| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155376 | A. BUILDING _____ B. WING _____ | 03/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| MAJESTIC CARE OF SHERIDAN | 803 S HAMILTON ST SHERIDAN, IN 46069 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0580<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to notify the physician timely of elevated blood sugar levels for 1 of 5 residents reviewed for unnecessary medications (Resident 67). Finding includes: The record for Resident 67 was reviewed on 03/04/20 at 10:50 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A care plan, provided by the Director of Nursing on 03/11/20 at 3:00 p.m., indicated Resident 67 was at risk for complications and symptoms of [DIAGNOSES REDACTED] (low blood sugar) and [MEDICAL CONDITION] (high blood sugar) and to check the blood sugars as ordered by the physician as well as document abnormal findings and notify the physician. A blood sugar result, on 02/22/20 at 9:45 p.m., was 381. There was no documentation of the notification to the physician on this day. A blood sugar result, on 03/01/20 at 1:45 p.m., was 364. There was no documentation of the notification to the physician on this day. A blood sugar result, on 03/03/20 at 5:29 p.m., was 383. There was no documentation of the notification to the physician on this day. A blood sugar result, on 03/07/20 at 8:21 p.m., was 404. There was no documentation of the notification to the physician on this day. During an interview, on 03/11/20 at 3:00 p.m., the Director of Nursing indicated she would find documentation to show the physician was notified of the elevated blood sugars. On 03/11/20 at 5:10 p.m, the Medical Records Clerk presented documentation indicating the physician was not notified of the elevated blood sugar for 02/22/20 until an appointment on 02/25/20. The physician was not informed of the elevated blood sugar on 03/01/20 until an office visit on 03/02/20. The physician was not informed of the elevated blood sugar result on 03/07/20 until an office visit on 03/09/20. A current facility policy, titled Change in a Resident's Condition or Status, dated as revised 5/17, provided by the Corporate Support Nurse on 03/11/20 at 3:25 p.m., indicated .Our facility shall promptly notify the .Attending Physician .of changes in the resident's medical .condition 3.1-5(a)(2) |
| F 0583<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Keep residents' personal and medical records private and confidential.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to provide privacy during a procedure for 1 of 3 residents observed for privacy (Resident 68). Finding includes: The record for Resident 68 was reviewed on 03/09/20 at 12:48 p.m. [DIAGNOSES REDACTED]. During a dressing change, on 03/06/20 at 9:38 a.m., Resident 68 was positioned with his brief removed, exposing his buttocks, for a dressing change to his coccyx. The window blinds were missing a section of slats, leaving a gap on the right side of the window, leaving the resident exposed to the parking lot. After the dressing change was completed, at 9:45 a.m., the Assistant Director of Nursing indicated he should have closed the blinds. During an interview, on 03/06/20 at 11:43 a.m., the Director of Nursing indicated even though the blinds were missing slats, all the windows were tinted so no one was able to see anything in the residents rooms from the parking lot. During an observation, on 03/06/20 at 12:44 p.m., through a window from the same parking lot, privacy curtains in the rooms, a fan in the window of rooms which did not have the blinds closed were observed. During an observation of the windows from the outside, on 03/06/20 at 2:56 p.m., Maintenance Employee 1 indicated the windows did not appear to be tinted. During an observation from the same parking lot, on 03/10/20 at 1:33 p.m., another resident (Resident 56) could be clearly observed, through her window, sitting in her room. During an observation from the same parking lot, on 03/11/20 at 08:15 a.m., another resident (Resident 12) could be clearly observed, through her window. The resident was sitting on her bed, wearing a hospital gown, holding an article of clothing in her hands. On 03/09/11 at 11:13 a.m., Maintenance Employee 2 provided a copy of a sticker which he indicated had come from a facility window. The sticker did not indicated who the manufacturer of the windows was, nor did it indicate whether the window had been tinted. A facility document, titled Work Order #58, was provided by the Director of Nursing on 03/06/20 at 3:23 p.m. The document indicated a work order to fix the blind was initiated on 03/06/20 at 10:22 a.m. A current facility policy, titled Resident Rights, provided by the Director of Nursing on 03/11/20 at 10:30 a.m., indicated .rights include the resident's right to .privacy and confidentiality 3.1-3(p)(4) |
