

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

PRINTED: 07/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2016
NAME OF PROVIDER OR SUPPLIER PROVIDENCE TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 910 COMPASSION CIRCLE ANCHORAGE, AK 99504	
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F 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 4/18-21/16. The sample included 10 residents, 3 unsampled residents. The sampled residents included 1 closed record. State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		6/5/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/17/2016

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 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed: 1) to honor the DNR (do not resuscitate) code status by calling 911 and 2) to honor the code status wishes for 1 resident (#8) out of 1 closed death record reviewed. These failed practices denied the resident the right to have his/her code status honored. Findings: Record review from 4/20-21/16 revealed the 87 year old Resident #8 was admitted to the facility on 12/17/15 for rehabilitation of a fractured hip and chronic C2 fracture (a fracture in one of the neck vertebrae) in rigid collar; gait instability (unstable walking); neuropathy (nerve disease where a person suffers decreased sensation & circulation); and chronic pain. The Resident had died in the facility on 12/23/15. Review of the Resident's face sheet on 4/20-21/16 revealed DNR was the code status. Review of the admitting physician's order on 4/20-21/16, dated 12/17/15, revealed documented code status "DNR, RN may pronounce (Note: applies only in event person has no pulse and is not breathing..." Review of the nursing notes on 4/20-21/16 revealed: 12/23/15 at 11:43 pm by Licensed Nurse (LN) #6	F 155	1) Actions taken for residents affected by the deficient practice. LN #7 (also named as #13 in the report) and LN #6 are no longer employed by Providence Transitional Care Center. Focused education for supervisor involved who advised the 911 call regarding policy surrounding DNR status, when to call 911 and to have documentation ready for EMS. completed 5/13/16 2) All residents have the potential to be affected by the alleged deficient practice 3) Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations regarding honoring residents' code status wishes. Education for care staff regarding how to determine a resident's code status; what to do if they are found unresponsive, with no pulse and not breathing. Education for care staff regarding preparing DNR paperwork to have immediately upon arrival of EMS. This education is reinforced during quarterly mock code exercises that occur on all shifts and will include scenarios for DNR. 4) To monitor compliance to the deficient practice, mock codes are maintained in Staff Development. Trends or concerns will be documented and brought to the Quality Council and a plan of action		

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F 155	<p>Continued From page 2</p> <p>"...was in the hallway by [Resident #8's] room. Heard a big bang...entered [Resident #8's] room...find [Resident] on the floor...asked [Resident #8] if [she/he] hurt [herself/himself] and no response. I yelled for help. The CNA [certified nursing assistant] closest to the room came in to assist, Blood pressure machine was put on, the machine did not give a reading. The [Residents] nurse LN #7 called 911..."</p> <p>12/24/15 at 5:27 am "Late Entry for: 12/23/2015" by LN #8, "At approximately/between 2142-2144 [9:42 pm - 9:44 pm], CNA approached this writer in the office and reported "We have a problem"...one of the [residents] fell. This writer asked the C.N.A. if the [Resident] was okay and if his PCN [primary care nurse] was aware and he stated yes, LN #7 is there but the [Resident] is unresponsive...this writer looked at the [Resident] and glanced that the [Resident] was cyanotic, laying on the floor. Advised PCN to call 911 immediately...[Resident] was unresponsive, obtunded with absence of pulse and not breathing at the time of assessment. BP [blood pressure] machine was connected to [Resident] and unable to get vital signs. Compression was not initiated upon confirming the code status on the wall...Paramedics arrived...started CPR...CPR ongoing when this writer showed the signed DNR status...Paramedics advised that her DNR status should be ready next time so they don't have to initiate CPR."</p> <p>12/24/15 at 11:23 pm by LN #13 "...I heard staff asked for assistance. I found LN #6 and Certified Nursing Assistant (CNA) #5 assessing [Resident]...on the floor. LN #6 and CNA #5 told me there is no pulse. I told them to start CPR but</p>	F 155	developed and implemented as directed by the Council.		

