STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. BUILDING _____ B. WING _____	C 02/14/2014

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F 000	INITIAL COMMENTS The Division of Health Service Regulation conducted a complaint investigation and a revisit survey on 2/10/14 through 2/12/14 and on 2/14/14. New deficiencies were cited and Tag F309 was recited at scope and severity of a D. The facility remains out of compliance.	F 000	Greenhaven Healthcare and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Green haven's response to this Statement of Deficiencies does not demote agreement with the Statement of Deficiencies nor does it constitute an admission that the deficiency is accurate. Further, Greenhaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceedings.	
F 176 SS=D	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(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to determine if it was safe for 1 of 1 resident; Resident #12 to self administer medications. Findings included: Resident #12 was admitted to the facility on 12/11/2006. Diagnosis included Paraplegia; Congestive Heart Failure; Chronic Obstructive Pulmonary Disease; Neurological Seizures; Hypertension; Neurogenic Bladder; Acute Kidney Failure; Depression; Anxiety; and Psychosis. Resident #12 ' s Minimum Data Set dated 1/7/2014 revealed he was cognitively intact and required extensive assist from the staff with his Activities of Daily Living. A record review of Resident #12 ' s Medication Administration Record (MAR) for 2/1/2014	F 176	**F176** 1) Resident # 12 was interviewed on 3/1/14 by the Director of Nursing (DON). The resident stated he did not wish to self- administer his medications.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Pullman | TITLE: administrator | (X6) DATE: 3-18-14

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

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F 176	Continued From page 1 through 2/28/2014 revealed his medication list as below: · Diamox 250 milligram (mg) take two tablets 500mg by mouth daily at 9:00 AM · Aspirin 81 mg take one tablet by mouth daily at 9:00 AM · Metoprolol 25 mg take ½ tablet 12.5 mg by mouth daily at 9:00 AM *Do Not Crush · Potassium Chloride 10 milliEquivalents (meq) Take one tablet by mouth daily at 9:00 AM *Take with Food *Do Not Crush · Certa-Vite one tablet by mouth daily at 9:00 AM · Zinc Sulfate 220 mg take one capsule by mouth daily for 90 days · Florastor 250 mg take one capsule by mouth twice daily 9:00 AM and 5:00 PM · Lasix 20mg take 3 tablets 60mg by mouth twice daily 9:00 AM and 5:00 PM · Keppra 1000mg take one tablet by mouth twice daily 9:00 AM and 5:00 PM through 2/10/2014 · Keppra 1000mg take by mouth daily 9:00 AM for one week and discontinue. Last dose 2/17/2014 · Biotene one application as directed twice daily 9:00 AM and 9:00 PM · Pro-Stat 30 Milliliters (ml) take by mouth twice daily 9:00 AM and 5:00 PM · Ferrous Sulfate 325 mg take one tablet by mouth twice daily 9:00 AM and 5:00 PM · Oxybutynin 5 mg take one tablet by mouth every 8 hours 6:00 AM, 2:00 PM, and 10:00 PM. · Depakote 500 mg take one tablet by mouth every night along with Depakote 250 mg 9:00 PM *Do Not Crush · Depakote 250 mg take one tablet by mouth every night along with Depakote 500 mg 9:00 PM	F 176	2) A 100% chart audit was completed by the Staff Facilitator on 3/6/14 to determine any resident that orders to self-administer medications. No resident currently has orders for self-administration Education on medication administration will be provided for 100% of the licensed nursing staff by the Staff Facilitator by March 25, 2014. Education on medication administration will be provided for all newly hired staff during orientation by the Staff Facilitator.	

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F 176	Continued From page 2 *Do Not Crush · Xalatin 0.005% Instill one drop into each eye every night 9:00 PM *Wait 3-5 minutes between two eye medications · Vitamin D3-50 50000 units take one capsule by mouth every month · OxyCODONE 5 mg take one tablet by mouth every 6 hours as needed for moderate pain · OxyCodone 5 mg take by mouth every 12 hours 9:00 AM and 9:00 PM · AKWA Tears one drop in both eyes every 12 hours 9:00 AM and 9:00 PM · Oxygen A record review of the Physician Orders for February confirmed Resident #12 ' s Medication list as above. An interview and observation on 2/11/2014 at 1100 AM revealed during resident care with Nurse #6 a small round white pill was observed in Resident # 12 ' s bed. The pill in the bed was confirmed by Nurse #6. Nurse #6 asked Resident #12 if he was aware there was a pill in the bed. Resident #12 answered yes. He reported the night shift nurse staff (around 10 PM) does not wake him up to take his medications. He reported that he has asked them too and it was easy to wake him; just turn a light on. Resident #12 was able to describe the nurses that have responded to his request but did not know who the nurse was the evening of 2/10/2014. Resident #12 reported when he woke up the morning of 2/11/2014 Resident #12 self administered a cup of medications from the bedside table. He reported he must have dropped one. Resident #12 then pointed to the bedside trash can and revealed his 8:00 AM medications were in the trash. Resident #12 reported he did not want to	F 176	3) All residents that wish to self-administer medications, including newly admitted residents, will be assessed by the Minimum Data Set (MDS) Coordinator for cognitive ability and understanding to safely self-administer medications. A Self-Administration Assessment was initiated on 3/11/14 to identify residents who are capable of self-administering medications. Reassessments for those residents that choose to self-administer medications will be conducted quarterly, by the MDS Coordinator and/or DON, and as needed to ensure the resident remains capable of self-administration. All completed assessments will be reviewed by the DON.	

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F 176	Continued From page 3 self administering a cup full of medication 2 hours after self administering a cup full of medications. Resident #12 wrapped the cup full of medications up in a paper towel and placed them on his bedside table. Resident #12 reported that a staff member cleaned his bedside table and unknowingly threw the paper towel with the cup full of medications in the bedside trash can. Nurse #6 assisted in removing the medications from the bedside trash. An interview on 2/11/2014 at 11:53 AM with Nurse #7 revealed she administered Resident #12 his morning medications on 2/11/2014. Nurse #7 verified her initials on Resident #12 ' s Medication Administration Record. She reported Resident #12 took his medications without difficulty. A second interview at 1:16 PM with Nurse #7 revealed she stayed and observed Resident # 12 taking his morning medications. An interview on 2/11/2014 at 1:00 PM with Nurse #5 revealed she administered Resident #12 ' s medications on the evening of 2/10/2014. Nurse #5 reported she woke Resident #12 up and asked him to please take his medication. Nurse # 5 acknowledged nursing has to observe residents taking medications and she stood there and made sure Resident #12 was awake and took his medication. On 2/11/2014 at 2:10 PM the medications found in Resident #12 ' s bed and bedside trash can were reviewed and identified with the Director of Nursing Listed as the following: The medication found in Resident #12 ' s bed was identified as:	F 176	The DON and/or the MDS Coordinator will present all assessments for self-administration of medications on Fridays during morning Administrative meetings. The Assessments will be reviewed in the morning clinical meeting for completion and accuracy by the SDC and/or the Administrator weekly x 4, then every two weeks x 1	

