P.O.C. ACCEPTED
5/7/13

PRINTED: 04/30/2013
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555645 | A. BUILDING _____ B. WING _____ | 03/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUBURN RAVINE TERRACE | 750 AUBURN RAVINE ROAD AUBURN, CA 95603 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an annual Recertification survey.<br><br>Representing the Department of Public Health:<br><br>HFEN 2493/29583<br>HFEN 2470/29421<br>HFEN 2589/31640<br><br>The facility census was 55 and the sample size was 14.<br><br>The Ombudsman was contacted prior to the survey and after entering. She was not present for Exit Conference. | F 000 | This proposed plan of correction is being submitted as required by regulation. Submission of this plan of correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This plan of correction serves as our credible allegation of compliance. | |
| F 156 SS=E | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing | F 156 | The facilities postings did have one incorrect address, however another similar posting on the same board reflected the correct addresses. I did change the form immediately and also notified the surveyor of the other form with the correct address. We will continue to monitor and update addresses as they become available. We will review on a quarterly as part of our quarterly QA process. The administrator or designee shall be responsible for keeping them current. | April 15 2013 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X5) DATE: 5/7/13

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 156 | Continued From page 1<br>facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and | F 156 | | |

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| F 156 | Continued From page 2<br>advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and staff interview, the facility failed to provide an updated posting with the correct address of where residents may file a complaint with the State survey and certification agency regarding resident abuse, neglect, and misappropriation of resident property in the facility for a census of 55. This failure had the potential to create a delay in processing the complaint(s).<br><br>The facility's federal postings were reviewed on 3/14/13 at 8 a.m. A letter, dated 1992, from the California Department of Public Health included the wrong address of the Department for filing complaint(s) against the facility. | F 156 | | |

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| F 156 | Continued From page 3<br><br>During an interview with the Administrator on 3/15/13 at 11:15 a.m., he acknowledged that the posted address had not been updated. | F 156 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview and clinical record review, the facility failed to ensure one of 14 sampled residents (5) received necessary treatment to promote healing when the pressure reducing air mattress was not being utilized.<br><br>Findings:<br><br>Resident 5 was admitted to the facility on 11/27/08 with a diagnoses that included palliative care, muscle weakness and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body).<br><br>Review of the 8/15/12 Nurse's Notes indicated new orders for three wound sites to "L (left), R (right) and coccyx area (Stage II pressure ulcer, a | F 314 | The pressure mattress was immediately turned on when it was reported. The other two air mattresses were checked at the same time and were in fact working as required.<br><br>Nursing staff have been in-serviced to check that any and all air mattresses are functioning as required and licensed nurses have been in-serviced to record on the treatment sheet 2 times per shift that each air mattress is functional.<br><br>CNA's were also in-serviced to check that the air mattress is functional each time they enter the room to service the resident.<br><br>The DON or designee will monitor this on a weekly basis and report the findings during our quarterly QA. | April 15 2013 |

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| F 314 | Continued From page 4<br>shiny or dry shallow ulcer).<br><br>Review of the "March 2013 Physician Orders," revealed an order dated 8/10/12 for "Air Mattress-Medline Advantage mattress."<br><br>On 3/12/13 two observations were made of Resident 5:<br>> 8:10 a.m., Resident asleep in bed asleep. Air pressure mattress unplugged.<br>> 2:28 p.m., Resident in bed. Air mattress unplugged.<br><br>In a concurrent interview with LN 1 on 3/12/13, she stated, "The bed should be plugged in at all times." | F 314 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and document review, the facility failed to serve food under sanitary conditions when;<br><br>1. During the Initial Kitchen Tour, the commercial grade can opener blade was observed to be worn | F 371 | Dietary staff have been in-serviced regarding the wear and cleanliness of the can opener and the proper use of hair nets. | |

