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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 157 SS=J | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, physician interviews and record reviews facility | F 157 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>Resident #1 no longer resides in the facility. Licensed Nurses #2, #3 and #4 who were identified as primary care providers in the assessment interventions and notification for clinical changes with resident #1 were individually in-serviced/re-educated by the Staff Development Coordinator (SDC) on the following policy and procedures for Notification, 24-Report/Change in Condition and Resident Refusal of/or Failure to Follow MD orders.<br><br>The Staff Development Coordinator (SDC) reeducated the Licensed Nurses to the centers policy and procedure for Physician and Responsible Party Notification/Change in Condition, 24-Report Book, Resident Refusal of/or Failure to Follow MD orders. The above in-service will be incorporated into the new employee orientation program for Licensed Nurses.<br><br>The DNS/ADNS/Unit Manager will audit through record review 5 residents on the 24 hour report for changes in resident's condition, for physician and family notification 3 times weekly for four weeks then 2 times weekly thereafter to ensure ongoing compliance in notification. | 2/23/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allen Phillips — TITLE: Executive Director — (X6) DATE: 2/22/12

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 157 | Continued From page 1<br>staff failed to notify the physician of continued combative behaviors, resident refusal of Lantus insulin at bedtime, continued refusals of finger stick blood sugars and failed to document blood pressures daily for three days for one (1) of fourteen (14) sampled residents. (Resident #1).<br><br>Immediate Jeopardy began on 1/19/12 when Resident #1 continued to exhibit combative behaviors and refused Lantus Insulin 25 units subcutaneously at bedtime. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place.<br><br>The findings are:<br><br>Resident #1 was admitted on 6/28/11 with diagnoses including uncontrolled type II diabetes, dementia, hypertension, and a stroke with left (L) sided weakness.<br><br>The most recent quarterly Minimum Data Set (MDS) dated 12/20/11 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The MDS also indicated Resident #1 had no behavioral symptoms directed toward others, required extensive assistance by staff for transfers, dressing and hygiene, required set up assistance only with eating, was incontinent of bowel and bladder and had upper and lower extremity impairment on one side.<br><br>A review of physician orders dated 6/28/11 revealed an order for Lantus insulin 14 units | F 157 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>Data results will be reviewed and analyzed at the facility monthly Performance Improvement (PI) Committee Meeting for 3 months with a subsequent plan of correction as needed. The Director of Nurses is responsible for overall compliance. | 2/23/12 |

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|---|---|---|---|---|
| F 157 | Continued From page 2 | F 157 | | |

subcutaneously daily at bedtime for diabetes; Amaryl 2 milligrams orally before breakfast for diabetes mellitus.

A review of physician orders dated 9/06/11 revealed an order to increase Lantus insulin to 17 units subcutaneously daily at bedtime.

A review of physician orders dated 11/8/11 revealed an order to increase Lantus insulin from 17 units to 20 units subcutaneously at bedtime and increase Finger stick Blood Sugars to before breakfast each morning and before supper each evening.

A review of laboratory results dated 12/21/11 indicated a hemoglobin A1C (a test to give an overall view of how the blood sugar levels are controlled or out of control in individuals with diabetes) was 11.9 percent (normal range was less than 7 percent).

A review of physician orders dated 12/27/11 revealed an order to increase Lantus insulin to 25 units daily at bedtime.

A review of a physician's progress note dated 1/17/12 revealed Resident #1 had increased confusion. "Patient has had tremendous decrease in level of consciousness in the last ten days. Was alert and communicating with decent memory and focus. Now unfocused, unable to answer questions directly. Vital signs/blood sugar not recorded last three (3) days. Confusion on patient with multiple medical problems. No obvious cause. Possible small stroke. Plan to check labs and monitor vitals."

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|---|---|---|---|---|
| F 157 | Continued From page 3<br>A review of physician orders dated 1/17/12 at 6:30 PM revealed an order to check blood pressure daily; finger stick blood sugars daily - fasting each morning; CBC; CMP; Blood Cultures x 2. Chest x-ray posteroanterior (PA) and lateral views due to increased confusion.<br><br>A review of the Medication Administration Record (MAR) dated 1/18/12 revealed Resident #1 refused finger stick blood sugars at 6:00 AM.<br><br>A review of the MAR dated 1/19/12 revealed Resident #1 refused finger stick blood sugars at 6:00 AM.<br><br>A review of a physician's progress note dated 1/19/12 revealed "patient combative, spitting and refusing meds." Blood sugar "high" according to nursing staff. "Dementia with possible mini strokes."<br><br>A review of nurse's notes dated 1/19/12 at 3:30 PM stated Resident #1 refused all medications, was spitting them out and was combative during care.<br><br>A review of the MAR dated 1/19/12 at 9:00 PM stated Resident #1 refused Lantus 25 units subcutaneously. There was no documentation in the nurse's notes the physician was called.<br><br>A review of nurse's note dated 1/20/12 stated Resident #1 refused meal and a nursing assistant attempted to feed resident. The notes further stated the resident was spitting out food, refused fluids and refused finger stick blood sugar and all medications. | F 157 | | |

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|---|---|---|---|---|
| F 157 | Continued From page 4<br>A review of the MAR dated 1/20/12 at 9:00 PM stated Resident #1 refused Lantus 25 units subcutaneously.<br><br>A review of the MAR dated 1/21/12 revealed Resident #1 refused finger stick blood sugars at 6:00 AM.<br><br>A review of nurse's notes dated 1/21/12 at 3:30 PM and signed by LN # 5 stated a venipuncture was performed this afternoon on Resident #1 and vital signs were documented as follows: temperature 101.0, pulse 154, BP 138/87, respiration's 20. Oxygen saturation percentage was 95% on room air, bilateral lung congestion was noted, resident was very difficult to arouse and warm to the touch. The notes further stated the resident had not eaten or taken any fluids this shift and the nurse was unable to get resident to take oral medications due to decreased level of consciousness.<br><br>A review of laboratory reports dated 1/21/12 at 2:41 PM revealed abnormal laboratory values as follows: Glucose 822 (critical value) normal range 70 -110<br>BUN 71 (critical value) normal range 7 - 18<br>Creatinine 3.60 (critical value) normal range 0.50 - 1.20<br>White Blood Cell 23.7 (high) normal range 4.8 - 10.8<br>Total Protein 8.6 (high) normal range 6.4 - 8.2<br>SGOT 53 (high) normal range 15 - 37<br>Calcium 10.6 (high) normal range 8.5 - 10.1<br>Carbon Dioxide 17 (low) normal range 21 - 32<br>Blood Cultures were positive with streptococcus and staphylococcus bacteria. | F 157 | | |