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F 176	Continued From page 4 · Lasix 20 mg tablet (Small white pill/labeled M2) o Diuretic The medications found in Resident #12 ' s bedside trash can that were confirmed with his MAR as medications he received were identified as: · One Keppra 1000 mg tablet (White oblong pill/labeled xo4) o Anticonvulsant · One Depakote 500 mg tablet (Pink oblong/labeled L007) o Anticonvulsant · One Depakote 250 mg tablet (Pink oblong/labeled L006) o Anticonvulsant · Two Oxybutynin 5mg tablets (Blue/labeled 4853) o Urinary Incontinence · One Florastor 250 mg capsule (Labeled Florastor) o Probiotic · One Oxycodone 5mg tablet (white round/Labeled V 48 10) o Opiod analgesic · One Lasix 20 mg tablet (white round/Labeled M2) o Diuretic The medications found in Resident #12 ' s bedside trash can that were not identified as prescribed to Resident #12 were identified as: · One Benadryl 25 mg tablet (Pink small oblong/labeled 135) o Antihistamine · Five Ibuprofen 200 mg tablets (Maroon round	F 176	month and then monthly x 1 month and then quarterly. 4) Assessments will be reviewed by the QA committee quarterly to identify trends and need for continued monitoring.	3-25-14

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F 176	Continued From page 5 pills/labeled 44 291) o Nonsteroidal Anti-Inflammatory · Two Robaxin tablets (white oblong pill/labeled 114) o Muscle Relaxant An interview on 2/11/2014 at 2:10 PM with the Director of Nursing revealed Resident #12 had not been assessed or signed the required paper to self medicate. Her expectation of the nursing staff was the nurses give the medication and observe the resident take the medications. If residents are sleepy nurses are expected to wake them up and make sure the medication is administered. If a resident refuses a medication nurses are to remove the medication from the resident room, document that the refusal, and notify the physician if needed.	F 176	**F309** 1) Resident # 9 was treated with Permethrin cream on 1/17/14 as part of a facility prevention plan for scabies. The resident had not verbalized any complaints of redness or itching and had not been assessed as having signs or symptoms of a scabies infection. On 2/19/14, the resident was re-treated with Ivermectin and part of a facility prevention plan. On 3/7/14, the resident was re-assessed by the Treatment nurse. There was no redness observed, no signs of infection or complaints of itching noted.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and record review the facility failed to a identify, prevent, and control the spread of a highly contagious skin condition caused by an infestation of the itch mite Scabies (Sarcoptes scabiei) for 1 of 15 residents (Resident #6) to	F 309		

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F 309	Continued From page 6 maintain optimal resident well being. Findings include: Resident #6 was admitted to the facility on 12/8/2010 and her Diagnosis included Cellulitis, Alzheimer ' s disease, Hypertension, Edema; Acute Kidney Failure, and Paraplegia. Most recent quarterly Minimum Data Set dated 12/3/2013 revealed Resident #6 was cognitively intact and required extensive assistance from the staff for Activities of Daily Living (ADL) and total dependence from staff for bathing. Record review of Resident #6 Physician Orders revealed an order dated 1/14/14 for Permethrin cream apply from the neck down Repeat in one week Record review for Resident #6 Physician Orders revealed an order dated 8/1/2013 for Permethrin 5% cream apply neck down on 8/3/2013 at 9:00 PM then shower on 8/4/2013 at 9:00 AM and repeat in 7 days. On 2/11/2014 at 4:10 PM an interview and observation with Resident #6 revealed she received the medicated cream for scabies. Resident #6 reported her legs still itch at night. An observation of exposed skin reveals Resident # 6 had a red scaled and irritated rash to lower extremities. An interview on 2/14/2014 with the Director of Nursing (DON) revealed she was not aware that Resident #6 was still c/o itching her staff had not informed her. On 2/12/2014 at 10:32 AM the DON provided a document that read as the following:	F 309	2) A 100% audit of all resident's skin was completed by the charge nurses on 2/17/14 to ensure residents were free of any signs or symptoms of scabies to include: skin infection, redness or itching. All current licensed staff will be educated by the Staff Facilitator on recognizing and reporting suspicious skin rashes to the physician to include signs and symptoms of scabies. In service for the nursing staff will be completed on 3/25/14. All nursing assistants were educated to report any skin abnormality to the charge nurse including signs and symptoms of scabies. This will be completed on 3/25/14. All newly hired nurses and nursing assistants will be educated on recognizing and reporting signs and symptoms of scabies during orientation the Staff Facilitator.	

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F 309	Continued From page 7 On 2/11/2014, The Medical Director, Administrator and Director of Nursing discussed · Rashes occurring in the building-residents and staff: is this scabies? · Possible treatments, i.e. cream versus oral tablet , [medication included incorrect] · If the choice was made to treat with the oral form, how long would it take for the pharmacy to get the medication to the facility · Need dermatology appointments to confirm diagnosis It was concluded that, the discussion would be continued on 2/12/2014 The document was signed by the DON and the Administrator. An interview on 2/14/2014 at 3:02 PM with the Attending Physician revealed in January all the residents were treated with the topical scabicide twice. The facility had not been able get an adequate amount of the oral treatment for scabies to treat the whole facility. The Physician revealed there was 150 tablets available. The dose per resident was based on weight and one resident may require 7 to 8 tablets. With 80 people in the building he would need 400 to 500 tablets to treat just the residents and not the staff. The Physician reported this was the 3rd occurrence of scabies infestation and his recommendation would be for the facility to not accept any more admissions and retreat the residents in house.	F 309	3) Residents will receive a full skin assessment twice weekly on their scheduled shower day by the charge nurse. This will be an on-going process. The results of the skin assessment will be documented in the electronic medical record. The DON and/or the MDS Coordinator will review ten residents weekly x 4 weeks to ensure compliance with completed skin assessments and referral to the physician as needed, then every 2 weeks x 1 month, then monthly x 2 months. A resident census will be utilized for verification of resident review. 4) The results of the skin assessments will be reviewed at the monthly QA meeting to identify trends and the need for continued monitoring.	3-25-14
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		

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F 312	Continued From page 8 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to provide grooming, personal hygiene, incontinent care, and, assistance with locomotion on the unit for 3 of 3 residents (Resident #1, #8 and #7) who required extensive assistance or total dependence from the staff. Findings include: 1) Resident #1 was admitted to the facility on 2/2/2013. His Diagnosis included Cardiovascular Accident Diabetes, Dementia, Psychosis, Depression, Hypertension, and Seizures. Resident #1 ' s annual Minimum Data Set (MDS) dated 11/20/2013 revealed Resident #1 ' s cognition was assessed and his Brief Interview for Mental Status indicated a score of zero which indicated cognitive impaired or did not answer the questions asked. Resident #1 required total dependence on the staff with his Activities of Daily Living (ADL) dressing and personal hygiene, and supervision with eating. On 2/10/2014 at 2:35 PM an observation of Resident #1 revealed him sleeping in bed not shaved, lint in his hair, and in a institutional gown with food crumbs on his face, chest and food crumbs including a piece of ham on his bed sheets. Resident #1 ' s bed side table was covered in food crumbs. On 2/10/2014 at 2:50 PM an interview with Nurse	F 312	**F312** 1) Resident #1 was bathed and groomed by the assigned nursing assistants on 2/10/14. The room was cleaned by Housekeeping staff on 2/10/14. Resident #8 was provided incontinent care upon identification by the assigned nursing assistant on 2/10/14. Resident # 7 was interviewed by the Social Worker on 3/12/14 to determine her preference regarding her morning schedule.	