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| F 371 | Continued From page 5<br>down and dirty.<br><br>2. During the Tray Line, two Dietary Aides were observed with hair nets partially covering their hair.<br><br>Findings:<br><br>1. On 3/12/13 at approximately 8:30 a.m., during the Initial Kitchen Tour, the commercial grade can opener blade was observed to be worn down with rust-type material and with a sticky substance around the tips.<br><br>In a concurrent interview with the Dietary Services Supervisor (DSS), she agreed the blade needed to be changed.<br><br>2. On 3/13/13 beginning at 11:20 a.m. during Tray Line, two female Dietary Aides were observed with hair nets covering 3/4 of their hair, leaving their bangs and part of the hair along the sides of their face un-covered.<br><br>A review of the facility's document entitled, "DRESS CODE FOR WOMEN AND MEN," revised 2/10, indicated, "Women-8. Hair net or hat which completely covers the hair."<br><br>During an interview with the DSS on 3/13/13 at 1:35 p.m., she stated, "Yes, the hair nets should be covering all the hair." | F 371 | The can opener was cleaned immediately and the blade was changed even though it was still quite new and functional.<br><br>The can opener is scheduled to be cleaned at least daily and the blade will be replaced as needed. The can opener will be checked weekly.<br><br>The dietary supervisor or designee will be responsible for monitoring. The findings will be reported during our quarterly QA. | April 15 2013 |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 428 | We will be creating a spread sheet which will summarize all residents on psychotropic medications. | |

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| F 428 | Continued From page 6<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility failed to ensure an annual gradual dose reduction (GDR) was attempted by the facility for one of 14 sampled residents (2).<br><br>Findings:<br><br>Resident 2 was admitted to the facility on 11/11/09 with diagnoses that included dementia with behavior disturbance and delusional disorder.<br><br>Review of the Medication Administration Record dated 3/1/13 to 3/31/13 indicated an order dated for "Seroquel (an antipsychotic) 50 milligrams 1 tablet 3 times a day for delusional disorder and dementia with behavioral disorder." The medication was ordered 8/17/11.<br><br>Review of the Medication Regimen Review dated 5/16/12 through 2/17/13 indicated the pharmacy consultant reviewed Resident 2's medications monthly. There was no indication the Seroquel order was reviewed for a gradual dose reduction, nor was there any indication the benefits of the medication's potential for clinically significant adverse consequences outweighed the risks. | F 428 | This spread sheet will summarize medication changes and dates so we can track the usage. This will be very helpful as it will show when the last medication change and Physician evaluation was recorded. We will review our findings on at least a monthly basis and review the outcomes at our quarterly QA.<br><br>The DON or designee will be responsible for assuring its compliance.. | April 15 2013 |

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| F 428 | Continued From page 7<br><br>Review of the facility policy and procedure entitled, "Section 9.3 Gradual Dose Reduction/Tapering of Medications Reference Card Sample," date 9/10, revealed, "Gradual Dose Reduction/Tapering in the Nursing Facility...Antipsychotics...Second generation (atypical) agents: quetiapine (Seroquel)...Frequency of GDR/tapering...Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, GDR twice in two separate quarters with at least one month between attempts; After first year, once per year."<br><br>In an interview with the DON on 3/15/13 at 7:25 a.m., she stated there was "No further documentation [in Resident 2's purged chart] regarding a gradual dose reduction of the Seroquel since the prescription was ordered [on 8/17/11] or documentation of the benefits versus risk documentation from MD." | F 428 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and | F 441 | Nursing staff to be in-serviced monthly regarding general infection control guidelines. These in-services are scheduled monthly for the next six months and quarterly thereafter. Included in this in-service will be:<br><br>1 & 2. Hand hygiene and sanitizing care equipment between residents. Such as | |