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|---|---|---|---|---|
| F 157 | Continued From page 5<br>A review of a transfer form dated 1/21/12 with no time revealed Resident #1 was transferred by emergency medical services to the hospital.<br><br>A review of a hospital history and physical dated 1/21/12 revealed Resident #1 was admitted with altered mental status with possibilities including infection and diabetic ketoacidosis (a serious complication of diabetes that occurs when the body produces very high levels of blood acids); sepsis and underlying infection with elevated white blood cell counts and urinary tract infection; rapid heart rate with fever and dehydration; acute renal failure and a large new acute left sided stroke.<br><br>During an interview on 1/30/12 at 1:15 PM LN #1 stated she was told during report from a night shift nurse on 1/21/12 Resident #1 did not drink or take her medications for the last couple of days. She stated she did not go to Resident #1's room immediately after report but went to her room later in the morning and the resident did not respond, moved her right (R) arm slightly and wouldn't talk to her. She explained she did not call the physician because she wanted to get the blood drawn first. She further stated she drew blood on the resident around noon and sent it to the laboratory and the laboratory called back with critical values. She explained she called the physician's answering service and sent Resident #1 to the hospital on 1/21/12 at approximately 3:00 PM.<br><br>During an interview on 1/30/12 at 3:10 PM with LN #3 she stated she was concerned on Friday evening 1/20/12 that Resident #1 was still abusive and refused her medications. She | F 157 | | |

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|---|---|---|---|---|
| F 157 | Continued From page 6 | F 157 | | |

explained she did not call the physician after Resident #1 refused her Lantus insulin at bedtime and stated she reported off to the night shift nurse to keep an eye on the resident because something did not seem right.

During an interview on 1/31/12 at 8:35 AM the physician stated Resident #1 had very volatile hypertension, diabetes and recent strokes. He stated he was not aware of the missed Lantus insulin doses on 1/19/12 and 1/20/12 and he was unaware of the resident's continued combative behaviors and confusion. He further stated staff should have told him about missed Lantus insulin doses, continued refusals of finger stick blood sugars and continued confusion and combativeness. He stated if he had known about the missed insulin doses and the continued refusals of finger stick blood sugars he would have ordered for them to do a finger stick blood sugar or he would have sent the resident to the hospital.

During an interview on 1/31/12 at 8:49 AM with LN #4 she stated she was Resident #1's nurse during the night shift on 1/20/12 and the resident was very noncompliant, combative and was physically and verbally abusive. She stated she tried to draw blood work but she couldn't get it and she tried to do a finger stick blood sugar but the resident wouldn't let her. She verified she did not call the physician during her shift but reported to the day shift on Saturday morning 1/21/12 she was unable to draw the blood and the resident had refused her medications and finger sticks.

During an interview on 1/31/12 at 3:36 PM with LN #5 she verified she was the nursing

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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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|---|---|---|---|---|
| F 157 | Continued From page 7<br>supervisor during the day on 1/21/12. She stated she did not receive a report from the night shift nurses that morning and she saw Resident #1 at approximately 11:00 AM on 1/21/12 to assist a nurse with drawing blood. She stated the resident "was not alert at all" when she went into her room. She stated she did not check the resident's vital signs or call the physician because she was focused on getting the blood drawn. She further stated Resident #1 was very sick when they drew her blood. She explained she took the blood to the laboratory and they called critical values to the facility within the hour and the resident was sent to the hospital.<br><br>During an interview on 1/31/12 at 9:00 AM the Director of Nurses (DON) stated she expected nursing staff to notify the physician when a resident refused insulin and they should notify the physician when a resident had continued combative behaviors and confusion and they should document information in the nurse's notes.<br><br>During a follow up interview on 1/31/12 at 10:25 AM the physician stated an elevated blood sugar would have been very serious for Resident #1 and affected her dehydration. He stated he verified his answering service had not received any calls from the facility after he saw the resident while he was in the facility on 1/19/12.<br><br>The Administrator was informed of Immediate Jeopardy on 1/31/12 at 4:10 PM for Resident #1.<br><br>The facility provided a credible allegation of compliance which included:<br><br>I. Resident # 1 was admitted to facility on June | F 157 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 157 | Continued From page 8<br>28, 2011. Resident #1 was transferred from facility to the hospital on January 21, 2012, related to changes in behavior, resulting in refusal of Finger Stick Blood Sugar (FSBS), refusal of routine insulin doses, and lack of notification to Physician of continued change in condition and status decline, as evidenced by critical laboratory values.<br>On January 31, 2012, three (3) nurses were identified as primary providers in the assessment, interventions and notification regarding clinical changes for Resident # 1. These nurses were individually in-serviced/educated by the Staff Development Coordinator (SDC) on the following processes.<br>· Notification: Nurses will notify physician and responsible party regarding, refusal of medications, diagnostic procedures, and/or changes in condition.<br>· Use of the 24-Hour Report Resident Change in Condition Book: Identifies acute changes in resident's conditions by utilizing check marks to identify type of change, narrative if indicated, and follow up validation by check mark of action taken with acute change in condition.<br>· Resident Refusal of/or Failure to Follow MD orders: Notification of physician, responsible party, nursing, and other interdisciplinary team members when residents refuse plan of care. Education to resident/family and documentation needed while also protecting resident right to refuse.<br>· Condition Change of a Resident and expectations on communication at change of shift: Nurses will utilize the 24 hour report as a communication tool to other shifts and nursing administration for changes in resident condition.<br>· Notification to physician and responsible party | F 157 | | |

| 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 157 | Continued From page 9<br>will be documented in the nurse's notes and identified as completed on the 24 hour Report.<br>· Protocols for Physician Notification: Provision of resource guidelines for nurse's recognition, identification, assessment, intervention, and documentation of pertinent and relevant information related to Resident Change in Condition.<br>The Medical Director, Executive Director, Director of Nursing Services and the Staff Development Coordinator conducted a Performance Improvement (PI) meeting on January 31, 2012 to address Resident #1's change in condition and hospitalization.<br>The Committee determined through root cause analysis the change in condition for Resident #1 was related to the delay in implementation of MD orders, and Physician notification of resident refusal of medications, diagnostic testing, and clinical decline that was not readily identified.<br>Based on this root cause, the ED and DNS developed a "Performance Improvement" plan on 1/31/2012 to provide the following interventions to prevent re-occurrence.<br>· Notification: Nurses will notify physician and responsible party regarding, refusal of medications, diagnostic procedures, and/or changes in condition.<br>· Use of the 24-Hour Report Resident Change in Condition Book: Identifies acute changes in resident's conditions by utilizing check marks to identify type of change, narrative if indicated, and follow up validation by check mark of action taken with acute change in condition.<br>· Resident Refusal of/or Failure to Follow MD orders: Notification of physician, responsible party, nursing, and other interdisciplinary team members when residents refuse plan of care. | F 157 | | |