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F 312	Continued From page 9 Assistant #7 revealed she provided resident #1 with a partial bath; face wipe, armpit, and private parts. Nurse Aid #7 reported Resident #1 received his shower on second shift but did not know the days. Nurse Aid #7 revealed she set Resident #1 up for his meal but she was not the one who removed the meal tray from Resident #1 ' s room. When asked if she rounds on her residents Nurse Aid #4 revealed every now and then Resident #1 calls we go check on him. Nurse Aid #7 started her last rounds to check the residents for incontinent care at 2:00 PM. At 2:50 PM Nurse Aid #7 revealed she had not done her last round on Resident #1. Nurse Aid #7 acknowledged Resident #1 needed to be groomed and cleaned after his meal but reported she was not responsible for cleaning the bed side table. When asked about the grooming, dressing and personal hygiene of Resident #1 Nurse Aid #7 revealed the Nurse Aid staff had 15 residents and only 4 hours to provide care because of shower schedules and assistance with resident meals. She reported it was too hard to wash hair, give showers or clean nails and the Nurse Aid staff did it when they could. On 2/11/2014 at 10:12 AM an observation was made of Resident #1 in bed in an institutional gown, face unshaven with breakfast crumbs on his face, chest and bedside table. Dirty linen was observed on the floor. On 2/11/2014 at 2:35 PM an observation was made of Resident #1 slouching in bed. His bedside table was over his lap with same morning crumbs. A second tray was pulled away from the bed out of reach with snack food on it. On 2/12/2014 at 11:00 AM an observation was	F 312	2) One hundred percent of residents were observed on 3/11/14 by Administrative staff for identification of any care issues. All nurses and nursing assistants will be in-serviced by the SDC on incontinent care, resident grooming after meal, cleaning the resident's room after meals and resident preferences for daily care. The education will be completed on 3/25/14. All newly hired nursing staff will receive education on incontinent care, resident grooming, grooming after meals, cleaning of resident rooms after meals and resident preference for daily care during orientation. 3) The Administrator, the Director of Nursing (DON), the Staff Facilitator, the Admissions Coordinator, the Activity Director, the Supply Clerk and/or charge nurses will make rounds using the	

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F 312	Continued From page 10 made of Resident #1 in his bed wearing a uniform gown and not groomed. His meal tray was still on the bedside table. There was a bag of dirty linen on the foot of his bed. On 2/12/2014 at 11:30 AM and interview with Nurse Aid #7 revealed the linen bag was not suppose to be left on Resident #1 ' s bed and the breakfast tray should have been removed. She reported her coworker had left at 9:30 AM and Nurse Aid #7 had to give resident showers. The replacement nurse aid Nurse Aid #3 arrived at 11:00 AM and the room assignment was changed. Nurse Aid #7 reported she did not ask her co-workers or management for help. 2) Resident #8 was admitted to the facility on 7/21/2011. Her diagnosis included Hypertension; Hyperthyroidism; Seizure Disorder; Chronic Venous Statis Bilateral Lower Extremities; and Cellulitis Bilateral Lower Extremities. Resident #8 ' s quarterly MDS dated 2/5/2014 revealed Resident #8 was cognitively intact. She required extensive assist from the staff for her bed mobility, locomotion, and dressing; and Resident #8 was total dependent on the staff for transfer, toilet use, and personal hygiene. On 2/10/2014 at 3:13 PM Nurse Aid #9 was interviewed and revealed she was entering Resident # 8 ' s room to provide incontinent care. Nurse Aid #9 (3-11 shift) revealed that Resident #8 had requested Nurse Aid # 8 (7-3 shift) to provide incontinent care prior to the end of her shift and she did not. On 2/10/2014 at 3:13 PM an observation was made on Resident #8. Incontinent care was provided by Nurse Aid #9. There was a strong	F 312	rounds tool on all halls daily Monday through Friday after breakfast. The Weekend Supervisor will make rounds daily on Saturday and Sunday after breakfast to identify resident care issues. All rounds sheets will be received and reviewed daily Monday through Friday by the Administrator for completeness. The rounds sheets completed on Saturday and Sunday will be received and reviewed by the Administrator or the DON on Monday. Any care issues identified will be addressed by the Administrative personnel that identified the care issue immediately with the assigned staff.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 11 odor of urine and the brief was saturated with urine and feces. On 2/10/2014 at 3:13 AM an interview with Resident #8 revealed that she had requested incontinent care from Nurse Aid #8 (7-3 shift) and she did not return to provide care prior to the end of her shift. Resident #8 reported she was in a wet brief for most of the day and that she had called the Administrator and told her that Nurse Aid #8 had not changed her before she left. Nurse Aid #8 ' s Timecard for 2/10/2014 revealed she clocked out at 2:53 PM 7 minutes prior to the end of her shift. During an interview on 2/14/2014 at 4:40 PM with the Administrator revealed that Nurse Aid #8 had quit her job. On 2/14/2014 at 8:21 AM an interview with Nurse Aid #8 revealed her reason for quitting was a personnel concern and not Resident #8. She reported Resident #8 did not like her. 3) Resident #7 was admitted to the facility on 8/13/2012. Her Diagnosis included Hypothyroidism, Asthma, Hypertension, Depression, Anxiety, and Blindness of both eyes. Resident #7 MDS dated 2/5/2014 revealed she was cognitively intact. She required extensive assist from the staff with bed mobility, dressing, toilet use, personal hygiene; and total dependence on staff for locomotion and bathing. On 2/12/2014 at 8:45 AM an interview with Resident #7 revealed she wanted to get up for the day and had requested assistance from the	F 312	All nurses and nursing assistants will be in-serviced on resident rights and the right for a resident to determine their daily schedule by the Social Worker. Daily rounds by Administrative staff will be on-going, Monday through Friday to identify care issues. Rounds on Saturday and Sunday will be completed by the Weekend Supervisor. Any care issue identified will be immediately addressed with the assigned staff. 4) The results of rounds will be reviewed at the monthly QA meeting to determine any trends and solutions for those identified concerns.	3-25-14

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F 312	Continued From page 12	F 312		

staff but was told by the staff member that the staff member could not get her up because she had to do showers first. Resident #7 reported that the evening of 2/11/2014 she had requested to visit a resident across the hall and she could not get a staff member to assist her.

An observation of Resident #7 on 2/12/2014 at 8:45 AM revealed she was not provided bathing or grooming.

On 2/12/2014 at 9:47 AM an interview with Resident #7 revealed she had again requested to get up for the day and was still waiting. She was informed the staff was providing showers to other residents.

An observation of resident #7 on 2/12/2014 at 9:47 AM revealed Resident #7 was still in bed not showered or groomed and her eaten breakfast tray remained on her bed side table.

On 2/12/2014 at 11:30 AM a third observation was made of Resident #7 and she had not received assistance with personal hygiene, bathing and locomotion from the staff.

On 2/12/2014 at 11:30 AM an interview with Nurse Aid #7 revealed her coworker had left at 9:30 AM and Nurse Aid #7 had to give resident showers. The replacement nurse aid Nurse Aid #3 arrived at 11:00 AM and the room assignment was changed. Nurse Aid #7 reported she did not ask her co-workers or management for help.

On 2/10/2014 at 2:16 PM in an interview the Director of Nursing revealed her expectations of the nursing staff was for them to assist and provide ADL care for the residents.