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| F 441 | Continued From page 8<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:.<br>Based on observations, staff interviews, clinical record review and policy and procedure review, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment and to help prevent the development of transmission of diseases and infections for three of 14 sampled residents (7, 4, and 11) and 2 randmon residents (27 and 35) when:<br><br>1. Perform hand hygiene between residents and sanitize care equipment for Resident 7 and Random Resident 35 while delivering care. | F 441 | Glucometers and Stethoscopes. The DON or designee shall monitor two times weekly and record the findings during quarterly QA.<br><br>3. Appropriate disinfectant cleaner will be mounted where the lift is stored and charged. Each lift shall be disinfected after each use. Staff to be in-serviced according to these guidelines.<br><br>The straps have been replaced. The new straps have a cleanable vinyl surface which can easily be cleaned after each use. The straps may also be removed and replaced as necessary.<br><br>The DON or designee shall monitor as least 2 times weekly and record their findings. The results will be presented at our quarterly QA. | April 15 2013<br><br>April 15 2013 |

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| F 441 | Continued From page 9<br><br>2. Sanitize medical equipment after delivering care for Random Resident 27.<br><br>3. Appropriately clean and disinfect care equipment after delivering care to Resident 4.<br><br>4. Maintain an unobstructed flow of urine by keeping the urine collection bag below the bladder for Residents 11.<br><br>5. Ensusure that clean resident care equipment was not stored in a utility room designated for dirty items only.<br><br>These failures had the potential to result in residents being exposured to infectious diseases.<br><br>Findings:<br><br>1. On 3/13/13, medication delivery to several residents was observed: At 11:35 a.m., LN 2 checked Random Resident 35's blood sugar (blood glucose: BG). BG is determined by poking a finger to draw a drop of blood which is placed on a strip and inserted in a blood glucometer (medical equipment that reads BG levels). LN 2 put on clean gloves before entering Random Resident 35's room with the glucometer. LN 2 obtained the blood sample and exited the room carrying the used glucometer in her gloved hands, both of which had been exposed to Random Resident 35's blood. LN 2 adjusted the placement of the medication cart with gloved hands and placed the glucometer on top of the cart, exposing the top of the medication cart to Random Resident 35's blood. LN 2 removed the | F 441 | | |

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| F 441 | Continued From page 10<br>gloves and wiped the surface of the glucometer with an alcohol wipe, then placed it on the surface of the medication cart that had been exposed to blood.<br><br>At 11:45 a.m. LN 2 exited Random Resident 35's room after giving an oral medication. LN 2 did not wash or sanitize her hands before moving the medication cart to the next resident room. LN 2 indicated Resident 7 needed a BG done as well but was not in her room. LN 2 stated Resident 7 was probably already in the dining room. LN 2 placed the glucometer into the front pocket of her uniform and proceeded to the dining room. After returning with Resident 7, LN 2 removed the glucometer from her pocket and placed it on the medication cart. LN 2 was asked if this glucometer remained in a clean condition at which time she retrieved a second glucometer from the top drawer and placed both on top of the cart which had not been cleaned.<br><br>In an interview on 3/13/13 at 11:50 a.m., LN 2 stated, "The cart and glucometers are not clean. I brought the glucometer out of the resident's room and placed it on the cart without cleaning them. I wiped down the glucometer with alcohol wipes. I am not aware of any other process to clean or disinfect them in between residents. I did put the glucometer in my pocket and I shouldn't have. The medication carts are cleaned on night shift, I am not aware of any other time they are cleaned. I will check with the Director of Staff Development (DSD) on how to clean them." LN 2 also stated she was unaware she had not washed or sanitized her hands after exiting the previous resident's room. On return from the DSD, LN 2 stated she was instructed to use | F 441 | | |

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

PRINTED: 04/30/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555645 | A. BUILDING _____ B. WING _____ | 03/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUBURN RAVINE TERRACE | 750 AUBURN RAVINE ROAD AUBURN, CA 95603 |

