair with a pressure pad alarm. The alarm on her bed was then fixed by maintenance and is now working.
On August 2, 2011 resident #17 was observed by the surveyor indicating that the alarm was in the "on" position. Resident #17's pressure pad was previously noted to be in the wheelchair with the alarm in the "on" position. The observation highlighted the need for staff to ensure that the alarm was properly set.

The alarm for resident #13 was replaced with another piece of detector by the Team Leader Nurse.

On August 16, 2011, all team leader nurses were in-service on the importance of maintaining the correct use of assistive devices. The education was completed with all nurses and licensed staff on August 30, 2011. New or returning licensed staff members including licensed therapy staff will receive education on the correct use of assistive devices prior to working on the units by the Nurse Educator, IDON or designee.

Residents with existing assistive devices are identified by the Restraints/Physical form generated from ECS. This form shows all residents using physical restraints or assistive devices. The Team Leader Nurse pulls this form daily and conducts visual checks throughout the day to ensure adherence to appropriate controls. This Restraints/Physical form is given to the IDON or designee daily indicating that all residents with assistive devices have them on and in the "on" position if applicable.
Continued From page 22

Observation on August 2, 2011, at 9:55 a.m., revealed the resident seated in a recliner, in the resident's room, without a pressure pad alarm in place.

Observation and interview, on August 2, 2011, at 10:00 a.m., with Registered Nurse (RN) #1, revealed the resident seated in a recliner, in the resident's room, and confirmed the pressure pad alarm was not in place.

Resident #12 was admitted to the facility on January 15, 2010, with diagnoses including Major Depressive Disorder, Hypertension, Arteriosclerotic Dementia, and Cerebrovascular Accident.

Medical record review of a falls risk assessment dated June 18, 2011, revealed the resident was at high risk for falls.

Medical record review of the Minimum Data Set dated July 18, 2011, revealed the resident had a history of falls.

Medical record review of the physician's recaptulation orders dated August, 2011, revealed, "...pressure pad alarm when in bed unassisted transfer attempts..."

Observation with Registered Nurse (RN) #2, on August 1, 2011, at 8:35 a.m., revealed the resident lying on the bed with the pressure pad alarm cord not attached to the alarm box.

The report indicates that these devices have been checked by the RN/LPN during that day.

The results of the assistive devices audits are given to the IDON. The IDON or designee then tracks and trends these results and reviews the overall effectiveness of the system and for resident outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.
Continued From page 23

Interview on August 1, 2011, at 8:35 a.m., with RN #2, in the resident's room, confirmed the pressure pad alarm cord was not attached to the alarm box.

Resident #17 was admitted to the facility on March 27, 2011, with diagnoses including Dementia, Osteoporosis, Seizures, Hypertension, Bipolar Disease, and Degenerative Disk Disease.

Medical record review of the Minimum Data Set dated June 16, 2011, revealed the resident required no assistance with decision making, had short term memory problems, and required moderate assistance with transfers.

Review of the Physician's Orders dated March 22, 2011, revealed, "Pressure pad alarm when in a chair, when in bed for safety unassisted transfer attempts."

Review of the facility's documentation dated March 26, 2011, revealed, "...Resident was seated in wheelchair across from station and was observed to have eyes closed and leaning forward and falling forward out of wheelchair...alarm sounding...a scrape to the left knee."

Review of the facility's documentation revealed dychrom was placed in the wheelchair on March 27, 2011.

Review of a nursing note dated June 20, 2011, at 6:06 p.m., revealed, "...found on floor up against wall on back...Call light was on. Bed alarm was not plugged in. Resident had been out for a procedure today and alarm was not plugged back in at the time of arrival to the unit...Resident noted..."
continued from page 24

F 323

to have a large hematoma on back of head, no
laceration, hematoma approximately 4 inches in
length...First Aide; Emergency Room..."

Review of a nursing note dated June 20, 2011, at
11:33 p.m., revealed the resident was returned to
the facility, with no new orders.

Observation on August 2, 2011, at 4:00 p.m.,
revealed the resident sitting in a wheelchair, in
the hall, with the pressure pad alarm in
wheelchair and turned to the on position.

Interview with the Team Leader of the west hall,
on August 2, 2011, at 3:30 p.m., at the nursing
station, confirmed the pressure pad alarm was
not plugged in, at the time, of the fall on June 20,
2011.

Resident #13 was admitted to the facility on
August 7, 2009 with diagnosis including Closed
Fracture of Neck of Femur, Senile Dementia, and
Parkinson's Disease.

Medical record review of the Minimum Data Set
dated April 5, 2011, and July 18, 2011, revealed
the resident required extensive assistance with
one person physical assistance for bed mobility
and transfer; did not ambulate in the room or
corridor, required limited assistance with one
person physical assistance for locomotion; and
had experienced two or more falls without injury.

Medical record review of the August 2011
Recapitulation Orders revealed "...Apply Dyce in
w/c (wheelchair) for safety AM (morning), PM
(evening) and NOC (at night) first date
08/30/10..."
Medical record review of the care plans dated April 20, 2011, and July 20, 2011, and the Certified Nurse Aide care plan posted on the interior of the resident's closet revealed a problem of "...Fatigued...Related to: Decline in functional status...History of falls, senile dementia, and over reaches for items without calling staff to assist...All Staff: Resident to have a doorknob to prevent sliding from wheeler..."

Observation and interview, with Licensed Practical Nurse (LPN) #3, on August 2, 2011, at 2:34 p.m., revealed the resident in the resident's room seated in the wheelchair. Further observation revealed LPN #3 and Certified Occupational Therapy Assistant (COTA) #1 assisted the resident to a standing position. Upon removal of the wedge cushion observation revealed no dyspnea in the wheelchair.