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F 155	<p>Continued From page 3</p> <p>LN #6 said [Resident] is DNR. I checked on the MAR [medication administration report] and confirmed DNR and supervisor notified then called 911. Paramedics came start CPR when they saw the paper for DNR they stopped and pronounced time of death at 2155 [9:55 pm]..."</p> <p>During an interview on 4/21/16 at 8:15 am, LN #9 was asked what would he/she do if a resident was found unresponsive, no pulse and not breathing. LN #9 replied he/she would call for help and check the code status by looking at the colored index card in the resident's room.</p> <p>During an interview on 4/21/16 at 9:00 am, LN #10 was asked what would he/she do if a resident was found unresponsive, no pulse and not breathing. LN #10 stated he/she would call for help and check the code status by looking at the colored index card in the resident's room.</p> <p>During an interview on 4/21/16 at 9:15 am, the Director of Quality Improvement (DQI) was asked if DNR was a code. The DQI said "No."</p> <p>In summary, record review revealed the Resident was a DNR; was found unresponsive, absence of pulse, and not breathing; DNR documentation was in the room; and staff verbally said this when a nurse told staff to start CPR. The facility failed to honor the wishes of the Resident by calling 911 and initiating CPR when there were multiple areas of documentation revealing the Resident was a DNR.</p>	F 155			
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO	F 166		6/5/16	

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F 166 SS=D	<p>Continued From page 4</p> <p>RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and policy review the facility failed to resolve and respond to 1 grievance in a timely manner for 1 resident (#2) of 1 resident. Specifically, a family member reported a grievance concerning the resident's missing money. The failure to resolve the grievance in a prompt manner denied the resident and family member a prompt resolution to the grievance. Findings:</p> <p>During an interview on 4/19/16 at 7:30 am in Resident #2's room, Resident #2 stated he/she wanted to talk about, "Money Issues...I lost \$20 first, then 5..."</p> <p>During the survey the Director of Quality Improvement (DQI) was asked for the investigation of Resident #2's missing money. The DQI produced an unusual occurrence report (UOR) (a reporting system where unusual situations or events are documented) for Resident #2's missing money.</p> <p>Review of the UOR revealed Resident #2's husband reported to Social Worker (SW) #1, on 9/9/15, there was one \$20 bill, one \$5 bill and 6 \$1 bills missing from Resident #2's room on 9/8/15. The husband said he knew how much</p>	F 166	<ol style="list-style-type: none"> 1. Actions taken for residents affected by the deficient practice: complaint to Social Worker was that she was missing \$20, (not \$31) and the money was returned to her. Education for LN #1 re: documentation of follow up to ensure the timeline of investigation is clear. 2. All residents have the potential to be affected by the alleged deficient practice 3. Systems and measures to ensure the alleged deficient practice does not recur: To enhance currently compliant operations regarding prompt resolution of grievances, all care staff will receive education for reporting and documentation of concerns to include appropriate timeline for follow up and documentation of timeline of investigation. Nursing supervisors log incoming resident concerns as they receive them and DON maintains oversight. Copies of concern forms are also forwarded to QI 4. To monitor compliance to the alleged deficient practice, resident concerns will be reported at facility safety huddle M-F. Concern log maintained by Nurse Supervisor and Clinical Manager. Trends or concerns will be documented and brought to the Quality Council and a plan 		

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F 166	<p>Continued From page 5</p> <p>money the Resident had because he had counted it so s/he could use it to purchase a shirt from the gift shop. The complaint was entered in the UOR electronic system 9/10/15 at 7:27 am by SW #1.</p> <p>Continued review of the UOR revealed a follow up note was entered in the system on 9/23/15 by Licensed Nurse (LN) #1. The note said "Searched on the room but didn't find the 20 dollar bill until after a week staff found a 20 dollar bill and a one dollar bill in our unit linen room on th [the] newly washed clothes...I gave the 20 dollar bill the [that] was found in the linen room to [Resident #2] on 9/23/15..."</p> <p>During the Quality Assurance and Performance Improvement interview on 4/21/16 at 9:15 am the DQI was asked about Resident #2's missing money. The DQI said she gets all the UOR's. She confirmed she would have received this UOR on 9/10/15 when it went into the electronic reporting system, but did not follow up with the incident. She also confirmed the investigation was not done timely, that it was too long a time between 9/9-23/15.</p> <p>There was no confirmed date when the investigation of the missing money was done; the Resident's family was not notified; and no investigation notes of any investigation until 9/23/15, 14 days after the initial complaint of the missing money. There was no documentation of the investigation regarding the rest of the money the husband said was missing.</p> <p>Review of the complaint/concern log on 4/20-21/16, revealed no information of Resident #2's complaint of the lost money was logged on the complaint/concern log.</p>	F 166	of action developed and implemented as directed by the Council.		