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|---|---|---|---|---|
| F 157 | Continued From page 10<br>Education to resident/family and documentation needed while also protecting resident right to refuse.<br>· Lab Protocol: Facility process of receiving orders, scheduling lab draw, validating return reports, review, reporting and documentation with follow up if indicated. Documentation of refusals, or inability to obtain diagnostic test with subsequent notification to physician and responsible party as indicated.<br>· Condition Change of a Resident and expectations on communication at change of shift: Nurses will utilize the 24 hour report as a communication tool to other shifts and nursing administration for changes in resident condition.<br>· Notification to physician and responsible party will be documented in the nurse ' s notes and identified as completed on the 24 hour Report.<br>II. On 1/31/2012 Facility RN's and LPN's were in-serviced and educated by the ADNS and SDC on the processes as described in Section "I" In-service bullets. Weekend nurses, and PRN nurses and remaining nurses who have not been in-serviced will be ineligible to work until this mandatory in-service training completed.<br>There have been no newly hired licensed nurses since January 31, 2012. Newly hired licensed nurses (RN's and LPN's) will be provided this training during new employee orientation that will be conducted by the SDC effective January 31, 2012 and thereafter.<br>III. On 01/31/2012 the new 24-hour report was initiated and will be utilized by the nurses, nursing administration and interdisciplinary team to communicate identified changes in resident condition, assessment, intervention, and notification to MD and RP of event, progress, critical lab values, and resolution of identified | F 157 | | |

| 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 157 | Continued From page 11<br>changes.<br>The DNS/ADNS/Unit Manager/Weekend Supervisor will do a review of medical records on residents identified on the 24 hour change in condition sheet for notification of MD and Responsible Party, documentation, and assessment of the resident, which will be done daily. The resident's medical record will be reviewed during morning meeting (Mon - Fri) and the Interdisciplinary team will address any areas of concern related to documentation, notification of MD and Responsible Party.<br>The DNS/ADNS/Unit Manager/Weekend Supervisor will be responsible for identification and resolution for any concerns on change of condition.<br>IV. The Unit Manager, Shift and Weekend Supervisors will audit new admissions, re-admissions, and the 24 hour report for change resident conditions on a daily basis. DNS/ADNS will be responsible for identification and resolution of concerns with change in Resident condition/s. Results of these audits will be analyzed and reviewed at the facility ' s monthly Performance Improvement (PI) meeting monthly for six (6) months and then quarterly thereafter.<br><br>Immediate Jeopardy was removed on 2/2/12 at 4:00 P.M. with interviews of licensed nursing staff who confirmed they received inservice training on 2/2/12 prior to reporting on duty.<br><br>Interviews with nursing staff revealed awareness of expectations to notify the physician and responsible party when a resident had a change in condition, use of the 24 Hour Report Resident Change in Condition Book, actions required with resident refusal of/or failure to follow physician's | F 157 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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|---|---|---|---|---|
| F 157 | Continued From page 12<br>orders, the laboratory protocol, communication at the change of shift regarding resident change in condition and documentation of notification to the physician and responsible party in the nurses notes.<br><br>Observations of the 24 Hour Reports and laboratory protocol on 2/2/12 revealed the documents were at the nurse's station and staff was completing documentation as in-serviced. | F 157 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 309 SS=J | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, physician interviews and record reviews facility staff failed to notify the physician of continued combative behaviors, resident refusals of Lantus insulin at bedtime, continued refusals of finger stick blood sugars and failed to document blood pressures daily for three days for one (1) of fourteen (14) sampled residents. (Resident #1).<br><br>Immediate Jeopardy began on 1/19/12 when Resident #1 continued to exhibit combative behaviors and refused Lantus Insulin 25 units subcutaneously at bedtime. The facility remains out of compliance at a lower scope and severity | F 309 | Resident #1 no longer resides in the facility. Licensed Nurses #2, #3 and #4 who were identified as primary care providers in the assessment interventions and notification for clinical changes with resident #1 were individually in-serviced/re-educated by the Staff Development Coordinator (SDC) on the following policy and procedures for Notification, Lab Protocol, Twenty-four Hour Report/Change in Condition and Resident Refusal of/or Failure to Follow MD orders.<br><br>The Staff Development Coordinator (SDC) reeducated the Licensed Nurses to the centers policy and procedure for Physician and Responsible Party Notification/Change in Condition, 24-Hour Report Book, Lab Protocol , Resident Refusal of/or Failure to Follow MD orders (with an emphasis on combative behaviors, resulting in refusal of insulin, blood pressure check and abnormal laboratory blood sugar findings). The above in-service will be incorporated into the new employee orientation program for Licensed Nurses. | 2/23/12 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 309 | Continued From page 13<br>of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems are put in place.<br><br>The findings are:<br><br>Resident #1 was admitted to the facility on 6/28/11 with diagnoses including uncontrolled type II diabetes, dementia, hypertension, and a stroke with left (L) sided weakness.<br><br>A review of physician orders dated 6/28/11 revealed Lantus insulin 14 units subcutaneously daily at bedtime for diabetes; Amaryl 2 milligrams orally before breakfast for diabetes mellitus; Norvasc 2.5 milligrams orally daily for blood pressure; Catapres 0.2 milligrams orally twice a day for blood pressure; Lopressor 150 milligrams orally twice daily for blood pressure. There were no physician orders to check finger stick blood sugars.<br><br>A review of an admission nurse's note dated 6/28/11 at 3:30 PM revealed Resident #1's blood pressure was 164/90. There was no documentation in the nurse's notes the physician was called.<br><br>A review of nurse's note dated 7/1/11 at 2:00 PM revealed Resident #1's blood pressure this AM was 194/91. Blood pressure was rechecked one (1) hour after blood pressure medication was given and blood pressure was 138/78.<br><br>A review of a vital sign flow sheet dated 7/3/11 revealed Resident #1's weekly blood pressure was 160/92. There was no documentation in the | F 309 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>The DNS/ADNS/Unit Manager will audit through record review 5 residents on the 24 hour report for changes in residents' condition, for physician and family notification 3 times weekly for four weeks then 2 times weekly thereafter to ensure ongoing compliance in notification for change of condition.<br><br>Data results will be reviewed and analyzed at the facility monthly Performance Improvement (PI) Committee Meeting for 3 months with a subsequent plan of correction as needed. The Director of Nurses is responsible for overall compliance. | 2/23/12 |

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|---|---|---|---|---|
| F 309 | Continued From page 14<br>nurse's notes the blood pressure was rechecked or the physician was called.<br><br>A review of a physician's progress note dated 7/12/11 revealed the physician was asked by Minimum Data Set (MDS) staff to see resident due to reports of anxiety and dementia. "Patient not available for exam at this time will evaluate at follow up visit next week."<br><br>A review of a nurse's note dated 7/13/11 revealed resident was having periods of confusion and physician was notified.<br><br>A review of a physician's order dated 7/13/11 revealed to check finger stick blood sugars before breakfast meal.<br><br>A review of a vital sign flow sheet dated 7/31/11 revealed Resident #1's weekly blood pressure was 146/84.<br><br>A review of a physician's progress note dated 8/2/11 revealed Resident #1 was seen on routine rounds and had increased systolic blood pressures (the systolic pressure is usually the first number recorded in the blood pressure) and her blood sugars were fluctuating in the 100 range in the mornings.<br><br>A review of a physician's order dated 8/2/11 revealed to increase Norvasc to 5 milligrams orally each day for elevated systolic blood pressures.<br><br>A review of a physician's progress note dated 9/6/11 revealed patient was seen and examined and medical record was reviewed. Finger stick | F 309 | | |

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| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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|---|---|---|---|---|
| F 309 | Continued From page 15 | F 309 | | |

blood sugars were in the 240 range in the mornings and blood pressures were averaging 130's/80's. Will plan to increase Lantus Insulin from 14 units to 17 units daily at bedtime.

A review of a physician's order dated 9/06/11 revealed to increase Lantus Insulin to 17 units subcutaneously daily at bedtime.

A review of a nurse's note dated 9/08/11 revealed Resident #1 was extremely agitated with nursing assistants, would not let them change her and refused all care.