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F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review the facility failed to provide sufficient nursing staff for 3 of 3 residents; (Resident #1, #8, & #7) who were dependent on the staff for necessary care to meet the needs of the residents. Findings included: 1) Resident #1 was admitted to the facility on 2/2/2013. His Diagnosis included Cardiovascular Accident Diabetes, Dementia, Psychosis, .	F 353	**F353** **1)** Residents # 1, 7 and 8 were provided the needed care upon identification by Administrative Staff on 2/10/14. **2)** One hundred percent of residents were observed on 3/11/14 by Administrative staff for identification of any care issues. All nurses and nursing assistants will be in-serviced by the Staff Facilitator on incontinent care, resident grooming after meal, cleaning of the resident's room after meal and resident preferences for daily care. The education will be completed on 3/25/14. All newly hired nursing staff will receive education on incontinent care, resident grooming, grooming after meals, cleaning of resident rooms after meals and resident preference for daily care during orientation.	

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F 353	Continued From page 14 Depression, Hypertension, and Seizures. Resident #1 ' s annual Minimum Data Set (MDS) dated 11/20/2013 revealed Resident #1 ' s cognition was assessed and his Brief Interview for Mental Status indicated a score of zero which indicated cognitive impaired or did not answer the questions asked. Resident #1 required total dependence on the staff with his Activities of Daily Living (ADL) dressing and personal hygiene, and supervision with eating. On 2/10/2014 at 2:35 PM an observation of Resident #1 revealed him sleeping in bed not shaved, lent in his hair, and in a institutional gown with food crumbs on his face, chest and food crumbs including a piece of ham on his bed sheets. Resident #1 ' s bed side table was covered in food crumbs. On 2/10/2014 at 2:50 PM an interview with Nurse Assistant #7 revealed she provided resident #1 with a partial bath; face wipe, armpit, and private parts. Nurse Aid #7 reported Resident #1 received his shower on second shift but did not know the days. Nurse Aid #7 revealed she set Resident #1 up for his meal but she was not the one who removed the meal tray from Resident #1 ' s room. When asked if she rounds on her residents Nurse Aid #4 revealed every now and then Resident #1 calls we go check on him. Nurse Aid #7 started her last rounds to check the residents for incontinent care at 2:00 PM. At 2:50 PM Nurse Aid #7 revealed she had not done her last round on Resident #1. Nurse Aid #7 acknowledged Resident #1 needed to be groomed and cleaned after his meal but reported she was not responsible for cleaning the bed side table. When asked about the grooming, dressing and personal hygiene of Resident #1 Nurse Aid	F 353	**3)** The Administrator, the Director of Nursing (DON), the Staff Facilitator, the Admissions Coordinator, the Activity Director, the Supply Clerk and/or charge nurses will make rounds using the rounds tool on all halls daily Monday through Friday after breakfast and to ensure sufficient nursing staff. The Weekend Supervisor will make rounds daily on Saturday and Sunday after breakfast to identify resident care issues and to ensure sufficient nursing staff. All rounds sheets will be received and reviewed daily Monday through Friday by the Administrator for completeness. The Administrator will review the posted staffing Monday through Friday to ensure adequate staff. The	

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F 353	Continued From page 15 #7 revealed the Nurse Aid staff had 15 residents and only 4 hours to provide care because of shower schedules and assistance with resident meals. She reported it was too hard to wash hair, give showers or clean nails and the Nurse Aid staff did it when they could. Nurse Aid #7 stated " I do not feel we have enough [sufficient staff] to get it done we can ' t get it all done " . On 2/10/2014 at 2:50 PM Nurse Aid #7 attempted to locate Nurse Aid #8 to inquire about Resident #1. Staff reported she had left for the day. Record Review of Nurse Aid #8 Timecard revealed on 2/10/2014 she clocked out at 2:52 PM 8 minutes before the end of her shift. On 2/10/2014 at 2:55 PM an observation was made of Nurse Aid #7 after the interview in Resident #1 room and Nurse Aid #7 left Resident #1 to go help someone before providing ADL care to resident #1. On 2/12/2014 at 11:00 AM an observation was made of Resident #1 in his bed wearing a uniform gown and not groomed. His meal tray was still on the bedside table. There was a bag of dirty linen on the foot of his bed. On 2/12/2014 at 11:30 AM and interview with Nurse Aid #7 revealed the linen bag was not suppose to be left on Resident #1 ' s bed and the breakfast tray should have been removed. She reported her coworker had left at 9:30 AM and Nurse Aid #7 had to give resident showers. The replacement nurse aid Nurse Aid #3 arrived at 11:00 AM and the room assignment was changed. Nurse Aid #7 reported she did not ask her co-workers or management for help.	F 353	Weekend Supervisor will review the staff sheet to ensure adequate weekend staff. The rounds sheets completed on Saturday and Sunday will be received and reviewed by the Administrator or the DON on Monday. Any care issues identified will be addressed by the Administrative personnel that identified the care issue immediately with the assigned staff. All nurses and nursing assistants will be in-serviced on resident rights and the right for a resident to determine their daily schedule by the Social Worker. Daily rounds by Administrative staff will be on-going, Monday through Friday to identify care issues. Rounds on Saturday and Sunday will be completed by the Weekend Supervisor. Any care issue identified will	

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F 353	Continued From page 16 Record review of the census during the survey revealed 87 residents in house. The daily staffing sheet for 2/12/2014 showed 6 nurse aids assigned between 7:00 AM and 3:00 PM; two nurse aids for the 100 hall, two nurse aids for the 200 hall and two nurse aids for the 400 hall. 2) Resident #8 was admitted to the facility on 7/21/2011. Her diagnosis included Hypertension; Hyperthyroidism; Seizure Disorder; Chronic Venous Statis Bilateral Lower Extremities; and Cellulitis Bilateral Lower Extremities. Resident #8 ' s quarterly MDS dated 2/5/2014 revealed Resident #8 was cognitively intact. She required extensive assist from the staff for her bed mobility, locomotion, and dressing; and Resident #8 was total dependent on the staff for transfer, toilet use, and personal hygiene. On 2/10/2014 at 3:13 PM an observation was made on Resident #8. Incontinent care was provided by Nurse Aid #9. There was a strong odor of urine and the brief was saturated with urine and feces. On 2/10/2014 at 3:13 PM an interview with Resident #8 revealed that she had requested incontinent care from Nurse Aid #8 and she did not return to provide care prior to the end of her shift. Resident #8 reported she was in a wet brief for most of the day and that she had called the Administrator and told her that Nurse Aid #8 had not changed her before she left. Resident #8 revealed she did not feel there was enough staff to take care of her needs. She further revealed that Nurse Aid #8 had not provided incontinent care for Resident #8 on 4 recent occasions and she had reported the 3rd and 4th occurrences to	F 353	be immediately addressed with the assigned staff. 4) The results of rounds will be reviewed at the monthly QA meeting to determine any trends and solutions for those identified concerns.	3-25-14