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F 166	Continued From page 6 Review of the facility "A handbook for patients and families"; undated, revealed "...A resident has the right to...Voice grievances to the facility...Obtain prompt efforts by the facility to resolve grievances the resident may have..." Review of the facility policy "Unusual Occurrences", revision date 12/15, revealed "Unusual Occurrence is a situation or event that has one or more of the following characteristics...Involves the loss of personal property...Investigation and resolution efforts should be completed within 7 days of being reported ..."	F 166			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		6/5/16	

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F 225	<p>Continued From page 7</p> <p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure suspected abuse and/or neglect was reported to the State Agency (SA) within 24 hours for 2 residents (#s 2 and 12) out of 2 residents reviewed for reporting to the SA. Resident #2 had 2 separate incidents not reported within 24 hours. Failure to report incidents to the SA within 24 hours created the potential for abuse and/or neglect due to lack of SA oversight, which would mitigate further incidents' of abuse and/or neglect. Findings:</p> <p>Review of the SA's Reports of Harm (ROH) log reviewed prior to the facility survey, revealed the facility had reported Resident #2's reports of</p>	F 225	<p>1. Actions taken for residents affected by the deficient practice: Resident #12 is no longer in our care. Investigation was completed and report of harm was found to be unsubstantiated. Completed 4/19/2016 Resident #2's incident from 1/15/16 was initially reported by the resident as resulting from her scratching her head. It was evaluated by the wound care team on 1/18/16 and appeared to be an injury. The report was filed on 1/18/16. Resident #2's incident from 5/11/15 was not filed in a timely manner. Education for Nurse Supervisors regarding expectation of timely notification to administrator and</p>		

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F 225	<p>Continued From page 8</p> <p>harm that were not reported within 24 hours from the date of the incidents. In addition the review revealed the facility did not report Resident #12 report of harm within 24 hours from the incident date.</p> <p>Review of the facility "STATE REPORTS LOG" on 4/20-21/16, revealed the following reports or harm reported to the SA:</p> <p>Resident #2's date of incident was 5/11/15 and was reported to SA on 5/14/15.</p> <p>Resident #2's date of incident was 1/15/16 and was reported to SA 1/18/16; and</p> <p>Resident #12's date of incident was 4/12/16 and was reported to SA 4/14/16.</p> <p>During a nursing supervisor interview for abuse and neglect, on 4/19/16 at 6:20 am, LN #2 was asked how he/she would report a potential ROH to the SA, specific to potential abuse and/or neglect. The LN said he/she didn't know how to report to the SA.</p> <p>During a nursing supervisor interview for abuse and neglect, on 4/19/16 at 5:10 pm, LN #1 was asked specifically about the late report to the SA of Resident #2's 4/12/16 date of potential abuse. The LN said he/she was on duty the date of the incident and confirmed the ROH was not reported to the SA within 24 hours.</p> <p>Review of the facility "Good Things to Know Questions & Answers to Help You in Your Work" notebook, revised date 8/15/15, was a notebook provided to staff. Review of the information, on 4/18-21/16, revealed "...Abuse and Neglect</p>	F 225	<p>DON and reporting of alleged incidents immediately (within 24 hours) Completed 4/26/2016</p> <p>2. All residents have the potential to be affected by the deficient practice</p> <p>3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations regarding prompt notification and initiation of investigation, all nursing and C NA staff educated regarding current policies for reporting alleged allegations involving mistreatment, neglect or abuse. The same education is included in new hire orientation. All nurse supervisors will be trained on how to complete an initial investigation so that the reporting can be made 7 days a week. DON and supervisor huddles daily M-F to review concerns and State Reports and ensure timely reporting and follow up. Any state report initiated is communicated to PTCC Administration 24 hours a day. Call log maintained with the state report log.</p> <p>4. To monitor compliance to the deficient practice, allegations of abuse are reported at facility-wide safety huddle M-F. All concerns will be addressed when identified. State report log maintained by Administrative Assistant. Trends or concerns will be documented and brought to the Quality Council and a plan of action developed and implemented as needed.</p>	

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F 225	Continued From page 9 Prevention...The initial report is required to be completed within 24 hours. Your timely reporting is crucial to getting this report in on time and could be essential for resident/patient safety." Review of the facility policy "Report and Investigation of Alleged Mistreatment, Abuse, or Neglect of a Resident or Reasonable Suspicion of a Crime", dated 12/7/15, revealed "PROCEDURE...Within 24 hours faxes Initial Report of Alleged Mistreatment, Abuse or Neglect of a Resident to Certification and Licensing [SA]..."	F 225			
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review the facility failed to communicate, respond or act upon concerns and/or recommendations brought forth during the past 10 months of the Resident Council Meeting minutes (for 7 of 37 residents that were interviewed). This failed practice had the potential to adversely affect residents' care, treatment and quality of life. Findings:	F 244	1. Action taken for residents affected by the deficient practice: At the Resident Council meeting on 5/10/16, Old Business included the response to the following past concerns: missing clothing, sugar free cookies, scheduling of morning medications, specific food requests, swimming pool, gift giving, the temperature on the north side and serving crackers with soup. Completed 5/10/16	6/5/16	