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|---|---|---|---|---|
| F 441 | Continued From page 11<br>(brand name) non-chlorine wipes to clean and disinfect the glucometer and medication cart. LN 2 proceeded to wipe down all surfaces with this product.<br><br>In a policy and procedure titled "Blood Glucose Meters and Infection Control" dated 11/17/09, the following was indicated. "3) Glucose meters should be assigned to individual residents. If this is not an option, the meter should be cleaned and disinfected between each resident's use. 4) Do not carry supplies and medications in pockets ... 7) Perform hand hygiene with soap and water or alcohol hand sanitizer immediately after removing gloves and before touching medical supplies used by other residents."<br><br>On 3/14/13 at 10 a.m. the Director of Nursing (DON) provided a document and stated, "This is from the glucometer manual on how to disinfect the meter." This document indicated, "Healthcare professionals should wear gloves when cleaning the [brand name] meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. To clean the outside of your blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol ... To disinfect the meter, dilute 1 ml of household bleach (5%-6% sodium hypochlorite solution in 9 ml of water to achieve a 1:10 dilution (final concentration of 0.5%-0.6% sodium hypochlorite." No other process for disinfection was indicated by the manufacturer.<br><br>2. In an observation on 3/13/13 at 12:15 p.m., LN 2 started a gastrostomy tube (GT) feeding on Random Resident 27. Before the feeding was | F 441 | | |

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FORM APPROVED
OMB NO. 0938-0391

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

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| | 555845 | A. BUILDING _____ B. WING _____ | 03/15/2013 |

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| F 441 | Continued From page 12<br>started, LN 2 placed a stethoscope on Random Resident 27's abdomen to determine correct GT placement. LN 2 then put the stethoscope around her neck, washed her hands, exited the room, and placed the stethoscope on the medication cart without cleaning it.<br><br>A procedure titled "Cleaning of Stethoscope," indicated, "The purpose of this procedure is to prevent cross contamination when cleaning a stethoscope ... Obtain alcohol swab and use firm pressure with rotary motion to clean stethoscope ear pieces, tubing, and diaphragm and bell. Wash hands."<br><br>In an interview on 3/13/13 at 12:20 p.m., LN 2 stated, "No. I did not clean the stethoscope after I used it on (Random Resident 27's name). I should have wiped it off with alcohol before placing it back on the cart."<br><br>3. Resident 4 was admitted to the facility on 2/8/13 with multiple diagnoses including stroke. A review of the Initial Minimum Data Set (MDS, a resident assessment tool), dated 2/20/13, indicated Resident 4's Brief Interview for Mental Status (BIMS) was 12 (out of 15) indicating "moderately impaired"; extensive assistance with at least two people assist for bed mobility, transfer, and toilet use; and frequently to always incontinent of urine and bowel.<br><br>Review of the clinical records for Resident 4 revealed the following:<br><br>a) "NURSING WEEKLY SUMMARY" notes, dated 3/7/13, indicated Resident 4 needed two staff assist for bed mobility and used of [brand | F 441 | | |

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|---|---|---|---|---|
| F 441 | Continued From page 13<br>name] lift for transfers.<br>b) Urine specimen obtained for culture on 3/5/13 revealed "Meth. Resistant Staph aureus" (MRSA, an infectious bacteria).<br><br>On 3/13/13 at 8:20 a.m., Certified Nursing Assistants (CNAs) 1 and 2 were observed entering Resident 4's room with a transfer lift. They were observed assisting Resident 4 from the wheelchair to the bed with the use of the transfer lift. A sling was wrapped around the resident's upper waist area and the two hooks from the sling were connected to the lift. Resident 4 was lifted up from a sitting to a standing position and was observed standing on the flatform of the lift with his two hands holding onto the handles of the lift while he was turned around towards the bed. When the two CNAs were done assisting Resident 4 to bed, CNA 1 was observed holding a small towel, squirted a hand sanitizer gel on the towel, then wiping the handles of the lift where Resident 4 placed his hands.<br><br>An interview with the Director of Staff Development (DSD) was conducted on 3/13/13 at 8:30 a.m. about the facility's practice for cleaning the transfer lift after being used by the residents. She stated, "We do not clean the lift after we are done using it on a resident. It is usually clean by the housekeeping everyday. The sling stays in the room with the resident."<br><br>During the Environmental Tour with the housekeeping/laundry supervisor on 3/14/13 at 8:40 a.m., she was interviewed about what and how often her housekeeping staff cleaned the transfer lift. She stated, "My staff would clean the | F 441 | | |