A review of a nurse's note dated 11/3/11 revealed Resident #1 was found during lunch with her tray on floor. The notes stated the resident was clammy and difficult to arouse, her blood sugar was 358. Vital signs were documented as follows: 136/76, pulse 72 and the physician was notified and no new orders were received.

A review of a physician's progress note dated 11/8/11 revealed the patient was seen in follow up, staff concerned about elevated blood sugars as high as 350. Continues to have blood sugars in a range from 290-150 in the mornings. Blood pressures are stable. Will plan to increase Lantus insulin and blood sugar checks.

A review of a physician's order dated 11/8/11 revealed to increase Lantus insulin from 17 units to 20 units subcutaneously daily at bedtime and increase finger stick blood sugars checks before breakfast each morning and before supper each evening.

A review of a vital sign flow sheet dated 12/18/11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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|---|---|---|---|---|
| F 309 | Continued From page 16<br>revealed Resident #1's weekly blood pressure was 134/76.<br><br>The most recent quarterly Minimum Data Set (MDS) dated 12/20/11 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The MDS also indicated Resident #1 had no behavioral symptoms directed toward others, required extensive assistance by staff for transfers, dressing and hygiene, required set up assistance only with eating, was incontinent of bowel and bladder and had upper and lower extremity impairment on one side.<br><br>A review of a nurse's note dated 12/12/11 at 6:45 PM revealed Resident #1 had slurred speech, drooping of the left (L) side of her face and her tongue was protruding from her mouth. The resident's blood pressure was documented as 104/68.<br><br>A review of a nurse's note dated 12/12/11 at 7:10 PM Resident' #1's blood sugar was 416 then rechecked and was 382 and the resident was transported to the hospital.<br><br>A review of a nurse's note dated 12/14/11 at 7:00 PM revealed Resident #1 returned to the facility from the hospital.<br><br>A review of a nurse's note dated 12/16/11 at 2:00 PM revealed Resident #1's blood pressure was 180/89. There was no documentation in the nurse's note the physician was called.<br><br>A review of a physician's order dated 12/20/11 revealed to increase Norvasc to 10 milligrams | F 309 | | |

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|---|---|---|---|---|
| F 309 | Continued From page 17<br>orally each day due to increased blood pressure.<br><br>A review of laboratory results dated 12/21/11 indicated a hemoglobin A1C (a test to give an overall view of how the blood sugar levels are controlled or out of control in individuals with diabetes) was 11.9 percent (normal range was less than 7 percent).<br><br>A review of a physician's progress note dated 12/27/11 revealed blood pressures over the last week range in 148-150's/80-90's. The notes further stated the resident's high blood pressure was severe, still uncontrolled and her diabetes was out of control.<br><br>A review of a physician's order dated 12/27/11 revealed to increase Lantus insulin from 20 units to 25 units daily at bedtime; increase Catapres to 0.3 milligrams orally twice daily for blood pressure.<br>.<br>A review of a physician's order dated 1/12/12 revealed to obtain a urinalysis and culture and sensitivity due to increased confusion.<br><br>A review of a nurse's note dated 1/13/12 revealed at 1:00 PM an in and out catheterization was performed on Resident #1 and cloudy yellow urine was obtained.<br><br>A review of laboratory results dated 1/13/12 revealed the urinalysis had abnormal results of urine glucose 300 (normal range 0-0.8) and a trace of albumin (normal range was no albumin present). The physician's initials were documented on the laboratory results but they were not dated or timed. | F 309 | | |

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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 18<br><br>A review of urine culture results dated 1/13/12 revealed "mixed bacterial flora, probable contamination." The physician's initials were documented on the laboratory results but they were not dated or timed.<br><br>A review of a nurse's note dated 1/17/12 revealed "late entry for 1/16/12." Resident #1 refused care of any kind until 10:00 PM on this shift, was verbally and physically abusive toward staff, was yelling at roommate and refused to allow brief to be changed until 10:00 PM.<br><br>A review of a nurse's note dated 1/17/12 revealed "late entry for 5:30 PM" Resident #1 took all contents of her dinner tray and poured them into bed. She rolled the sheets up and yelled for a nursing assistant to change sheets. The sheets were changed and the resident stated she poured the food out because she didn't want it.<br><br>A review of a physician's progress note dated 1/17/12 revealed increased confusion. "Patient has had tremendous decrease in level of consciousness in the last ten days. Was alert and communicating with decent memory and focus. Now unfocused, unable to answer questions directly. Vital signs/blood sugar not recorded last three (3) days. Confusion on patient with multiple medical problems. No obvious cause. Possible small stroke. Plan to check labs and monitor vitals."<br><br>A review of physician's orders dated 1/17/12 at 6:30 PM revealed blood pressure daily; finger stick blood sugars daily - fasting each morning; CBC; CMP; Blood Cultures x 2. Chest x-ray | F 309 | | |

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| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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|---|---|---|---|---|
| F 309 | Continued From page 19<br>posteroanterior (PA) and lateral views due to increased confusion.<br><br>A review of a nurse's note dated 1/17/12 at 7:00 PM revealed Resident #1 was verbally and physically abusive toward staff and the physician was notified.<br><br>A review of a physician's order dated 1/17/12 at 7:40 PM revealed Haldol 0.5 milligrams orally every four (4) hours as needed for agitation.<br><br>A review of a nurse's note dated 1/17/12 at 7:40 PM revealed Resident #1 received Haldol 0.5 milligrams orally.<br><br>A review of a nurse's note dated 1/19/12 revealed "late entry for 1/18/12" a Nursing Assistant (NA) reported Resident refused care at 12:30 AM and 2:30 AM and demanded three (3) times to leave her alone. At 5:00 AM the NA was able to provide peri-care and at 6:30 AM the resident refused Synthroid and finger stick blood sugar. There was no documentation in the nurse's notes the physician was called.<br><br>A review of a nurse's note dated 1/18/12 at 4:00 PM revealed Resident #1 was aggressive times two (2) on this shift, refused to be changed and the responsible party was notified.<br><br>A review of the Medication Administration Record (MAR) dated 1/18/12 revealed Resident #1 received Haldol 0.5 milligrams at 9:00 AM and 9:00 PM.<br><br>A review of a physician's progress note dated 1/19/12 revealed "patient combative, spitting and | F 309 | | |

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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 20 | F 309 | | |

refusing meds." Blood sugar "high" according to nursing staff. "Dementia with possible mini strokes." Change to Catapres Patch."

A review of a physician's order dated 1/19/12 revealed "correction" Haldol 5 milligrams orally or intramuscularly every four (4) hours as needed for agitation; discontinue Catapres 0.3 milligrams orally and begin Catapres patch 0.3 milligrams and change weekly.

A review of a nurse's note dated 1/19/12 at 3:30 PM revealed Resident #1 refused all medications, was spitting them out and was combative during care. There was no documentation in the nurses notes the physician was called.

A review of the MAR dated 1/19/12 stated Resident #1 received Haldol 5 milligrams intramuscularly at 5:00 PM.

A review of a nurse's note dated 1/19/12 at 5:30 PM revealed Resident #1 was screaming, refusing care and was physically combative. The resident's blood pressure was documented as 98/65 and there was no documentation in the nurse's notes the physician was called.