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F 244	<p>Continued From page 10</p> <p>Review of the Resident Council Meeting Minutes, dated June 16, 2015 through April 13, 2016, revealed residents had voiced concerns and/or recommendations in the meeting minutes. The review revealed no documented response, communication or action(s) taken by administration. Some of the Resident's concerns or recommendations were:</p> <ul style="list-style-type: none"> · Missing clothing; · Would like sugar free cookies; · Can the morning medications be given earlier; · Specific food requests; · Swimming pool; · Gift giving; · North side of the facility is cold; and · Want crackers always put on their trays when they have soup. <p>During a Resident Council Group interview, on 4/20/16 from 11:00 am to 11:45 am, it was confirmed by 4 of the 7 Residents who attended the meeting that the facility had not followed up with them regarding any concerns or recommendations made during their council meetings from June 2015 to April 2016.</p> <p>During an interview on 4/20/16 at 9:00 am Activities Coordinator (AC) stated "I have not written down any of the follow-ups as old business. I need to do that." The AC confirmed there was no documentation of the residents' concerns and/or recommendations being addressed.</p>	F 244	<p>2. All residents have the potential to be affected by the deficient practice</p> <p>3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations regarding listening to and acting upon resident and family recommendations and concerns that are voiced in resident council meetings, education provided for Activities staff for taking minutes and process for running a meeting. Protocol developed for Resident Council meeting process to include address of prior concerns as Old Business. Concern forms are available at the meetings if resident verbalizes a concern. Council minutes are forwarded to the DON in a timely manner. The DON and/or Social Worker will respond and/or forward concerns and recommendations to the appropriate staff member and respond to the residents in a timely manner. Concerns will be logged according to protocol.</p> <p>4. Problems or trends are documented and submitted to the Quality Council and a plan of action is developed and implemented as needed. When activities reports to QC, the report will include RC concerns trends and any issues with follow up.</p>		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 910 COMPASSION CIRCLE ANCHORAGE, AK 99504		
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F 244	<p>Continued From page 11</p> <p>During an interview on 4/20/16 at 2:40 pm the Director of Nursing (DON) was asked what the resolution procedure was when residents had a concern or recommendation in the Resident Council meetings. The DON said nursing leadership should be aware of the concerns or recommendations. If the concern or recommendation was related to food then dietary would be notified, and specifically, the requests for sugar free cookies would go to the dietician. She further stated in the next Resident Council meeting the "Old Business" would be brought up and the status of any concerns or recommendations would be documented.</p> <p>During an interview on 4/21/16 at 8:30 am, the Dietician was asked if she would expect to be told of any comments/recommendations residents may have during the resident council meetings. She was specifically asked about 1 resident's request for sugar free cookies. She said, "Yes."</p> <p>Review of the Resident's Handbook, undated, revealed "Patient [Residents] concerns and recommendations are taken to department leaders who follow through and report back to the Council."</p>	F 244			
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		6/5/16	

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F 281	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to ensure staff followed current standards of practice for medication administration. Specifically: 1) topical medication administration was delegated to non-licensed staff for 3 residents (#s 1; 3; and 4) of 4 sampled residents whose morning cares were observed and 2) application of topical medication was not applied per medication guidelines for 1 resident (#3). When tasks are delegated to staff without appropriate skills and/or training and professional standards are not followed, residents are at greater risk for poor outcomes. Findings:</p> <p>Resident #1</p> <p>Record review from 4/18-21/16 revealed Resident #1 was admitted to the facility on 2/16/16 with diagnosis that included Candidiasis (fungal infection caused by yeast) with a rash.</p> <p>Observation on 4/19/16, from 9:10 am - 9:40 am, revealed Certified Nursing Assistant (CNA) #1 applied nystatin powder to Resident #1's abdominal skin folds during morning cares.</p> <p>Review of Resident #1's physician order, start date 3/2/16, revealed "Drug: Nystatin Powder...topical...twice a day as needed...for Candidiasis...Administration Instructions: Apply...to folds."</p> <p>During an interview on 4/19/16 at 9:30 am, CNA #1 stated he/she always applied the nystatin powder during morning care when assigned to this Resident.</p>	F 281	<ol style="list-style-type: none"> 1. Actions taken for residents by the deficient practice: Resident #1, 3 and 4 showed no adverse effects from the deficient practice. Identified staff members and C NA Group Leader have been counseled regarding delegation of topical medication administration to non-licensed staff members. Addressed in nursing safety huddles. 2. All residents have the potential to be affected by the deficient practice 3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations to ensure services provided meet professional standards for application of topical medications, education for all Nursing and C NA staff re: standards of care for administration of topical medications in line with the State of Alaska Nurse Practice Act. Nurse Manager, supervisor or designee to audit cares for patients with nystatin prescription to ensure LN is applying the medication all shifts weekly x 4 weeks and on-going as needed. 4. To monitor compliance to the alleged deficient practice, audits will be forwarded to the DON/QI. Problems or trends are documented and submitted to the Quality Council and a plan of action is developed and implemented as needed 		