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

PRINTED: 04/30/2013
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 441 | Continued From page 14<br>lift with a germicidal cleaner in the morning and before leaving from work at 3:30 p.m." When asked if her housekeeping department would be notified by the nursing staff of equipment that needed to be sanitized after being used by a resident who was on isolation precaution, she stated, "I am not aware of that process. I don't know who cleans it."<br><br>During an interview with Housekeeper 1 on 3/14/13 at 2:35 p.m., she acknowledged that she cleaned the transfer lift only in the morning and before she left the facility at 3:30 p.m. She stated, "We do not have housekeeping in the afternoon and evening."<br><br>In a concurrent interview with the DSD on 3/14/13 at 3:30 p.m., the transfer lift was checked again and multiple dark red/brown stains were observed on the right velcro knee strap. When the DSD was asked about the stains, she acknowledged the stains should not have been there. She stated, "The straps do not come off. I do not know how housekeeping cleans the lift."<br><br>A review of the facility's undated procedure entitled, "METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)" indicated,"...Patient Care Equipment: Appropriate cleaning, disinfection and sterilization of patient care equipment are important in limiting the transmission of organisms."<br><br>4. Resident 11 was admitted to the facility on 9/17/05 with multiple diagnoses including neurogenic bladder (dysfunction of the urinary bladder caused by injury of the nerves supplying | F 441 | 4. All nursing staff have been trained on the importance of keeping the urinary bags below | |

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

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FORM APPROVED
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| F 441 | Continued From page 15<br>the bladder).<br><br>During an observation on 3/13/13 at 9 a.m., CNA 1 pushed a transfer lift into Resident 11's room. Resident 11 was in bed, both siderails were up, and a urinary drainage bag was hooked onto the lower side of the bed. CNA 1 removed the urinary drainage bag from the side of the bed, lowered one of the siderails, and placed the urinary drainage bag on the bed next to Resident 11. Before turning the resident to sit on the side of the bed, CNA 1 lifted the urinary drainage bag above the level of the resident's bladder. Urine in the urinary tube was observed backflowing towards the resident's bladder.<br><br>According to the LIPPINCOTT MANUAL OF NURSING PRACTICE, Sixth Edition, 1995, "PRINCIPLES OF CARE WHEN MANAGING A CLOSED DRAINAGE SYSTEM were ...2. Urine flow must be downhill:<br>a. Raising the bag will cause reflux of contaminated urine from the bag into the patient's bladder...<br>c. To prevent bacterial contamination."<br><br>During an interview with the DSD at 11:45 a.m. on 3/13/13, she stated, her expectation of her staff was "I expect them to place the bag below the resident's bladder."<br><br>A review of the facility's undated policy titled "URINARY CATHETERS" indicated "Maintain unobstructed urine flow by keeping the collection bag below the level of the bladder..."<br><br>5. During the Environmental Tour on 3/14/13 at | F 441 | the level of the residents . bladder. This will ensure that urine does not flow back into the bladder. The proper steps for handling closed urinary equipment has been reviewed with the staff in is now being followed.<br><br>The DON or designee will be assigned to monitor and evaluate at least monthly during our monthly QA process. This QA process assigns several staff members to specifically evaluate this issue and records the findings..<br><br>The results of these findings shall be reported at our quarterly QA. | April 15 2013 |

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

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| F 441 | Continued From page 16<br>8:40 a.m., a room that had the sign "Utility Room" was inspected. Six clean bedpans were found inside one of the cupboards.<br><br>At 3:20 p.m. on 3/14/13, an inspection of the utility room was conducted again with the DSD and the Medical Secretary. The six bedpans were observed inside one of the cupboards, the DSD and the Medical Secretary acknowledged the items should not have been stored in the utility room since they were clean and never used. The DSD stated, "The utility room is designated for dirty items only." | F 441 | The bed pans were removed and destroyed.<br><br>Staff have been in-serviced that any clean items that might be stored in the utility room shall be in a separate area and labeled as clean. The DSD or designee shall monitor on at least a monthly basis for compliance. | April 15 2013 |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record reviews and staff interviews, the facility failed to ensure the documentation within the clinical records for one of 14 sampled residents (12), and one random resident (19) when the residents' total intake and | F 514 | Any negative findings shall be reported during the quarterly QA. | |