Interview with LPN #3 and COTA #1 on August 2, 2011, at 2:34 p.m., in the resident's room, confirmed the dyspnea was not in the wheelchair as ordered by the physician and per the care plan.

F371
FOOD PROCUREMENT, STORE/PREPARE/SERVE - SANITARY

The facility must:
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions.

F371
Equipment will be maintained in a sanitary manner.

The microwave, can opener slot blade, floor mixer and legs to the floor mixer have been cleaned by the dietary staff and are absent of debris.

A new cleaning schedule has been established (Attachment 12)

On August 18, 2011, in-services were provided by the Dietary Manager to all dietary staff regarding the new cleaning...
Continued From page 26

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility dietary department failed to maintain equipment in a sanitary manner.

The findings included:

Observation on August 1, 2011, beginning at 8:25 a.m., with the Certified Dietary Manager and Assistant Dietary Manager present, revealed the following:
1. The interior surface of the microwave had dried splattered debris present. Observation on August 2, 2011, at 7:30 a.m., revealed the interior of the microwave had dried splattered debris present.
2. The can opener slot, blade and blade contact area had a heavy accumulation of black, sticky debris.
3. The floor mixer was covered with plastic. Upon removal of the cover observation revealed the mixer beater arm had an area with a build-up of white dried debris. Further observation revealed the mixer legs had a heavy accumulation of white debris.

Interview on August 1, 2011, beginning at 8:25 a.m., with the Certified Dietary Manager and Assistant Dietary Manager present during the observation, confirmed the microwave interior had dried splattered debris. Further interview confirmed the can opener slot, blade and blade contact area had a heavy accumulation of black, sticky debris. Further interview revealed the plastic cover meant the equipment was clean and schedule. Any new or returning to work associates or agency personnel will be trained on this new cleaning schedule by the Dietary Manager or designee prior to working.

The Dietary Manager or designee will visually monitor for the cleanliness of the equipment daily X 4 weeks, then weekly X 3 weeks (Attachment 13) If it is noted to be unsanitary, it will be cleaned immediately by the Dietary Manager or designee.

The Dietary Manager or designee then tracks and trends these results and reviews the overall effectiveness of the system and for cleanliness. The results of this tracking and trend are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.
### F 371
Continued From page 27 ready to use. Further interview confirmed the floor mixer beater arm had an area with a build-up of white dried debris and the mixer legs had a heavy accumulation of white debris.

Interview with the Certified Dietary Manager on August 2, 2011, at 7:30 a.m., confirmed the microwave interior had dried splatter debris present.

### F 441
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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

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

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands appropriately.

Staff will wash hands appropriately.

The ADON instructed the Team Leader Nurse of resident # 6 to re-clean around the PEG tube with wound cleanser (antimicrobial) and reapply bacitraim ointment to PEG tube on the day in question.

Upon notification to Nursing administration by the survey team of the error, the (LPN # 6) nurse was immediately removed from administering further treatments. She was placed on suspension pending a complete investigation. She was terminated on August 8, 2011.

On August 31, 2011, after almost a month of observation resident # 6's physician has determined there have been no skin infections related to this incident per a conversation with the IDON.

The Nurse Educator or designee will interview all employees regarding proper hand washing techniques, including before and after donning gloves, on or before August 24, 2011. Any new, or returning to work employee or agency staff will be in...
Continued from page 26

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 linen so as to prevent the spread of
infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy review, and
interview, the facility failed to ensure staff
appropriately wash the hands after application of
antibiotic ointment for one (#6) of twenty-nine
residents reviewed.

The findings include:

Observation on August 2, 2011, at 7:52 a.m.,
revealed Licensed Practical Nurse (LPN) #6
applied gloves, administered medications to
resident #6 through a feeding tube, and flushed
the feeding tube with water. Continued
observation revealed LPN #6 removed the gloves
and without washing the hands, applied fresh
gloves, removed a gauze pad from the feeding
tube site and applied antibiotic ointment to
the feeding tube site with a gloved finger of the right
hand. Continued observation revealed LPN #6
changed the glove on the right hand without
washing or sanitizing the hands, and reconnected
the resident's tube feeding.

Review of the facility's policy Hand Hygiene
revealed "...Hand hygiene is generally considered

serviced prior to working on the units or in
their designated areas.

The staff will be monitored for appropriate
hand washing techniques by the IDON,
Nurse Educator and/or Team Leaders
weekly X 4, then monthly X 3.
Additionally, all staff will be monitored
visually to ensure hands are washed when
appropriate.

Results of these monitors will be given to
the Nurse Educator. The Nurse Educator or
designee tracks and trends these results and
reviews the overall effectiveness and
outcomes of the system. The results of this
tracking and trending are presented to the QI
Team composed of the Medical Director,
DON, ADON, Administrator, Restorative
Nurse, MDS Nurse, Therapy Manager,
Dining Manager, Activity Manager, Nurse
Educator, Medical Records and Human
Resources Manager at the QI meetings held
monthly but no less than quarterly.
Continued From page 29 the most important single procedure for preventing healthcare-associated infections...Although antiseptics and other handwashing agents do not sterilize the skin, they can reduce microbial contamination..." Review of the facility's policy Using Gloves revealed "...Wash hands before applying and after removing gloves. Gloves do not replace hand hygiene..."

Interview on August 2, 2011, at 8:15 a.m., with LPN #6, in the resident's room, confirmed the hands were not washed after applying antibiotic ointment to the resident's feeding tube site, and confirmed the hands were not washed each time the gloves were removed prior to applying fresh gloves.