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F 281	<p>Continued From page 13</p> <p>In addition, the Resident stated that all CNA's apply Nystatin powder during morning care.</p> <p>Resident #3</p> <p>Record review on 4/19-21/16 revealed Resident #3 was readmitted to the facility on 1/5/15 with diagnoses to include obesity and dermatitis to skin folds.</p> <p>Observation on 4/19/16 at 6:15 am revealed CNA #2 applied nystatin powder to Resident #3's wet abdominal folds and upper extremities during morning care.</p> <p>Review of Resident #3's Medication Administration Record (MAR), dated 4/12-22/16, revealed "02/02/16...Drug: Nystatin Powder...topical...twice a day as needed...for Candidiasis prophylaxis...Apply to affected areas..."</p> <p>Resident #4</p> <p>Record review from 4/19-21/16 revealed Resident #4 was admitted to the facility on 12/19/07 with diagnoses to include obesity, edema, and diabetes.</p> <p>A continuous observation during morning cares on 4/19/16 from 10:00 am -10:50 am revealed CNA #s 3 and 4 applied nystatin to multiple skin folds during am cares.</p> <p>Interview on 4/21/16 at 8:40 am LN #5 stated nystatin powder should be applied to clean dry skin otherwise it would not be effective. In</p>	F 281			

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F 281	Continued From page 14 addition he/she said the application of nystatin should be done by a nurse, not a CNA. During an interview on 4/21/16 at 11:00 am, Pharmacist #1, was asked about the process for applying nystatin powder. He/she stated the powder should be applied to dry skin due to clumping and the inability to spread throughout the surface. The medication should be dispensed by licensed nurses.	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to: 1) respond to a dialysis center's communication concerns regarding 1 resident (#7) of 1 resident reviewed for dialysis services from an outside dialysis center and 2) follow the resident daily care plan (RDCP) for 1 resident (#4) of 9 residents whose care plans were reviewed. Failure of the facility to respond to the dialysis center's recommendations and to follow a resident's care plan had the potential to place the	F 309	1. Actions taken for residents affected by the deficient practice: Resident #7 a. Dialysis communication sheets since 4/21/16 have been reviewed and concerns addressed and documented. Completed 5/13/16. b. Education for staff involved regarding protocol for hemodialysis and responsibility for reviewing the communication book and documenting	6/5/16	

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F 309	<p>Continued From page 15</p> <p>resident's at risk for not receiving appropriate care and services. Findings:</p> <p>Resident #7</p> <p>Record review from 4/20-21/16 revealed Resident #7 was admitted to the facility with diagnoses that included chronic kidney disease end stage and diabetes. The review also revealed the Resident was to receive dialysis services at an offsite dialysis center.</p> <p>Review of the RDCP, updated 3/15/16, revealed the Resident "goes to dialysis...M-W-F, P/U 0530; to take dialysis book & sack lunch/snacks ready".</p> <p>Review on 4/20-21/16 of the "Dialysis Communication" [communication sheet between the facility and the dialysis center], dated 12/22/15 - 3/28/16 revealed multiple notes from the dialysis center of the Resident being hungry; lunch not sent with the Resident; and 1 note of an old sandwich the Resident had stating "Pt [Resident] had old sandwich in bag. Please replace lunches."</p> <p>In addition, the dialysis center had documented multiple notes regarding the Resident's medication Midodrine (a medication taken for low blood pressure) not being sent with the Resident on dialysis days and that the Resident needed the medication to "safely remove fluid".</p> <p>Review of the facility policy "Hemodialysis", dated 12/1/15, revealed "Setup before dialysis...Order sack lunch or snack from kitchen as appropriate...Primary Care Nurse: When the resident is sent to dialysis...Send sack lunch or</p>	F 309	<p>actions taken on concerns in the medical record.</p> <p>Resident # 4</p> <ol style="list-style-type: none"> Roho cushion has been replaced and is inflated. Completed 5/13/16 Education for C NA staff re: standard to check ROHO cushion every shift and prior to transferring a resident to the wheel chair. All residents on dialysis and who utilize a Roho cushion in their wheelchair have the potential to be affected by the deficient practice Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations ensuring dialysis communication is addressed and Roho cushions are properly inflated: <ol style="list-style-type: none"> Nursing staff/dietary education on policies for hemodialysis and documentation of follow up on communication. Education for CNA staff on Roho cushion standards. Roho audits to be completed by C NA Group Lead or designee -100% of cushions in use each shift weekly x 4 and samples on-going as needed. Nurse Manager or DON audits of dialysis communication and follow up weekly x 4 and on-going as indicated To monitor compliance to the deficient practice, the Roho and dialysis audits will be forwarded to DON/QI. Concerns are addressed when identified. Any problems or trends are documented and submitted to the Quality Council and a plan of action is developed and implemented as 		