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|---|---|---|---|---|
| F 514 | Continued From page 17<br>output measurements were not accurately recorded on the certified nursing assistants (CNAs) worksheets and in the "kiosk" (computer record device). This dual method of documentation had the potential for confusion, duplication and inaccurate totals of intake and output.<br><br>Findings:<br><br>On 3/13/13 at 9:15 a.m., the MDS coordinator, the DSD coordinator, and Medical Records (MR) supervisor commented that intake and output records were documented on paper worksheets completed by CNAs and also reported in the "kiosk" by CNAs. MDS coordinator and MR supervisor stated that the facility was in a period of transition and using both systems,paper and the "kiosk."<br><br>Documentation of urine output via the Activities of Daily Living (ADL) verification Worksheet was inconsistently recorded.<br><br>a. A review of the clinical record for Resident 12 revealed the following:<br><br>> On 3/6/13, Resident 12's record of bladder continence indicated the presence of a catheter at times and incontinency at other times.<br>> On 3/7/13, Resident 12's urine was measured at 450 cc. documentation revealed Resident 12 was incontinent.<br>The intake records in the "kiosk" reflected an overlap and possible duplication in reporting totals. The "shift" totals were for the following periods of time: | F 514 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|---|
| F 514 | Continued From page 18<br>6:31 a.m.-2:30 p.m.,<br>10:31 a.m.-6:30 am,<br>2:31 p.m.-10:30 am,<br>2:31 p.m.-10:30 p.m., and<br>10:31 p.m.-6:30 am.<br><br>b. A review of the clinical record for Random Resident 19 revealed that on 3/10/13 total intake for Random Resident 19 via the handwritten paper worksheet was "860 cc (cubic centimeter, a unit of measurement) and "1120 cc" via the "kiosk." There were two different and distinct totals of input for the same 24 hour period of time. This discrepancy revealed the possibility of inaccurate totals of intake.<br><br>The MDS coordinator acknowledged that as of 3/13/13 the handwritten total was correct and that licensed nurses should used the handwritten totals.<br><br>A review of the Medication Administration Records (MAR) revealed that licensed nurses placed a check mark in a box indicating that fluid was given to a resident with a tube feeding. There was no consistent documentation of an amount of fluid given to a resident. These inconsistencies made it difficult to determine if totals were accurate.<br><br>An interview with LN 4 on 3/13/13 at 9:15 a.m. validated these concerns. | F 514 | We will discontinue manual charting regarding the items being recorded with the computer charting system. This has been reported for correction. DON, MDS and DSD or designee to monitor.<br><br>Improvements and corrections will be reported on a least a weekly basis. The findings will be reported at our quarterly QA | April 15 2013 |
| F 518 SS=D | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS<br><br>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing | F 518 | | |

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| F 518 | Continued From page 19<br>staff; and carry out unannounced staff drills using those procedures.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to train all employees in emergency procedures when Dietary Aide (DA) 1 did not know what to do if the fire alarm went off, where the fire alarms and fire extinguisher were located or how to use the fire extinguishers.<br><br>Findings:<br><br>During the Disaster and Emergency Preparedness interview with the kitchen staff on 3/13/13 at approximately 1:35 p.m., DA 1 was unable to identify the location of the fire extinguishers in the main kitchen area or which fire extinguisher to use if there were a grease fire or where the fire alarms were located.<br><br>In an interview with the Dietary Services Supervisor on 3/13/13 at 1:55 p.m., she stated that she periodically reviewed the fire drill protocols with the kitchen staff. She stated, "[DA 1] should know this information." | F 518 | Dietary staff will be in-serviced regarding the location of the fire extinguishers and there usage. This will be done during orientation and at least two times annually.<br><br>Administrator or designee will monitor and findings to be reported at the quarterly QA. | April 15 2013 |