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F 353	Continued From page 17 the Administrator. On 2/10/2014 at 3:13 PM Nurse Aid #9 was interviewed and revealed she was entering Resident # 8 ' s room to provide incontinent care. Nurse Aid #9 revealed that Resident #8 had requested Nurse Aid # 8 to provide incontinent care prior to the end of her shift and she did not. Nurse Aid #9 was asked if she received a shift report from Nurse Aid #8 and she answered that she was suppose to report off at shift change but she had not been receiving a shift report because Nurse Aid #8 leaves before the end of her shift. Nurse Aid #9 revealed there was not enough staff to care for the residents and she was responsible for providing care to 16 total care residents. Nurse Aid #9 revealed one of her residents request service every 15 minutes. Again Nurse Aid reported the facility does not have enough staff and she starts her shift providing overdue incontinent care; removing lunch trays and sweeping lunch off the floor; emptying urinals, indwelling catheter bags, and trash cans when she feels she should be providing showers. On 2/10/2014 at 3:30 PM an observation of Nurse Aid #9 revealed she emptied urinals, removed lunch trays, and removed dirty linen and trash from resident rooms prior to starting her duties. 3) Resident #7 was admitted to the facility on 8/13/2012. Her Diagnosis included Hypothyroidism, Asthma, Hypertension, Depression, Anxiety, and Blindness of both eyes. Resident #7 MDS dated 2/5/2014 revealed she was cognitively intact. She required extensive assist from the staff with bed mobility, dressing, toilet use, personal hygiene; and total dependence on staff for locomotion and bathing.	F 353		

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F 353	Continued From page 18 On 2/12/2014 at 8:45 AM an interview with Resident #7 revealed she wanted to get up for the day and had requested assistance from the staff but was told by the staff member that the staff member could not get her up because she had to provide showers to other residents. Resident #7 revealed the facility was always short staffed. Resident #7 reported that the evening of 2/11/2014 she had requested to visit a resident across the hall and she could not get a staff member to assist her and revealed the staff was swamped getting residents to bed so she did not get to visit with her friend. An observation of Resident #7 on 2/12/2014 at 8:45 AM revealed she was in bed and not showered or groomed. On 2/12/2014 at 9:47 PM an interview with Resident #7 revealed she had again requested to get up for the day and was still waiting. An observation of resident #7 on 2/12/2014 at 9:47 AM revealed Resident #7 was still in bed not showered or groomed and her breakfast tray remained on her bed side table. On 2/12/2014 at 11:30 AM a third observation and interview with Resident #7 revealed she had not received assistance from the staff. On 2/12/2014 at 11:30 AM and interview with Nurse Aid #7 revealed her coworker had left at 9:30 AM and Nurse Aid #7 had to give resident showers. The replacement Nurse Aid arrived at 11:00 AM and the room assignment was changed. Nurse Aid #7 reported she did not ask for help and she felt there was not enough staff	F 353		

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F 353	Continued From page 19 available to meet the resident ' s care needs. Record review of January 2014 Resident Concern revealed on 11/19/2013 Resident #8 and #7 reported a staff member was not answering the call bells timely. Resolution was a change of staff providing care. Additional Resident Concerns for January 2014 included residents were not being changed; screaming out for help; had been asking for a bath for 2 days; nurses were not changing colostomy bag; not completely dressed on multiple occasions; hair was not being washed including shower days; had to use the bathroom without assistance; and not receiving showers. On 2/10/2014 at 2:16 PM in an interview the Director of Nursing revealed her expectation of the nursing staff was for them to assist and provide ADL care for the residents and it was an expectation that a shift report was given. On 2/14/2014 at 4:40 PM in an interview the Administrator revealed the nurse aids complained if they work together with two of three staff members.	F 353	**F441** 1) Contact precautions were initiated for resident # 10 and # 14 on 1/9/14 and 2/13/14. One hundred percent of the facility staff received an in-service on scabies and were provided educational materials that included signs and symptoms of scabies, interventions to prevent transmission and treatment options, and infection control practices by the Director of Nursing on 2/17/14. Resident # 10 was seen by the dermatologist on 1/9/14. Treatment was initiated on 1/9/14 and the resident was re-treated on 1/17/14 per physician recommendation. Resident # 10 room-mate was treated and the room deep cleaned after each treatment by the Housekeeping Department on 1/9/14 and 1/17/14. Resident # 14 was treated on	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 20 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, resident interview and observation the facility failed to implement contact precautions, in-service the staff on prevention and control; and follow the Plan of Correction put in place to prevent and control the spread of a highly contagious skin condition caused by an infestation of the itch mite Scabies (Sarcoptes scabiei) for 2 of 15 residents	F 441	2/13/14. Resident # 14 room-mate was also treated and the room deep cleaned after treatment by the Housekeeping Department on 2/13/14. After resident # 14 received treatment and showered, she was returned to her room to be dressed. Facility staff promptly intervened and removed Resident # 14 before any articles in the room were touched. **2)** A 100% audit of all resident's skin was completed by the charge nurses to ensure residents were free of any skin infection, redness or itching on 2/17/14. A 100% review was completed on all residents with infections to include scabies utilizing the infection control log on February 17-19, 2014 by the facility's consultants to	

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F 441	Continued From page 21 (Resident #10 & #14) treated with a topical scabicide. Findings included: A record review of the facility Scabies policy dated 2005 included; Clinical presentation in the elderly and immunosuppressed individuals, the infestation often appears as a generalized dermatitis more widely distributed than the burrows with extensive scaling and sometimes vesiculation and crusting (known as Norwegian scabies). Diagnosis may be established by recovering the mite from its burrow by skin scraping and identifying it microscopically. Mode of transmission is by direct contact with infested skin. Persons with Norwegian scabies are highly contagious because of the large number of mites that are present in the exfoliating skin. Incubation Period is two to six weeks before onset of itching; one to four days after re-exposure. Period of Communicability is until mites and eggs are destroyed by treatment; ordinarily after one or occasionally two courses of treatment, a week apart. Susceptibility and Resistance; some resistance is suggested since immunocompromised individuals are susceptible to hyperinfestation. Fewer mites succeed in establishing themselves on individuals previously infested as opposed to those with no prior exposure. Treatment is topical scabicide, i.e., Kwell, Eurax, Elimite; apply according to manufacturer ' s instruction to be effective. Except for Elimite, re treatment is necessary in 7 to 10 days to kill any newly hatched mites that may have survived the	F 441	ensure appropriate precautions have been implemented and infection control practices are followed to prevent and control infections. The Facility Facilitator will educate staff on expectations regarding infection control practices by 3/21/14. All newly hired staff will be educated regarding infection control practices to include information about contact precaution during orientation. All staff identified with a suspicious rash will be sent home to acquire treatment and will not be allowed to return to work for 24 hours post treatment.	

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F 441	Continued From page 22 initial treatment. Prevention 1) educate your staff on early detection and reporting of rashes in residents to nurse or for staff to his/her immediate supervisor 2) activate surveillance program to detect infestation as soon as possible and 3) suspect that any undiagnosed pruritic (itching) skin condition might be scabies. Control by contact precautions for 24 hours after start of effective treatment. Laundering of clothing, bedding, and personal articles of infested individual; particularly important for individuals with Norwegian scabies because the potential for formite [an object (as a dish or an article of clothing) that may be contaminated with infectious organisms and serve in their transmission] transmission is high. 1) On 2/10/2014 at 2:00 PM an interview with the Director of Nursing (DON) revealed The facility had one resident, Resident # 10 with a confirmed diagnosis of scabies on 1/9/2014. Record review of Resident # 10 revealed an admission date of 11/19/2012. Resident # 10 was not in the facility during the investigation but resided on the 400 hall. A Physician Progress note dated 1/6/2014 revealed Resident #10 had a persistent pruritic rash to the abdomen and thighs that had been unresponsive to topical steroids and a course of oral steroids. She was due to be seen by Dermatology on 1/9/2014. Nurse Notes dated 1/9/2014 revealed the Resident #10 returned from the Dermatology consult, received new order for treatment of scabies. A dermatology consult report for Resident #10 no date revealed a positive scabies lab test. Physician Orders revealed orders for the topical	F 441	**3)** All residents with infections to include signs and symptoms of scabies will be reviewed by the Director of Nursing or the Staff Facilitator monthly on-going utilizing the infection control program and documented on the infection control log to ensure that appropriate isolations precautions and infection control practices are being utilized to prevent and spread infections. Any staff member with confirmed scabies will provide verification of treatment and clearance by a medical professional prior to returning to work. These verifications will be confirmed by the specific department manager prior to allowing the staff member to return to work. The Administrator will review and initial the infection control logs monthly x 3 months for completion.	