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F 309	<p>Continued From page 16</p> <p>snack if appropriate...Medication sent with resident...After dialysis...Check the notebook immediately upon return for communication or physician recommendations. Check the communication sheet to see if there was any concern noted...If there was a concern during dialysis, follow up as appropriate...Nurse Supervisor/PCN [Primary Care Nurse]... will review the flow sheet for any incidents and medication given during dialysis.</p> <p>During an interview on 4/21/16 at 9:15 am the Director of Quality Improvement (DQI) was asked for the contract between the facility and the dialysis center. The DQI said there was no contract with the dialysis center but there was a business associate agreement with the dialysis center.</p> <p>Review of the business associate agreement, on 4/21/16, provided by the DQI revealed the agreement was between the dialysis center and another facility, not Providence Transitional Care Center (PTCC). There was no mention of PTCC in the agreement.</p> <p>Resident #4</p> <p>Record review from 4/18-21/16 revealed Resident #4 was admitted to the facility with diagnoses that included obesity and diabetes.</p> <p>Observations on 4/19/16 from 10:00 am - 10:50 am, during morning care for Resident #4 revealed, a Roho cushion (specifically designed air filled cushion used to redistribute weight and minimize pressure sores) in the Resident's wheel</p>	F 309	needed		

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F 309	Continued From page 17 chair was deflated. During the same observations Certified Nursing Assistant (CNA) #3 and #4 assisted the Resident into the Hoyer lift after morning care and moved the lift over the wheelchair. Before the Resident was seated in the wheelchair the Surveyor intervened by commenting on the flat Roho cushion. The Resident remained suspended in the Hoyer lift while Licensed Nurse (LN) #11 inflated Roho cushion. During an interview on 4/19/16 at 10:50 am the LN #4, who was also present during morning cares for the Resident, stated the "cushion should be checked every shift." Review of the RDCP, updated 4/16/16, revealed "Roho cushion: [check] for inflation q [every] shift."	F 309			
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		6/5/16	

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F 328	<p>Continued From page 18</p> <p>Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: .</p> <p>Based on record review and interview the facility failed to:</p> <p>1) ensure the electronic medical record was accurate and printed all information on cares specific to medication administration in such a way that a retroactive review could be done for 1 resident (#1) of 3 residents with central lines observed; 2) provide documentation of a central line infection investigation that was diagnosed and treated for 1 resident (#1), of 3 residents with a central line; and 3) ensure intravenous site cares were documented accurately for 1 resident (#1) of 3 residents. Failure to have systems in place for accurate review and audit placed all residents at risk for decreased quality of care.</p> <p>Findings:</p> <p>Resident #1</p> <p>Record review from 4/18-21/16 revealed Resident #1 was admitted to the facility with diagnoses to include osteomyelitis (bone infection) of left foot with methicillin resistant staph aureus (MRSA). In addition, the Resident had a PICC (percutaneous indwelling central catheter; a form of intravenous (IV) access that can be used for a prolonged period of time).</p> <p>Medication Administration Record (MAR)</p>	F 328	<p>1. Actions taken for residents affected by the deficient practice: Resident #1 was transferred to another facility during the survey period. Blood cultures and line tip cultures for resident did not reveal a PICC line infection. PICC line infection was presumptive, working diagnosis for the ordering of cultures. Per physician note of 3/10/16 PICC line infiltration... Final results of line tip cultures and blood cultures have returned, and are negative. Will discuss with Dr. McAlister, the attending physician, and plan to discontinue these antibiotics. Antibiotics were discontinued the same day Education and counseling for staff caring for residents affected on the following:</p> <p>a. PCN caring for resident #10 who did not cleanse central line cap ended her employment at PTCC on 4/19</p> <p>b. LN #12 re: cleansing of hub</p> <p>c. LN #5 re complete flushing of antibiotic before disconnecting</p> <p>d. Nurse who wrote updated PICC line order (from continuous to intermittent) educated regarding components of a complete order for PICC line to include length of line</p> <p>e. LN caring for resident #1 who documented incorrect site regarding accurate documentation.</p> <p>2. All residents with PICC and peripheral</p>		