| F 0604<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to complete an assessment for a self-release seat belt for 1 of 3 resident's reviewed for physical restraints. (Resident 78) Finding includes: The record for Resident 78 was reviewed on 03/05/2020 at 10:11 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An undated care plan indicated the resident was at risk for falls related to dementia with confusion. Interventions included, but were not limited to, self-release belt alarm to wheelchair. An Admission Minimum Data Set (MDS) assessment, dated 12/03/2019, indicated the resident was severely cognitively impaired. An Adaptive Device Review- V3 document, dated 12/17/2019, provided by the Director of Nursing on 03/06/2020 at 11:00 a.m., indicated there were not answers documented for the following questions; if the resident could easily and on command release the seat belt, whether the device restricted or prevented the resident's freedom of movement and if the device restricted the resident's normal access to their body. An undated Adaptive Device Review- V2 document, provided at the same time, indicated the answers to the same questions as not applicable. During an interview, on 03/06/2020 at 11:12 a.m., the Director of Nursing indicated the documentation should have been fully completed. A current facility policy, titled Use of Restraints, dated 04/2017, provided by the Director of Nursing on 03/06/2020 at 4:11 p.m., indicated .evaluation for the need of restraints will be documented 3.1-26(s) |
| F 0656<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to develop a care plan for [MEDICAL CONDITION] and to develop an accurate cardiac care plan for 1 of 3 residents reviewed for care plans (Resident 70). Finding includes: On 03/04/20 at 8:53 a.m., Resident 70 was observed up in his wheel chair with his feet elevated. The resident had [MEDICAL CONDITION] to both lower extremities. On 03/05/20 at 12:04 p.m., the resident was observed sitting in his wheel chair. The resident had [MEDICAL CONDITION] to both lower extremities and was wearing Ted hose (Elastic stockings which compress the superficial veins in the lower limbs). On 03/06/20 at 3:14 p.m., the resident was observed with [MEDICAL CONDITION] to both lower extremities. On 03/09/20 at 10:11 a.m., the resident was observed with both feet elevated and wearing his Ted hose. On |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>03/10/20 at 09:35 a.m., the resident was in his room up in a wheel chair and wearing Ted hose. On 03/11/20 at 11:04 a.m., the resident was sitting in a wheel chair in his room. He was wearing his Ted hose and his feet were not elevated. At this time, he indicated he was educated on elevating his feet and wearing Ted hose to help with the [MEDICAL CONDITION]. The record for Resident 70 was reviewed on 03/05/20 at 11:02 a.m. [DIAGNOSES REDACTED]. There was no care plan for [MEDICAL CONDITION] in the record. A care plan, revised on 12/03/19, indicated Resident 70 was at risk for impaired cardiac output. An intervention initiated 12/03/19 indicated the resident was taking a diuretic and a potassium replacement. A review of Resident 70's physician's orders [REDACTED]. A physician's orders [REDACTED]. During an interview, on 03/11/20 at 11:42 a.m., the Minimum Data Set (MDS) Coordinator indicated a care plan addressing [MEDICAL CONDITION] should have been completed. She also completed the cardiac care plan and indicated the [MEDICATION NAME] and potassium were incorrect and she must have hit the wrong button. A current facility policy, titled Care Plans, Comprehensive Person-Centered, revised on 12/16, provided by the Director of Nursing on 03/11/20 at 10:10 a.m., indicated .The comprehensive, person-centered care plan will .Incorporate identified problem areas .Reflect treatment goals, timetables and objectives in measurable outcomes A current facility policy, titled Documentation Guidelines For The Medical Record, provided by the Director of Nursing on 03/10/20 at 12:56 p.m., indicated .Document the correct information 3.1-35(a) |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to assess, document and notify the physician of bruises for 1 of 1 resident reviewed for non-pressure related skin conditions. (Resident B) Finding includes: During an observation, on 03/04/2020, Resident B had a large bruise on the back of both her hands. During an observation, on 03/06/2020 at 10:00 a.m., with the Director of Nursing, the bruising to the back of the resident's hands was present. The record for Resident B was reviewed on 03/05/2020 at 2:21 p.m. [DIAGNOSES REDACTED]. A care plan, dated as revised 01/25/2019, indicated Resident B was at risk for skin breakdown. Interventions included, but were not limited to, a skin inspection weekly and as needed, document and notify the physician of abnormal findings. A physician's orders [REDACTED]. A Weekly Nursing Summary, dated 03/02/2020, provided by the Director of Nursing on 03/05/2020 at 10:00 a.m., indicated the resident did not have any open areas, skin tears or bruises. A Weekly Nursing Summary, dated 03/06/2020, provided by LPN 3 on 03/06/2020 at 11:00 a.m., indicated the resident had a 2 cm (centimeter) x 3 cm bruise on the back of her right hand and a 7 cm x 3 cm bruise on the back of her left hand. There was no indication the physician was notified. During an interview, on 03/06/2020 at 10:00 a.m., the Director of Nursing indicated the bruises should have been documented on the weekly skin assessment sheet. A current policy, titled Skin Management, dated October 2019, provided by the Director of Nursing on 03/06/2020 at 12:25 p.m., indicated .5. a) Care plan interventions will be implemented .8. a) The licensed nurse is responsible for assessing any and all skin alterations This Federal tag relates to Complaint IN 790. 3.1-37(a) |