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F 441	Continued From page 23 scabicide (Elimite/Permethrin) dated 1/9/2014 and 1/17/2014. Record review of the Physician Order dated 1/9/2014 read Elimite 5% cream. Dispense 1 tube. Apply neck down, leave on overnight. Wash off in the morning. Repeat in one week. Record review of nurse progress notes dated 1/10/2014 at 5:13 AM reveal the topical scabicide was applied to Resident #10. Record review of Resident #10 group activity log for January included her participated in group activity on 1/9/2014 at 11:09 AM and 11:46 AM; on 1/10/2014 at 12:51 PM and 1:53 PM; and on 1/11/2014 at 2:59 PM. Resident #10 group activity log revealed she participated in group activities 7 days after the application of Elimite the topical scabicide, on 1/16/2014 at 2:16 PM, 2:28 PM and 2:48 PM; on 2/17/2014 at 9:24 PM; and on 2/18/2014 at 2:59 PM. 2) An observation on 2/14/2014 at 4:15 PM revealed Resident #14 had been placed on contact precautions. Interview on 2/14/2014 at 4:35 PM with the DON revealed her knowledge of the contact precaution signs placed for Resident #14 for scabies treatment. Resident #14 was treated with the topical scabicide on 2/13/2014. On 2/14/2014 at 4:25 PM Resident #14 was observed in the shower room with Nurse Aid #5 and #1. An interview on 2/14/2014 at 4:25 PM with Nurse Aid #5 and Nurse Aid #1 revealed they had been	F 441	4) The results of the infection control logs will be reviewed at the monthly QA meeting to identify trends and the need for continued monitoring. 3/25-14 **F441** 1) Contact precautions were initiated for resident # 10 and # 14 on 1/9/14 and 2/13/14. One hundred percent of the facility staff received an in-service on scabies and were provided educational materials that included signs and symptoms of scabies, interventions to prevent transmission and treatment options, and infection control practices by the Director of Nursing on 2/17/14. Resident # 10 was seen by the dermatologist on 1/9/14. Treatment was initiated on 1/9/14 and the resident was re-treated on 1/17/14 per physician	

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F 441	Continued From page 24 in-serviced on the plan of correction for scabies. Nurse Aid #5 and #1 revealed Resident #14 needed a shower because the topical scabicide was applied the night before which was greater than the 8 hour application requirement. Nurse Aid #5 and #1 were aware the resident room had to be cleaned but did not know where housekeeping was. When asked what they intended to do with Resident #14 after her shower was complete they reported they were going to return Resident #14 to her room. Observation on 2/14/2014 at 4:33 PM Nurse Aid #1 and Nurse Aid #5 escorted Resident # 14 back into her room in her bath towels. The facility corporate nurse stopped them at the resident ' s bedside and asked them to remove her from her room. No housekeeping staff was observed near or in Resident #14 ' s room, from the 4:15 PM to 4:33 PM observation. 3) Record Review of the Plan of Correction titled POC Skin Rash dated 1/9/2014 read as the following: 1) How will corrective action be accomplished for the resident? On 1/9/2014 it was identified that one resident (Resident #10) had a confirmed diagnosis of scabies [Sarcoptes scabiei]. a. The Director of Nursing made the facility Administrator and medical Director aware of the findings and treatment orders. b. She was treated with Permethrin [a topical scabicide brand name Elimite] 2 times over a 7 day period. c. The resident, her roommate, the resident ' s husband who was a resident, and his roommate were treated preventatively as well.	F 441	recommendation. Resident # 10 room-mate was treated and the room deep cleaned after each treatment by the Housekeeping Department on 1/9/14 and 1/17/14. Resident # 14 was treated on 2/13/14. Resident # 14 room-mate was also treated and the room deep cleaned after treatment by the Housekeeping Department on 2/13/14. After resident # 14 received treatment and showered, she was returned to her room to be dressed. Facility staff promptly intervened and removed Resident # 14 before any articles in the room were touched. **2)** A 100% audit of all resident's skin was completed by the charge nurses to ensure residents were free of any skin infection, redness or itching on 2/17/14. A 100% review was completed on all residents with infections to	

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F 441	Continued From page 25 d. After the residents received treatment, their rooms were sanitized. All clothing and linens were washed. e. Facility Medical Director, in conjunction with the administrator and Director of Nursing, established an action plan for the prophylactic treatment of all residents. Additionally, all staff members were counseled and offered treatment. 2) How will corrective action be accomplished for all residents that have the potential to be affected? a. Skin assessments (100%) were conducted to assess for symptomatic residents to ensure those residents received 2 treatments as needed. b. All residents received 2 treatments over a 7 day period. c. All resident rooms were sanitized once the resident was treated. d. Staff members experiencing symptoms will be checked by an administrative nurse and sent home with Permethrin provided by the facility. 3) What measures or systemic changes will be put in place to ensure correction? a. Skin audits will be conducted every other day times 2 weeks then weekly there after. b. The Director of Nursing will review results of the Skin Audits every other day for 2 weeks then monthly for changes. 4) How does the facility plan to monitor its performance to ensure that solutions remain in place? a. The results of these audits will be discussed quarterly at the Quality Improvement Committee Meeting times 3 to determine the frequency and the need for QI. On 2/11/2014 at 4:27 PM an interview with Nurse Aid # 2 revealed she had not received an in-service on scabies. She had been sent home 3	F 441	include scabies utilizing the infection control log on February 17-19, 2014 by the facility's consultants to ensure appropriate precautions have been implemented and infection control practices are followed to prevent and control infections. The Facility Facilitator will educate staff on expectations regarding infection control practices by 3/21/14. All newly hired staff will be educated regarding infection control practices to include information about contact precaution during orientation. All staff identified with a suspicious rash will be sent home to acquire treatment and will not be allowed to return to work for 24 hours post treatment.	