A review of the MAR dated 1/19/12 at 9:00 PM revealed Resident #1 refused Lantus 25 units subcutaneously. There was no documentation in the nurses notes the physician was called.

A review of a nurse's note dated 1/20/12 revealed Resident #1 refused meal and a nursing assistant attempted to feed resident. The notes further stated the resident was spitting out food, refused fluids and refused finger stick blood sugar and all

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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

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|---|---|---|---|---|
| F 309 | Continued From page 21<br>medications. There was no documentation in the nurses notes the physician was called.<br><br>A review of the monthly medication administration record (MAR) dated January 2012 revealed there were no blood pressures documented on 1/17/12, 1/18/12, or 1/20/12 according to a physician's order to check blood pressures daily. In addition, the MAR revealed documentation by nursing staff on 1/18/12 resident "refused blood sugar and medications; on 1/19/12 "refused finger stick for blood sugar check"; on 1/20/12 "refused finger stick for blood sugar check" and on 1/21/12 "refused finger stick for blood sugar check and fluids."<br><br>A review of laboratory reports drawn in the facility and dated 1/21/12 at 2:41 PM revealed abnormal laboratory values as follows: Glucose 822 (critical value) normal range 70 -110<br>BUN 71 (critical value) normal range 7 - 18<br>Creatinine 3.60 (critical value) normal range 0.50 - 1.20<br>White Blood Cell 23.7 (high) normal range 4.8 - 10.8<br>Total Protein 8.6 (high) normal range 6.4 - 8.2<br>SGOT 53 (high) normal range 15 - 37<br>Calcium 10.6 (high) normal range 8.5 - 10.1<br>Carbon Dioxide 17 (low) normal range 21 - 32<br>Blood Cultures were positive with streptococcus and staphylococcus bacteria.<br><br>A review of a nurse's note dated 1/21/12 at 3:30 PM and signed by LN # 5 stated a venipuncture was performed this afternoon on Resident #1 and blood cultures, CBC, CMP were obtained. Resident #1's vital signs were documented as follows: temperature 101.0, pulse 154, BP | F 309 | | |

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|---|---|---|---|---|
| F 309 | Continued From page 22 | F 309 | | |

138/87, respiration's 20. Oxygen saturation percentage was 95% on room air, bilateral lung congestion was noted, resident was very difficult to arouse and warm to the touch. A responsible party was notified and the Director of Nurses (DON) was notified. The notes further stated the resident had not eaten or taken any fluids this shift and the nurse was unable to get the resident to take oral medications due to decreased level of consciousness.

A review of a transfer form dated 1/21/12 with no time indicated resident was transferred by emergency medical services to the hospital.

A review of a hospital history and physical dated 1/21/12 revealed Resident #1 was admitted to the hospital with altered mental status with possibilities including infection and diabetic ketoacidosis (a serious complication of diabetes that occurs when the body produces very high levels of blood acids); sepsis and underlying infection with elevated white blood cell counts and urinary tract infection; rapid heart rate with fever and dehydration; acute renal failure and a large new acute left sided stroke.

During an interview on 1/30/12 at 1:15 PM LN #1 stated she usually worked the 7:00 AM to 7:00 PM shift on Saturday, Sunday and Monday. She further stated Resident #1 had high blood pressure and elevated blood sugars. She explained she checked the resident's blood sugar with a blood glucose meter and when it was greater than 500 the meter would read "HI." She verified she sent Resident #1 to the hospital on 1/21/12 at approximately 3:00 PM. She stated she was told during report from a night shift nurse

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|---|---|---|---|---|
| F 309 | Continued From page 23 | F 309 | | |

Resident #1 did not drink or take her medications for a couple of days. She explained she went to the resident's room later in the morning and the resident did not respond but moved her right (R) arm slightly and wouldn't talk to her. She further stated she had been told nursing staff and laboratory staff had tried to draw blood from the resident for several days but were unsuccessful. She explained she drew the blood around noon and sent it to the laboratory and the laboratory called back with critical values. She stated she checked Resident #1's vital signs and her heart rate was "really high" but she did not remember documenting them in the resident's medical record. She further stated she called the doctor, the responsible party and her supervisor called the Director of Nurses (DON).

During an interview on 1/30/12 at 2:20 PM with LN #2 she stated she asked the physician to look at Resident #1 on Tuesday 1/17/12 while he was in the facility. She stated the resident was kicking and hitting when they went to the room. The physician examined the resident, LN #2 checked her blood sugar and it was in the 200 range but did not remember checking her blood pressure. She explained she saw Resident #1 the next day and she was still combative and refusing medications, finger stick blood sugars and personal care.

During an interview on 1/30/12 at 3:10 PM with LN #3 she stated she was concerned on Friday evening 1/20/12 that Resident #1 was still abusive and refused her medications. She stated Resident #1 had high blood pressure and high blood sugars. She explained she had called the doctor earlier in the week and got an order for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 309 | Continued From page 24 | F 309 | | |

Haldol because Resident #1 was screaming and yelling. She further explained a laboratory person attempted to draw the resident's blood on 01/20/12 but was unsuccessful. She stated she reported off to the night shift nurse to keep an eye on the resident because something did not seem right. She further stated before the resident became confused and combative she always wanted to take her blood pressure medicine because she had a headache when she didn't take it.

During an interview on 1/31/12 at 6:42 AM with Nursing Assistant (NA) #1 she stated she provided care to Resident #1 on 1/19/12 during the night shift. She explained she reported to the nurse the resident refused care at 12:30 AM and at 2:30 AM. She stated the resident allowed her to provide peri-care.

During an interview on 1/31/12 at 8:35 AM the physician stated Resident #1 had very volatile hypertension, diabetes and recent strokes. He stated he examined her during the last week she was in the facility and she was distant, less alert and less pleasant. He stated he was very worried about her blood pressure and one missed dose of blood pressure medication was critical for her. He stated he was not aware of the missed Lantus insulin doses on 1/19/12 and 1/20/12, he was unaware staff were unable to draw blood after he ordered the tests on 1/17/12 and he was unaware of the continued refusals of finger stick blood sugars after he saw the resident on 1/19/12. He further stated staff should have told him about missed Lantus insulin doses, the inability to draw her blood and continued confusion and combativeness. He explained he was very