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to implement measures to prevent a facility acquired pressure ulcer (a shallow open area or blister on the skin) for 1 of 2 resident's reviewed for pressure ulcers. (Resident 39) Finding includes: On 03/05/2020 at 9:59 a.m., Resident 39 was observed to have a pressure ulcer to her left outer ankle. The record for Resident 39 was reviewed on 03/09/2020 at 2:01 p.m. [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 07/30/2019, indicated the resident did not have a pressure ulcer upon admission but was at risk for developing one. A Pressure Ulcer-Weekly Observation document, dated 01/21/2020, indicated the resident acquired a stage 2 pressure ulcer on 01/21/2020. A physician's orders [REDACTED]. A review of the resident's treatment administration record, dated 01/01/2020 thru 01/31/2020, did not indicate any pressure relieving interventions in place prior to 01/21/2020. A comprehensive care plan related to the resident being at risk for alterations in skin integrity was requested from the Director of Nursing, on 03/10/2020 at 4:04 p.m. The care plan could not be provided and at this time, the Director of Nursing indicated the care plan had been deleted. During an interview, on 03/11/2020 at 4:58 p.m., the Corporate Support Nurse indicated she could not find documentation where preventative interventions to maintain skin integrity were in place prior to 01/21/2020. A current policy, titled Care Plans, Comprehensive Person-Centered, dated 12/2016, provided by the Director of Nursing, on 03/11/2020 at 10:10 a.m., indicated .12. The comprehensive, person-centered care plan is developed within 7 days of the completion of the required comprehensive assessment (MDS) 3.1-40(a)(1) |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to assess a resident's ability to provide [MEDICAL CONDITION] care, failed to ensure suction equipment was kept at the bedside and failed to ensure the resident had the necessary supplies to perform [MEDICAL CONDITION] care for 1 of 1 resident reviewed for respiratory services. (Resident 16). Finding includes: During an observation of the resident's room, with LPN 7, on 03/09/20 at 12:04 p.m., a replacement [MEDICAL CONDITION], suction equipment and a [MEDICAL CONDITION] cleaning kit were not found in the room. When asked, Resident 16 was able to produce an extra [MEDICAL CONDITION] from a red coffee can full of batteries kept on a bedside table. The [MEDICAL CONDITION] was not in an occlusive package. At this time, LPN 7 had no comment. LPN 7 did ask the resident if he had supplies to clean his [MEDICAL CONDITION] and then checked the drawers next to the bed. She did not find supplies for [MEDICAL CONDITION] care. She then indicated she would get a [MEDICAL CONDITION] cleaning kit for the resident and left the room. An attempt to interview the resident about [MEDICAL CONDITION] care and the storage of the extra [MEDICAL CONDITION] resulted in being asked to leave the room. The record for Resident 16 was reviewed on 03/09/20 at 12:25 p.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A care plan, dated as revised on 12/13/19, indicated the resident was at risk for infection due to his [MEDICAL CONDITION] and preferred to care for his site and supplies independently and to ensure the resident had all supplies necessary to provide [MEDICAL CONDITION] site care and supply maintenance. A care plan, dated as revised on 06/17/19, indicated Resident 16 required assistance with activities of daily living due to his [MEDICAL CONDITION] and a [MEDICAL CONDITION]. The resident would have his care needs met daily with the assistance of the staff (revised 12/19). The care plan indicated he needed one staff assistance with bed mobility (revised 06/19), one staff assistance with dressing (revised on 06/19), one staff assistance with personal hygiene (revised 06/19), one staff assistance with toilet use (revised on 06/19) and one staff assistance with transfers (revised 06/19). During an interview, on 03/10/20 at 3:30 p.m., the Director of Nursing indicated there should have been an assessment for the resident to provide his own [MEDICAL CONDITION] care and it might be located in medical records in the back up chart. During an interview, on 03/11/20 at 11:03 a.m., the Medical Records Clerk indicated she did not have a record for the resident in medical records. A policy on [MEDICAL