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F 328	<p>Continued From page 19</p> <p>Record review of the printed MAR for Resident #1 from 2/16 - 4/16/16, revealed the documentation for central line care and peripheral sites was not systematically organized or easily interpreted for daily documentation of cares.</p> <p>Further review of the MAR documentation revealed:</p> <ul style="list-style-type: none"> -No documentation of the length of the 2nd PICC line placed on 4/2/16; -No PICC line documentation at the time of central line dressing change on 3/12/16; -No documentation of site assessment for infection on NOC [night shift] on 3/27; 3/28; or 4/4/16; -Location of the PICC was not documented on each treatment line of the MAR to identify the line site. <p>Review of the daily flushes for peripheral IV sites revealed no location of the IV site was documented.</p> <p>Review of the Nursing Progress Notes, dated 3/9/16 at 6:33 pm, revealed "Patient has URE (upper right extremity) PICC line". The PICC line was placed in the left upper extremity on 3/4/16.</p> <p>Review of IV Therapy note dated, 3/10/16 at 6:34 am, revealed "PICC line to her URE [upper right extremity] is patent and infusing well." The PICC line was placed in the left upper extremity on 3/4/16.</p>	F 328	<p>lines</p> <p>3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations regarding proper care of central lines: the central line EMAR order set revised and streamlined for more efficient documentation and easy reference to protocols. Education for nursing staff regarding standards of care for PICC lines and documentation as well as complete infusion of antibiotics. Staff Development to audit cleansing of random sample of hubs (minimum of 5) weekly x 4 weeks and on-going as indicated. Central and peripheral line audits by Nurse Supervisors, Manager or designee to include dressing changes, appropriate care of the line per protocol and accurate documentation weekly on-going for all with Central or PICC lines</p> <p>4. To monitor compliance to the deficient practice, the hub audits and line audits will be forwarded to DON/QI. Concerns are addressed when identified. Any problems or trends are documented and submitted to the Quality Council and a plan of action is developed and implemented as needed</p>		

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F 328	<p>Continued From page 20</p> <p>During an interview on 4/21/16 at 11:00 am the MAR was reviewed with the Nurse Manager (NM). The NM stated the MAR does print out confusing data, and confirmed the peripheral sites had no location documented on the MAR.</p> <p>PICC Infection</p> <p>Review of the nursing progress note, dated 3/2/16 at 8:07 am, revealed "PICC upper R [right] arm has yellow drainage. Site is inflamed and reddened."</p> <p>Further review of the nursing progress notes, dated 3/3/16 at 00:54 am, revealed "PICC line site has purulent drainage, red, tender, and swollen."</p> <p>Review of the Physician's Orders dated 3/2/16 at 2:00 pm, revealed "dx: PICC line infection...PICC line redness and pain, and infection..."</p> <p>Further review of the Physician's Order dated 3/2/16 at 3:35 pm, revealed "After PICC removed and tip culture sent, start cefipime...and flagyl...IV...for 10 days dx [diagnosis]: PICC infection."</p> <p>During an interview on 4/21/16 at 9:05 am Infection Control coordinator stated the facility did not perform surveillance and had no documentation for the PICC line infection or PICC line care by staff.</p> <p>Central Line Medication Administration</p> <p>Resident #10</p>	F 328			