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F 441	Continued From page 26 times for scabies treatment. On 2/11/2014 at 4:30 PM an interview with Nurse #1 revealed he did not receive an in-service for scabies. Nurse #1 reported the staff treated resident and resident rooms in a scattered pattern based on resident and staff availability. Nurse #1 reported the residents continued to go to activities and the dining room on the same days whether they were treated with the topical scabicide or untreated. On 2/14/2014 at 12:41 an interview with Nurse Aid #6 revealed she was treated for scabies 3 times since she started in December. Nurse Aid #6 reported she was not out of the facility for a full 24 hours. She would go home in the middle of the shift and then be back at 3:00 PM for her next shift. If she observed a resident with scabies she called a nurse would not follow through with an observation. The topical scabicide was not applied to the whole hall and the residents treated and untreated would go to activities or the dinning hall. Sometimes the topical scabicide was applied and the shower did not happen for 3 days because of staffing and shower schedules. The rooms were not getting deep cleaned. The staff assignments were changed to different halls during the outbreak. Nurse Aid #6 reported she never had an in-service on scabies. Interview on 2/14/2014 at 4:30 PM with NA# 4 revealed she did not receive an in-service on scabies from the facility. An interview on 2/14/2014 at 3:02 PM with the Attending Physician revealed in January all the residents were treated with the topical scabicide twice. The facility had not been able get an	F 441	**3)** All residents with infections to include signs and symptoms of scabies will be reviewed by the Director of Nursing or the Staff Facilitator monthly on-going utilizing the infection control program and documented on the infection control log to ensure that appropriate isolations precautions and infection control practices are being utilized to prevent and spread infections. Any staff member with confirmed scabies will provide	

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F 441	Continued From page 27	F 441		

adequate amount of the oral treatment for scabies to treat the whole facility. The Physician revealed there was 150 tablets available. The dose per resident was based on weight and one resident may require 7 to 8 tablets. With 80 people in the building he would need 400 to 500 tablets to treat just the residents and not the staff. The Physician reported this was the 3rd occurrence of scabies infestation and his recommendation would be for the facility to not accept any more admissions and retreat the residents in house.

On 2/12/2014 at 9:15 AM an interview with the DON revealed she was the facility Infection Control Nurse and was aware Residents had been treated with a topical scabicide but could not recall treatments from August to December of 2013. The DON reported the facility track and trended the outbreaks and referred to the skin assessment audits preformed in January 2014. When asked if the scabies outbreak had been reviewed by the QA (Quality Assurance) committee the DON responded by saying " it is something we would take to QA " .

A record review of the Completed In-service Training Report with Staff Attending dated 2/14/2014 for the skin audit procedure that included all shifts revealed signature for 12 of the18 known nurse staff. The procedure included; the skin audit instructions included 100% skin audits will be conducted for residents on even numbered days of February. The day shift was to assess the residents in odd numbered rooms, the evening shift was to assess the residents in even number rooms, and the night shift was to assess the residents missed by the day and evening shift staff. Check marks with staff initials were to be

verification of treatment and clearance by a medical professional prior to returning to work. These verifications will be confirmed by the specific department manager prior to allowing the staff member to return to work. The Administrator will review and initial the infection control logs monthly x 3 months for completion.

4) The results of the infection control logs will be reviewed at the monthly QA meeting to identify trends and the need for continued monitoring.

3-25-14

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F 441	Continued From page 28 documented on a daily census sheet when a shin assessment was completed. Concerns were to be reported to the treatment nurse. Record review of the skin assessment audits dated for 2/4/2014, 2/6/2014, 2/8/2014, and 2/10/2014 revealed they were not completed at 100%. On 2/4/2014 the census designated for the even number rooms on the 200 hall was blank with no check boxes, nurse initials, or assessment descriptions. For 2/4/2014 there was no census for skin assessments on the 400 hall residents. On 2/6/2014 there was no census for skin assessment for the 100 hall residents, no census for skin assessment for the residents in odd number rooms on the 400 hall, and even number rooms on the 200 hall. On 2/10/2014 there was only one assessment for the 100 hall even numbered resident rooms and a hand written list of residents with skin descriptions. Record Review of the Plan of Correction binder In-service dated 1/11/2014 included subject 1) scabies hand out from Gilford City 2) hand washing, 3) standard precautions, 4) handling of linens. Signature log revealed 30 signatures of the 60 nurses on staff. During an interview on 2/14/2014 at 4:40 PM with the Administrator her expectation was for the staff to follow the Plan of Correction.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		

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F 520	Continued From page 29 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to identify an infection control quality deficiency, in-service the staff, and oversee implementation of the plan of correction for 6 of 15 residents (Resident #10, #5, #6, #8, #14, & #15) reviewed for infection control. Findings included: Record Review of the Plan of Correction titled POC Skin Rash dated 1/9/2014 read as the following: 1) How will corrective action be accomplished for the resident? On 1/9/2014 it was identified that one resident (Resident #10) had a confirmed	F 520	**F520** 1) Resident # 10, #5, #6, #8, #14, and #15 were treated for signs and symptoms of scabies on January 9, 2014 and January 14,2014 . 2) An order was given by the MD to treat all residents for rashes with oral Ivermectin to include resident # 10, #5, #8, #14, and # 15 on February 18, 19 and 20, 2014. All residents were treated for rashes per physician order as residents allowed on February 18-20, 2014. All resident's rooms, clothing, and common areas were cleaned by housekeeping on February 18-20, 2014. A 100% audit of all resident's skin was completed by the charge nurses on February 17, 2014 to ensure residents were free of any skin infection,	

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F 520	Continued From page 30 diagnosis of scabies [Sarcoptes scabiei]. a. The Director of Nursing made the facility Administrator and medical Director aware of the findings and treatment orders. b. She was treated with Permethrin [a topical scabicide brand name Elimite] 2 times over a 7 day period. c. The resident, her roommate, the resident ' s husband who was a resident, and his roommate were treated preventatively as well. d. After the residents received treatment, their rooms were sanitized. All clothing and linens were washed. e. Facility Medical Director, in conjunction with the administrator and Director of Nursing, established an action plan for the prophylactic treatment of all residents. Additionally, all staff members were counseled and offered treatment. 2) How will corrective action be accomplished for all residents that have the potential to be affected? a. Skin assessments (100%) were conducted to assess for symptomatic residents to ensure those residents received 2 treatments as needed. b. All residents received 2 treatments over a 7 day period. c. All resident rooms were sanitized once the resident was treated. d. Staff members experiencing symptoms will be checked by an administrative nurse and sent home with Permethrin provided by the facility. 3) What measures or systemic changes will be put in place to ensure correction? a. Skin audits will be conducted every other day times 2 weeks then weekly there after. b. The Director of Nursing will review results of the Skin Audits every other day for 2 weeks then monthly for changes. 4) How does the facility plan to monitor its	F 520	redness or itching. A 100% review was completed on all residents with infections to include scabies utilizing the infection control log on February 19-20, 2014 by the facility consultants to ensure appropriate precautions have been implemented and infection control practices are followed to prevent and control infections. The Staff Facilitator will educate staff on expectations regarding infection control practices to be completed by All newly	

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F 520	Continued From page 31 performance to ensure that solutions remain in place? a. The results of these audits will be discussed quarterly at the Quality Improvement Committee Meeting times 3 to determine the frequency and the need for QI. On 2/10/2014 at 2:00 PM an interview with the Director of Nursing (DON) revealed The facility had one resident, Resident # 10 with a confirmed diagnosis of scabies on 1/9/2014. Record review of Resident #10 Physician Order dated 1/9/2014 read Elimite 5% cream. Dispense 1 tube. Apply neck down, leave on overnight. Wash off in the morning. Repeat in one week. Record review revealed the facility treatment of choice for a topical scabicide was Permethrin/Elimite. The directions on the Physician Orders for the topical scabicide were to apply from the neck to the soles of the feet, leave on for 8 hours, then shower off and repeat in 7 days. Record review of Resident # 5 revealed Physician Orders for topical scabicide on 8/1/2013, 12/30/2014, and 1/30/2014. Record review of Resident #6 revealed Physician Orders for topical scabicide dated 1/14/2014 and 8/1/2013. On 2/11/2014 at 4:10 PM an interview and observation with Resident #6 revealed she received the medicated cream for scabies. Resident #6 reported her legs still itch at night. An observation of exposed skin reveals Resident # 6 had a red scaled and irritated rash to lower	F 520	hired staff will be educated regarding infection control practices to include contact precautions during orientation. A QI was completed related to infection control and the plan of correction and taken to the Quality Assurance committee on 2/18/14. The Quality Assurance committee on 2/18/14 consisted of the Director of the nursing, the Administrator, and the MDS Coordinator. **3)** All data collected for identified areas of concerns to include infection control will be taken to the Quality Assurance committee for review monthly. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to	