CONDITION] care and emergency supplies was requested on 03/06/20 at 1:56 p.m., on 03/11/20 at 10:47 a.m., the Director of Nursing indicated she was still looking for the policy. The only information she could provided was titled [MEDICAL CONDITION] Care on 03/11/20 at 12:09 p.m. A policy for self administration of [MEDICAL CONDITION] care was requested on 03/11/20 at 12:09 p.m. At 12:27 p.m., the Director of Nursing indicated a self administration of medication policy was the closest policy the facility had and this was the policy which would be used as they do not have any policies covering self administration of procedures. A procedure, titled [MEDICAL CONDITION] Care, provided by the Director of Nursing on 03/11/20 at 12:09 p.m., indicated .A replacement [MEDICAL CONDITION] must be available at the bedside at all times .A suction machine, supply of suction catheters .sterile gloves and flush solution, must be available at the bedside at all times A current facility policy, titled Self-Administration of Medications, dated as revised 12/16, provided by the Director of Nursing on 03/11/20 at 12:29 p.m., indicated .Residents have the right to self-administer .if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering .is clinically appropriate for the resident .The staff and practitioner will periodically .reevaluate a resident's ability to continue to self-administer 3.1-47(a)(4) |
| F 0757<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to have an accurate [DIAGNOSES REDACTED]. Finding includes: The record for Resident 53 was reviewed on 03/04/20 at 9:48 a.m. Diagnoses included, but were not limited to, [MEDICAL |

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| F 0757<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>CONDITIONS] and hypertension (high blood pressure). A physician's orders [REDACTED]. There was no [DIAGNOSES REDACTED]. The order, as written, in the Medication Administration Record [REDACTED]. During an interview, on 03/10/20 at 10:40 a.m., LPN<br>7 indicated [MEDICATION NAME] was used to treat [MEDICAL CONDITION] (swelling caused by vessels leaking fluid into body<br>tissues) and chronic heart failure and she would not expect a resident to take [MEDICATION NAME] for a [DIAGNOSES REDACTED]. A facility policy, titled Medication and Treatment Orders, revised on 07/16, provided by the Director of Nursing on 03/09/20 at 8:30 a.m., indicated .Orders for medications must include .Clinical condition .for which the medications is prescribed 3.1-48(a)(4) |
| F 0758<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to monitor for targeted behaviors for [MEDICAL CONDITION] medications for 2 of 5 residents reviewed for unnecessary medications (Resident 32 and 29). Findings include: 1. The record for Resident 32 was reviewed on 03/10/2020 at 2:09 p.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. The record for Resident 32 did not include targeted behaviors to monitor related to the resident's depression and psychotic delusions. 2. The record for Resident 29 was reviewed on 03/04/2020 at 4:02 p.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. The record for Resident 29 did not include targeted<br>behaviors to monitor for related to the resident's anxiety, depression and psychotic delusions. During an interview, on 03/10/2020 at 11:01 a.m., the Director of Nursing indicated residents on [MEDICAL CONDITION] medications should have specific targeted behaviors documented in the medical record. During an interview, on 03/10/2020 at 11:09 a.m., the Behavioral Care Specialist indicated he did not get specific when he wrote an alteration in mood care plan. A current policy, titled Care Plans, Comprehensive Person-Centered, with a revised date of 12/2016, provided by the Director of Nursing on 03/11/2020 at 10:10 a.m., indicated .10. Identified problem areas and their causes, and developing interventions that are targeted and meaningful to the resident 3.1-48(a)(3) 3.1-48(b)(2) |
| F 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to provide consistent documentation of a safety device assessment for 1 or 3 residents reviewed for safety device assessments (Resident 36) and failed to accurately document Foley catheter care for 1 of 2 residents reviewed for catheter care (Resident 19). Findings include: 1. On 03/03/20 at 11:20 a.m., Resident 36 was observed sitting, in a wheel chair, with a secured lap belt (seat belt) across his hips. On 03/04/20 at 11:11 a.m., Resident 36 was observed sitting, in a wheel chair, with a secured lap belt in place. On 03/06/20 at 09:38 a.m., Resident 36 was observed sitting, in a wheel chair, with a secured lap belt in place. At this time, with the Assistant Director of Nursing, the resident was able to unsecure the lap belt and re-secure it without difficulty. The record for Resident 36 was reviewed on 03/04/20 at 09:47 a.m. [DIAGNOSES REDACTED]. At the time of the record review there was no assessment for the seat belt found in the chart. On 03/06/20 at 10:34 a.m., a safety device assessment was not