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 25<br>worried about the resident's blood pressure and wanted her to stay as calm as possible because he thought she might have another stroke. He stated if he had known about the missed insulin doses and the continued refusals of finger stick blood sugars he would have ordered for them to do a finger stick blood sugar or he would have sent the resident to the hospital.<br><br>During an interview on 1/31/12 at 8:49 AM with LN #4 she stated she was Resident #1's nurse during the night shift on 1/20/12 and the resident was very noncompliant, combative and was physically and verbally abusive. She stated she tried to draw the blood work but she couldn't get it and she tried to do a finger stick blood sugar but the resident wouldn't let her. She verified she did not call the physician during her shift but reported to the day shift on Saturday morning 1/21/12 she was unable to draw the blood and the resident had refused her medications and finger sticks.<br><br>During an interview on 1/31/12 at 9:00 AM the Director of Nurses (DON) stated she expected nursing staff to notify the physician when a resident refused blood sugars or insulin, they should assess and monitor the resident when there was a significant change in their condition and they should document information in the nurses notes.<br><br>During a follow up interview on 1/31/12 at 10:25 AM the physician stated an elevated blood sugar would have been very serious for Resident #1 and affected her dehydration. He stated he verified his answering service had not received any calls from the facility after he saw the resident while he was in the facility on 1/19/12. | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 309 | Continued From page 26<br><br>During an interview on 1/31/12 at 12:55 PM with NA #2 she stated she saw Resident #1 on 1/21/12 at lunch time and she was sitting up in her bed with her mouth open and she "looked like she was in a daze." She explained the resident looked pale, was not talking and did not act the way she normally did. She stated the resident did not get out of bed all day and when the nurse drew blood from both arms the resident did not try to pull away or fight her.<br><br>During an interview on 1/31/12 at 3:36 PM with LN #5 she verified she was the nursing supervisor during the day on 1/21/12. LN #5 stated she saw Resident #1 at approximately 11:00 AM on 1/21/12 to assist a nurse to draw blood on the resident. She stated the resident "was not alert at all" when she went into her room and she was very sick at that point. She explained she took the blood to the laboratory and they called critical values to the facility within the hour. She stated she did not ask anyone to check vital signs or do an assessment because she was helping the nurse draw the blood and then she transported the blood to a laboratory out of the facility.<br><br>During an interview on 2/1/12 at 11:22 AM with NA# 3 she stated she was assigned to care for Resident #1 on 1/21/12. She stated the resident was "really out of it" that day and would not talk to her and she did not look good at all. She stated she did not talk to the nurse and did not check the resident's vital signs. She explained she changed the resident's brief once before she went to the hospital because it was wet and she thought one of the other NA's changed her earlier that | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 27<br>morning.<br><br>The Administrator was informed of Immediate Jeopardy on 1/31/12 at 4:10 PM for Resident #1.<br><br>The facility provided a credible allegation of compliance which included:<br><br>I. Resident # 1 was admitted to facility on June 28, 2011. Resident #1 was transferred from facility to the hospital on January 21, 2012, related to changes in behavior, resulting in refusal of Finger Stick Blood Sugar (FSBS), refusal of routine insulin doses, and lack of notification to Physician of continued change in condition and status decline, as evidenced by critical laboratory values.<br>On January 31, 2012, three (3) nurses were identified as primary providers in the assessment, interventions and notification regarding clinical changes for Resident # 1. These nurses were individually in-serviced/educated by the Staff Development Coordinator (SDC) on the following processes.<br>· Notification: Nurses will notify physician and responsible party regarding, refusal of medications, diagnostic procedures, and/or changes in condition.<br>· Use of the 24-Hour Report Resident Change in Condition Book: Identifies acute changes in resident's conditions by utilizing check marks to identify type of change, narrative if indicated, and follow up validation by check mark of action taken with acute change in condition.<br>· Resident Refusal of/or Failure to Follow MD orders: Notification of physician, responsible party, nursing, and other interdisciplinary team members when residents refuse plan of care. | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 28<br>Education to resident/family and documentation needed while also protecting resident right to refuse.<br>· Condition Change of a Resident and expectations on communication at change of shift: Nurses will utilize the 24 hour report as a communication tool to other shifts and nursing administration for changes in resident condition.<br>· Notification to physician and responsible party will be documented in the nurses notes and identified as completed on the 24 hour Report.<br>· Protocols for Physician Notification: Provision of resource guidelines for nurse's recognition, identification, assessment, intervention, and documentation of pertinent and relevant information related to Resident Change in Condition.<br>The Medical Director, Executive Director, Director of Nursing Services and the Staff Development Coordinator conducted a Performance Improvement (PI) meeting on January 31, 2012 to address Resident #1's change in condition and hospitalization.<br>The Committee determined through root cause analysis the change in condition for Resident #1 was related to the delay in implementation of MD orders, and Physician notification of resident refusal of medications, diagnostic testing, and clinical decline that was not readily identified.<br>Based on this root cause, the ED and DNS developed a "Performance Improvement" plan on 1/31/2012 to provide the following interventions to prevent re-occurrence.<br>· Notification: Nurses will notify physician and responsible party regarding, refusal of medications, diagnostic procedures, and/or changes in condition.<br>· Use of the 24-Hour Report Resident Change | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 29<br>in Condition Book: Identifies acute changes in resident ' s conditions by utilizing check marks to identify type of change, narrative if indicated, and follow up validation by check mark of action taken with acute change in condition.<br>· Resident Refusal of/or Failure to Follow MD orders: Notification of physician, responsible party, nursing, and other interdisciplinary team members when residents refuse plan of care. Education to resident/family and documentation needed while also protecting resident right to refuse.<br>· Lab Protocol: Facility process of receiving orders, scheduling lab draw, validating return reports, review, reporting and documentation with follow up if indicated. Documentation of refusals, or inability to obtain diagnostic test with subsequent notification to physician and responsible party as indicated.<br>· Condition Change of a Resident and expectations on communication at change of shift: Nurses will utilize the 24 hour report as a communication tool to other shifts and nursing administration for changes in resident condition.<br>· Notification to physician and responsible party will be documented in the nurses notes and identified as completed on the 24 hour Report.<br>II. On 1/31/2012 Facility RN's and LPN's were in-serviced and educated by the ADNS and SDC on the processes as described in Section "I" In-service bullets. Weekend nurses, and PRN nurses and remaining nurses who have not been in-serviced will be ineligible to work until this mandatory in-service training completed.<br>There have been no newly hired licensed nurses since January 31, 2012. Newly hired licensed nurses (RN's and LPN's) will be provided this training during new employee orientation that will | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 30<br>be conducted by the SDC effective January 31, 2012 and thereafter.<br>III. On 01/31/2012 the new 24-hour report was initiated and will be utilized by the nurses, nursing administration and interdisciplinary team to communicate identified changes in resident condition, assessment, intervention, and notification to MD and RP of event, progress, critical lab values, and resolution of identified changes.<br>The DNS/ADNS/Unit Manager/Weekend Supervisor will do a review of medical records on residents identified on the 24 hour change in condition sheet for notification of MD and Responsible Party, documentation, and assessment of the resident, which will be done daily. The resident's medical record will be reviewed during morning meeting (Mon - Fri) and the Interdisciplinary team will address any areas of concern related to documentation, notification of MD and Responsible Party.<br>The DNS/ADNS/Unit Manager/Weekend Supervisor will be responsible for identification and resolution for any concerns on change of condition.<br>IV. The Unit Manager, Shift and Weekend Supervisors will audit new admissions, re-admissions, and the 24 hour report for change resident conditions on a daily basis. DNS/ADNS will be responsible for identification and resolution of concerns with change in Resident condition/s. Results of these audits will be analyzed and reviewed at the facility ' s monthly Performance Improvement (PI) meeting monthly for six (6) months and then quarterly thereafter.<br><br>Immediate Jeopardy was removed on 2/2/12 at 4:00 P.M. with interviews of licensed nursing staff | F 309 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 309 | Continued From page 31<br>who confirmed they received inservice training on 2/2/12 prior to reporting on duty.<br><br>Interviews with nursing staff revealed awareness of expectations to notify the physician and responsible party when a resident had a change in condition, use of the 24 Hour Report Resident Change in Condition Book, actions required with resident refusal of/or failure to follow physician's orders, the laboratory protocol, communication at the change of shift regarding resident change in condition and documentation of notification to the physician and responsible party in the nurses notes.<br><br>Observations of the 24 Hour Reports and laboratory protocol on 2/2/12 revealed the documents were at the nurse's station and staff was completing documentation as in-serviced. | F 309 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 312 SS=E | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility staff failed to change towels after they were soiled during incontinence care and failed to follow proper technique during incontinence care for four (4) of four (4) sampled residents (Resident #3, #5, #7 and #8). | F 312 | Resident #3, #5, #7, and #8 is receiving proper incontinent care. The Staff Development Coordinator (SDC) re-educated NA #4 and #5 regarding proper technique during incontinent care.<br><br>The Staff Development Coordinator (SDC) will re-educate the Nursing Assistants to the centers policy and procedure in providing incontinent care. An incontinent care clinical competency will be performed by the SDC with the centers Nursing Assistants to ensure proper technique is maintained during incontinent care. The above inservice will be included in the orientation program for Nursing Assistants. | 2/23/12 |