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F 520	Continued From page 32 extremities. Record review of Resident # 8 revealed Physician Orders for topical scabicide dated 7/30/2014, 1/17/2014 and 1/30/2014. Record review of Resident #14 revealed Physician Orders for the topical scabicide dated 1/14/2014, 1/31/2014, and 2/13/2014. Record Review of Resident #15 Physician Orders for topical scabicide dated 1/30/2014 1/14/2014, and 2/13/2014. On 2/11/2014 at 4:27 PM an interview with Nurse Aid # 2 revealed she had been sent home 3 times for scabies treatment. On 2/11/2014 at 4:30 PM an interview with Nurse #1 revealed he did not receive an in-service for scabies. On 2/14/2014 at 12:41 an Interview with Nurse Aid #6 revealed she was treated 3 times for scabies since she started in December 2013. On 2/14/2014 at 3:33 PM an interview with Nurse #4 revealed she was sent home on 2/11/2014 with the topical scabicide On 2/14/2014 at 4:30 PM an interview with NA# 4 revealed she did not receive an in-service on scabies from the facility. 2) An observation on 2/14/2014 at 4:15 PM revealed Resident #14 had been placed on contact precautions. Interview on 2/14/2014 at 4:35 PM with the DON	F 520	improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting. The Administrator will be responsible to review and ensure that appropriate data is collected for all areas of identified concern to include infection control and taken to the Monthly Quality Assurance committee on going. The Quality Assurance	

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	345132	A. BUILDING _____ B. WING _____	C 02/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 33 revealed her knowledge of the contact precaution signs placed for Resident #14 for scabies treatment. Resident #14 was treated with the topical scabicide on 2/13/2014. On 2/14/2014 at 4:25 PM Resident #14 was observed in the shower room with Nurse Aid #5 and #1. An interview on 2/14/2014 at 4:25 PM with Nurse Aid #5 and Nurse Aid #1 revealed they had been in-serviced on the plan of correction for scabies. Nurse Aid #5 and #1 revealed Resident #14 needed a shower because the topical scabicide was applied the night before which was greater than the 8 hour application requirement. Nurse Aid #5 and #1 were aware the resident room had to be cleaned but did not know where housekeeping was. When asked what they intended to do with Resident #14 after her shower was complete they reported they were going to return Resident #14 to her room. Observation on 2/14/2014 at 4:33 PM Nurse Aid #1 and Nurse Aid #5 escorted Resident # 14 back into her room in her bath towels. The facility corporate nurse stopped them at the resident ' s bedside and asked them to remove her from her room. No housekeeping staff was observed near or in Resident #14 ' s room, from the 4:15 PM to 4:33 PM observation. An interview on 2/14/2014 at 3:02 PM with the Attending Physician revealed in January all the residents were treated with the topical scabicide twice. The facility had not been able get an adequate amount of the oral treatment for	F 520	committee will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Treatment nurse, Director of Nursing, Dietary Manager, Housekeeping Supervisor, and Staff Development Coordinator. 4) The results of the minutes from the monthly Quality Assurance Committee will be reviewed at the Quarterly Quality Assurance Committee meeting on going to identify trends and the need for continued monitoring.	3-25-14

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F 520	Continued From page 34 scabies to treat the whole facility. The Physician revealed there was 150 tablets available. The dose per resident was based on weight and one resident may require 7 to 8 tablets. With 80 people in the building he would need 400 to 500 tablets to treat just the residents and not the staff. The Physician reported this was the 3rd occurrence of scabies infestation and his recommendation would be for the facility to not accept any more admissions and retreat the residents in house. A record review of the Completed In-service Training Report with Staff Attending dated 2/14/2014 for the skin audit procedure that included all shifts revealed signature for 12 of the 18 known nurse staff. The procedure included; the skin audit instructions included 100% skin audits will be conducted for residents on even numbered days of February. The day shift was to assess the residents in odd numbered rooms, the evening shift was to assess the residents in even number rooms, and the night shift was to assess the residents missed by the day and evening shift staff. Check marks with staff initials were to be documented on a daily census sheet when a shin assessment was completed. Concerns were to be reported to the treatment nurse. Record review of the skin assessment audits dated for 2/4/2014, 2/6/2014, 2/8/2014, and 2/10/2014 revealed they were not completed at 100%. On 2/4/2014 the census designated for the even number rooms on the 200 hall was blank with no check boxes, nurse initials, or assessment descriptions. For 2/4/2014 there was no census for skin assessments on the 400 hall residents. On 2/6/2014 there was no census for skin assessment for the 100 hall residents, no	F 520		

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F 520	Continued From page 35 census for skin assessment for the residents in odd number rooms on the 400 hall, and even number rooms on the 200 hall. On 2/10/2014 there was only one assessment for the 100 hall even numbered resident rooms and a hand written list of residents with skin descriptions. Record Review of the Plan of Correction binder In-service dated 1/11/2014 included subject 1) scabies hand out from Gilford City 2) hand washing, 3) standard precautions, 4) handling of linens. Signature log revealed 30 signatures of the 60 nurses on staff. Record review of the facility QA minutes dated 1/14/2014 included: · Scabies 1/9/2014 Resident #10 · Diagnosis from outside consultant · Treatment arrived on this date. · Preventative treatments administered for her husband, and his roommate, as well as her roommate. · Skin assessments preformed throughout facility, as well as preventative measures. · Facility to continue to monitor staff for use of universal precautions on all residents. Interview on 1/14/2014 at 4:35 PM with the DON was asked for a list of residents that had complained of itching with rash. She was unable to produce a list but generated a hand written list for the months suggested by the surveyor; August 2013, December 2013, January 2014, and February 2014. Record review of the Hand written list revealed 4 residents for the month of August that did not include Resident # 5 who had an order for topical scabicide on 8/1/2013 and resident #8 who had	F 520		

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F 520	Continued From page 36 an order for topical scabicide on 7/30/2013. On 2/12/2014 at 9:15 AM an interview with the DON revealed she was the facility Infection Control Nurse and was aware Residents had been treated with a topical scabicide but could not recall treatments from August to December of 2013. The DON reported the facility followed the outbreaks and referred to the skin assessment audits preformed in January 2014. When asked if the scabies outbreak had been reviewed by the QA (Quality Assurance) committee the DON responded by saying " it is something we would take to QA " . On 2/12/2014 at 10:32 AM the DON provided a document that read as the following: On 2/11/2014, The Medical Director, Administrator and Director of Nursing discussed · Rashes occurring in the building-residents and staff: is this scabies? · Possible treatments, i.e. cream versus oral tablet , [medication included incorrect] · If the choice was made to treat with the oral form, how long would it take for the pharmacy to get the medication to the facility · Need dermatology appointments to confirm diagnosis It was concluded that, the discussion would be continued on 2/12/2014 The document was signed by the DON and the Administrator. During an interview on 2/14/2014 at 4:40 PM with the Administrator her expectation was for the staff to follow the Plan of Correction.	F 520		