found in the resident's record, an assessment for the lap belt was requested from the Director of Nursing. On 03/06/20 at 3:34 p.m., a Safety Device Review (an assessment for the lap belt) was in process. At this time, a copy of the current assessment in process was requested of the Director of Nursing. She indicated she was not able to access and print it at this time. On 03/06/20 at 3:52 p.m., the Safety Device Assessment was closed and was visible in the assessment list as having been completed on 02/17/20, the document had a closed date of 03/06/20 at 15:52 (3:52 p.m.) On 03/06/20 at 4:00 p.m., an Adaptive Device Review was provided by the Director of Nursing. The assessment had an effective date of 02/17/20 at 15:34 (3:54 p.m.) The family notification date, on the assessment was 03/17/20. During an interview, on 03/06/20 at 4:00 p.m., the Minimum Data Set (MDS) Coordinator indicated she completed the assessment on 02/17/20. During an interview, on 03/06/20 at 4:26 p.m., the Director of Nursing indicated there was not a policy on how long an assessment could be left open and she could not access the assessment while it was in process by the MDS Coordinator at 3:34 p.m. earlier in the day. During an interview, on 03/10/20 at 4:04 p.m., the Executive Director indicated he did not understand how the information was not in the record and appeared in the record later.<br><br>2. On 03/05/2020 Resident 19 was observed with a Foley catheter in place. A physician's orders [REDACTED]. A care plan, dated 01/07/2020, indicated Resident 19 had a Foley catheter and was to have it changed monthly. A MAR (Medication Administration Record), printed on 03/05/2020 and provided by the Director of Nursing, indicated there were not any nursing initials for 03/02/2020 to indicate the resident's catheter was changed as indicated in the physician's orders [REDACTED]. change on 03/09/2020 at 10:53 a.m. A MAR printed on 03/09/2020 and provided by the Director of Nursing on 03/09/2020 at 4:50 p.m., indicated the ADON's initials were documented on 03/02/2020 indicating he changed the resident's catheter. During an interview, at this time, the ADON indicated he changed the catheter on 03/02/2020 and only changed the catheter bag on 03/09/2020. He was busy and forgot to document, on 03/02/2020, the catheter change but he indicated he had 30 days to go back and initial it was completed without having to add charted late or a late entry. A facility policy, titled Documentation Guidelines For The Medical Record, dated 2018, provided by the Director of Nursing on 03/10/20 at 12:56 p.m., indicated .Document the correct information .When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record .Identify the new entry as a late entry .Enter the current date and time-do not try to give the appearance that the entry was made on a previous or an earlier time .no late entries will be permitted after 24 hrs 3.1-50(a)(2) |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure appropriate hand washing procedures were followed after removal of soiled gloves for 1 of 1 random observations of cleaning emesis (vomit) off the floor of the dining area (Resident 46) and for 1 of 1 resident reviewed for catheter care (Resident 40). Findings include: 1. During a random dining observation, on 03/03/20 at 12:48 p.m., Resident 46 had two episodes of emesis in the dining area which resulted in emesis on the resident, table and floor. Resident 46 was removed from the dining area, other residents were moved from the table and Housekeeper 4 attended to the clean up. After cleaning the emesis with gloved hands, Housekeeper 4 returned to her cart, parked at the dining room entrance, removed her gloves and immediately put on another pair of gloves without washing or sanitizing her hands. During an interview, on 03/03/20 at 12:56 p.m., Housekeeper 4 indicated she was aware of the handwashing and gloving policies but did not follow protocol because she was cleaning up emesis. 2. During an observation of catheter care for Resident 40, on 03/05/20 at 11:29 a.m.,with RN 6 in attendance, CNA 5 washed her hands, donned gloves and completed the care, without incident, placed soiled linen in a bag, cleaned up the supplies and then removed her gloves and left the room. During an interview, on 03/05/20 at 11:37 a.m., CNA 4 was not given the opportunity to indicated when she should have washed or sanitizer her hands, instead RN 6 indicated the CNA should have washed or sanitizer her hands after removing her gloves. The record for Resident 40 was reviewed on 03/06/20 at 2:46 p.m. [DIAGNOSES REDACTED]. A facility policy, titled Handwashing/Hand Hygiene, dated as revised 08/15, provided by the Director of Nursing on 03/03/20 at 3:40 p.m., indicated .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection .Use an alcohol-based hand rub .or, alternatively, soap .and water for the following situations .After contact with blood of bodily fluids .After removing gloves .The use of gloves does not replace hand washing/hand hygiene 3.1-18(l) |