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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 312 | Continued From page 32<br>The findings are:<br><br>1. Resident #3 was admitted to the facility with diagnoses including hypertension, history of urinary tract infections and a stroke.<br><br>The admission Minimum Data Set (MDS) dated 1/14/12 indicated moderate impairment in short and long term memory and moderate impairment in cognition for daily decision making. The resident required extensive assistance by staff for activities of daily living. The MDS indicated bladder incontinence was not rated because the resident had an indwelling catheter that was removed after admission and she was continent of bowel.<br><br>During an observation of incontinence care on 1/30/12 at 11:15 AM Nurse Aide (NA) #4 and NA #5 entered Resident #3's room, washed their hands, and put on gloves. NA #4 and NA #5 removed the resident's pants and brief that was saturated with liquid diarrhea stool to the bottom sheet on the bed. NA #5 wet a towel with a no rinse cleanser and wiped down the left side of the resident's groin, down the right groin and down inside the labia and placed the soiled towel inside a plastic bag on the foot of the bed. NA # 4 and NA #5 turned the resident to her right side and NA #4 removed the soiled towel from the plastic bag and handed it to NA #5 and she wiped the resident's buttocks multiple times with the same surface of the towel. NA #5 placed a clean brief on the resident, removed her gloves and washed her hands.<br><br>During an interview on 1/30/12 at 11:35 AM with NA #5 she stated once she started cleaning the | F 312 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>The SDC, Assistant Director of Nurses (ADNS) and Unit Manager (UM)will monitor through direct observation incontinent care for 5 residents 2 times weekly for four weeks then weekly x 4 to ensure ongoing compliance.<br><br>Data results will be reviewed and analyzed at the facility monthly Performance Improvement (PI) Committee Meeting for 3 months with a subsequent plan of correction as needed. | 2/23/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 312 | Continued From page 33<br>resident she didn't have enough towels and used the soiled towel because she didn't have any other towels available. She further stated she shouldn't have used a soiled towel from the plastic bag to further clean the resident.<br><br>During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation when staff used towels during incontinence care, they should turn it over and use the clean side if it was not soiled. She further stated if the towel was soiled, nursing staff should discard it into a plastic bag and use a clean towel to continue cleaning the resident.<br><br>During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her expectation nursing staff should always wipe from front to back and discard a towel or washcloth when it was soiled during incontinence care. She further stated it was unacceptable for nursing staff to remove a soiled towel from a plastic bag and use it to clean a resident.<br><br>2. Resident #5 was admitted to the facility with diagnoses including acute renal failure, high blood pressure and diabetes.<br><br>The most recent quarterly Minimum Data Set (MDS) dated 11/25/11 indicated moderate impairment in short and long term memory and moderate impairment in cognition for daily decision making. The resident required total assistance by staff for activities of daily living and was always incontinent of bladder and frequently incontinent of bowel. | F 312 | | |

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|---|---|---|---|
| | 345159 | A. BUILDING _____ B. WING _____ | C 02/02/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LINCOLN NURSING CENTER INC | 1410 EAST GASTON ST LINCOLNTON, NC 28092 |

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|---|---|---|---|---|
| F 312 | Continued From page 34<br>During an observation of incontinence care on 1/30/12 at 11:53 AM Nurse Aide (NA) #5 and NA #6 entered Resident #5's room, washed their hands and put on gloves. NA #5 removed the resident's brief that was saturated with urine and wiped back and forth across the top of the resident's perineal area, inside the left (L) groin and down inside the perineal area. NA #5 and NA #6 turned the resident to her (L) side and the resident had a bowel movement. NA #5 took a wet towel and wiped the resident's buttocks back and forth. The resident was assisted by NA #5 and NA #6 to turn on her back and a clean brief was placed on her.<br><br>During an interview on 1/30/12 at 11:35 AM with NA #5 she stated she had been taught to wipe from front to back during incontinence care and didn't realize she had wiped back and forth with the wet towel.<br><br>During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation staff should clean from front to back and should not wipe back and forth.<br><br>During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her expectation nursing staff should always wipe from front to back and discard a towel or washcloth when it was soiled during incontinence care.<br><br>3. Resident #7 was admitted to the facility with diagnoses including chronic kidney disease, hypertension, diabetes and Alzheimer's dementia.<br><br>The most recent quarterly Minimum Data Set | F 312 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 312 | Continued From page 35<br>(MDS) indicated impairment in short and long term memory and was moderately impaired in cognition for daily decision making. The resident required total assistance by staff for activities of daily living and was always incontinent of bladder and frequently incontinent of bowel.<br><br>During an observation of incontinence care on 12/23/11 at 4:05 PM Nurse Aide (NA) #7 and NA #8 entered Resident #7's room, washed their hands and put on gloves. NA #7 and NA #8 removed the resident's pants and brief that was saturated with urine to the bottom sheet and mattress on the bed. NA #7 assisted the resident to turn to his right (R) side and NA #8 wiped the resident's buttocks back and forth with a wet towel and dried him. NA #8 assisted the resident to turn on his back and NA #7 took a wet towel and wiped back and forth across the resident's perineal area, down the right (R) and left (L) groin and cleaned his penis and scrotum without changing the towel. NA #7 and NA #8 placed a clean brief and clean pants on the resident and removed their gloves and washed their hands.<br><br>During an interview on 1/30/12 at 4:23 PM with NA #7 she stated she had been taught to wipe from front to back during incontinence care but forgot when she cleaned the resident.<br><br>During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation when staff used towels during incontinence care, they should turn it over and use the clean side if it was not soiled. She further stated if the towel was soiled, nursing staff should discard it and use a clean towel to continue | F 312 | | |

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| F 312 | Continued From page 36<br>cleaning the resident.<br><br>During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her expectation nursing staff should always wipe from front to back and discard a towel or washcloth when it was soiled during incontinence care.<br><br>4. Resident #8 was admitted to the facility with diagnoses including urinary tract infections, malnutrition and anxiety disorder.<br><br>The most recent annual Minimum Data Set (MDS) dated 1/25/12 indicated no impairment in short and long term memory and no impairment in cognition for daily decision making. The resident required extensive assistance by staff for activities of daily living. The MDS also indicated Resident #8 had a suprapubic catheter and was always incontinent of bowel.<br><br>During an observation of incontinence care on 1/30/12 at 4:25 PM Nurse Aide (NA) #9 entered Resident #8's room, washed her hands and put on gloves. NA #9 removed the resident's brief and took a wet towel and wiped inside the resident's labia, down the right (R) groin and then down the left (L) groin. NA #9 assisted the resident to turn on her left (L) side and the resident had a bowel movement. NA #9 wiped the resident's buttocks back and forth multiple times and placed a clean brief on the resident.<br><br>During an interview with NA #9 on 1/30/12 at 4:35 PM she stated she had been taught to clean a resident from front to back during incontinence care but was very nervous and not sure what she actually did. | F 312 | | |

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| F 312 | Continued From page 37<br><br>During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation when staff used towels during incontinence care, they should turn it over and use the clean side if it was not soiled. She further stated if the towel was soiled, nursing staff should discard it and use a clean towel to continue cleaning the resident.<br><br>During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her expectation nursing staff should always wipe from front to back and discard a towel or washcloth when it was soiled during incontinence care. | F 312 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 441 SS=E | 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<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 | F 441 | Resident #3, #7, and #8 is receiving proper incontinent care. The Staff Development Coordinator (SDC) re-educated NA #4 and #5 regarding proper hand washing and disposal of soiled linen during incontinent care.<br><br>The Staff Development Coordinator (SDC) will re-educate the Nursing Assistants to the centers policy and procedure in providing incontinent care with an emphasis on proper hand washing and disposal of soiled linen. An incontinent care clinical competency will be performed by the SDC with the centers Nursing Assistants to ensure proper hand washing technique is maintained during incontinent care to include proper disposal of soiled linen. The above inservice will be included in the orientation program for Nursing Assistants. | 2/23/12 |

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| F 441 | Continued From page 38<br>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 and record reviews facility staff failed to remove gloves and wash hands after providing incontinence care for three (3) of four (4) residents observed during incontinence care (Resident #3, #7 and #8) and failed to properly dispose of soiled linen in one (1) of four (4) residents (Resident #8).<br><br>The findings are:<br><br>1. During an observation of incontinence care on 1/30/12 at 11:15 AM Nurse Aide (NA) #4 and (NA) #5 entered the Resident #3's room, washed their hands, and put on gloves. NA #5 removed the resident's pants and brief that was saturated with diarrhea. The bottom sheet of the bed was also saturated with diarrhea. NA #5 provided | F 441 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>The SDC, Assistant Director of Nurses (ADNS) and Unit Manager (UM)will monitor through direct observation incontinent care for 5 residents 2 times weekly for four weeks then weekly x 4 to ensure ongoing compliance with handwashing and disposal of soiled linen during incontinent care.<br><br>Data results will be reviewed and analyzed at the facility monthly Performance Improvement (PI) Committee Meeting for 3 months with a subsequent plan of correction as needed. The Director of Nurses is responsible for overall compliance. | 2/23/12 |

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| F 441 | Continued From page 39 | F 441 | | |

incontinence care to Resident #3 and placed a soiled towel into a plastic bag on the bed. Resident #3 was turned to her left side and NA #4 took the soiled towel out of the plastic bag and handed it to NA #5 and she wiped the resident's buttocks with the soiled towel several times and placed it back into the plastic bag. NA # 4 pulled the soiled sheets off the bed and with her soiled gloves still on, opened the drawer of the resident's bedside table and removed a tube of cream and handed it to NA #5. NA #5 with her gloves still on applied cream to the resident's buttocks, put a clean brief on the resident and touched the resident ' s sweater. NA #4 with her soiled gloves still on picked up the resident's blanket and covered the resident.

During an interview on 1/30/12 at 11:15 AM with NA #4 she stated she was supposed to change her gloves when they were soiled and when they were finished with incontinence care. NA #4 stated she didn't have enough towels when she started doing the incontinent care and realized she shouldn't have removed the soiled towel from the plastic bag but the resident needed to be cleaned and she didn't have any other towels to use.

During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation staff should remove their gloves and wash their hands after providing incontinence care and before touching any clean items in the resident's room.

During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her

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| F 441 | Continued From page 40 | F 441 | | |

expectation nursing staff should remove their gloves and wash their hands when they were soiled or after they completed incontinence care and before they touched anything clean in the resident's room.

2. During an observation of incontinence care on 1/30/12 at 4:05 PM Nurse Aide (NA) #7 and (NA) #8 entered Resident #7's room, washed their hands, and put on gloves. NA #7 and NA #8 removed the resident's pants and brief that was saturated with urine to the bottom sheet and mattress and the resident had a bowel movement during incontinence care. NA #8 with her soiled gloves still on, placed a clean brief under the resident, picked up a clean pair of pants, put them on the resident, and picked up the resident's shoes and put them on the resident.

During an interview on 1/30/12 at 4:23 PM with NA #8 she stated she had been taught to change her gloves when she finished with care. She further stated she should change her gloves if she touched something dirty and she should have changed her gloves before she touched any of the resident's clean clothing.

During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation staff should remove their gloves and wash their hands after providing incontinence care and before touching any clean items in the resident's room.

During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her expectation nursing staff should remove their

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| F 441 | Continued From page 41 | F 441 | | |

gloves and wash their hands when they were soiled or after they completed incontinence care and before they touched anything clean in the resident's room.

3. During an observation of incontinence care on 1/30/12 at 4:25 PM Nursing Assistant (NA) #9 entered Resident #8's room and washed her hands and put on gloves. She removed the resident's brief and provided incontinence care. With her gloves still on she assisted the resident to turn to her left (L) side and resident had a bowel movement. NA #9 cleaned the resident with a wet towel, tossed the soiled towel toward a plastic bag at the foot of the bed and the towel landed on top of the resident's blanket with the soiled side touching the blanket. NA #9 with her soiled gloves still on placed a clean brief under the resident and covered the resident with her sheets and blanket, picked up the soiled towel and placed it into the plastic bag.

During an interview on 1/30/12 at 4:35 PM NA #9 stated she should have put the soiled towel inside the plastic bag on the foot of the resident's bed and it should not have touched the resident's blanket. She further stated she should have had the plastic bag closer to her and she should have changed her gloves when she took the soiled brief off the resident and before she touched anything clean.

During an interview on 1/31/12 at 2:47 PM the Staff Development Coordinator who was also in charge of infection control stated it was her expectation staff should remove their gloves and wash their hands after providing incontinence care and before touching any clean items in the

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| F 441 | Continued From page 42<br>resident's room.<br><br>During an interview on 1/31/12 at 3:05 PM the Director of Nurses (DON) stated it was her expectation nursing staff should remove their gloves and wash their hands when they were soiled or after they completed incontinence care and before they touched anything clean in the resident's room. The DON further stated soiled linen should always be placed inside the plastic bag and it was unacceptable for soiled linen to touch a resident's bed linens or other clean items. | F 441 | | |