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F 328	<p>Continued From page 21</p> <p>Observation on 4/21/16 at 6:00 am revealed LN #12 preparing to administer intravenous medication to Resident #10. The LN wiped the top of the cap for 12 seconds but did not cleanse the threads on the cap before the medication tubing was connected to the PICC cap.</p> <p>Resident #11</p> <p>Observation on 4/21/16 at 7:20 am revealed LN #12 preparing to discontinue an intravenous medication via the tunneled line from Resident #11. The LN wiped the top of the cap for 13 seconds but did not cleanse the threads of the cap prior to flushing the catheter.</p> <p>In addition, the antibiotic medication vial, attached to the bag of fluids to be infused had approximately 1-1.5 mls of a yellow colored liquid antibiotic remaining in the vial at the time the medication was discontinued.</p> <p>During an interview on 4/21/16 at 8:10 am, LN #5 was asked to retrieve the medication tubing, vial, and empty bag of intravenous fluids for the Surveyor. On examination of the vial, the LN confirmed with the Surveyor that the vial contained antibiotic medication the Resident should have received.</p> <p>During an interview on 4/21/16 at 9:00 am the Nurse Manager also confirmed the vial contained approximately 1-1.5 ml of antibiotic the Resident should have received.</p>	F 328			

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F 371 F 371 SS=F	Continued From page 22 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: . Based on observation, interview and record review the facility failed to ensure: 1) kitchen staff used correct test strips to test the sanitizing solutions and maintained concentration of sanitizing solutions within acceptable parameters; 2) dietary staff consistently performed hand hygiene according to accepted standards of practice; 3) food temperatures were monitored after food had been microwaved; and 4) correct temperature monitoring techniques when using a food thermometer. These failed practices caused a potential for food contamination and increased the risk for food-borne illnesses (based on a census of 37). Findings: Sanitizing Solution: Observation during the initial tour on 4/18/16 at 10:21 am the Dietary Coordinator tested the sanitizing solution with a test strip and stated the	F 371 F 371	1. Actions taken for residents affected by the deficient practice: a. The sanitizing solution was re-mixed to the proper concentration. Kitchen staff verified that there is only one type of strip used in the kitchen and that they have the proper strips Completed 4/18/16 b. Education and review of kitchen hand hygiene protocols with Cook #2 Completed 5/12/16 c. Protocol revision to include reheating and temperature monitoring after microwaving. Developed in conjunction with Dietary Manager. Completed 5/12/16 d. Review of food temperature check policy with Dietary Manager. Completed 5/11/16 2. All residents have the potential to be affected by the deficient practice 3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations to ensure sanitary food	6/5/16	

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F 371	<p>Continued From page 23</p> <p>test measured at less than 50 ppm. In addition, stated 50 ppm was the correct concentration. Cook #1 stated while the DC was testing a second sanitation solution the wrong test strips were being used.</p> <p>During an interview on 4/20/16 at 12:28 pm Dietary Manager (DM) stated the facility used QAC QR test strip in the sanitizing solution and the acceptable range should be 200 ppm (parts per million).</p> <p>Review of the facility policy "Solutions for Cleaning and Sanitizing", dated 4/13/16, revealed "...using a QAC QR test stripe in the sanitizing solution. The acceptable range for the sanitizing solution should be 200 ppm."</p> <p>Hand Hygiene Observation on 4/20/16 at 7:30 am, revealed Cook #2 washing hands in the sink without using soap then returned to the food prep area. Another observation on 4/20/16 at 8:05 am, Cook #2 again, rinsed his hands without using soap, donned a glove, turned the faucet on with the gloved hand then returned to the food prep counter and sliced an orange. Further observations on 4/20/16 at 8:31 am and 11:39 am Cook # 2 was observed multiple times not performing hand hygiene with soap and not performing hand hygiene after glove removal. In addition, the Cook was observed preparing foods with one gloved hand.</p> <p>Review of facility policy "Disposable Glove Usage" dated 3/2013, revealed "Gloves must be worn when handling (directly touching) ready to eat food... Hands must be washed prior to putting on gloves or when changing gloves...Gloves must</p>	F 371	<p>storage, preparation, distribution and serving of food the following systems and measures will be developed</p> <p>a. Log for monitoring of sanitizing solution has been developed and solution will be spot-checked weekly by the Dietary Manager or designee and verified that it is at 200 ppm Completed 5/10/2016</p> <p>b. Education for all kitchen staff in proper mixing of sanitizing solution, hand hygiene protocols including disposable glove use for the kitchen, protocols for reheating and proper methods of checking food temperatures</p> <p>c. Hand hygiene audits in kitchen by Support Services Director, Infection Preventionist, QI or designee weekly x 4 weeks and monthly on-going or as indicated</p> <p>d. Log for monitoring of re-heated foods implemented and reviewed by Dietary Manager or designee. Completed 5/10/2016</p> <p>4. To monitor compliance to the deficient practice: Logs and audits to be maintained by Dietary Manager with oversight from Support Services Director. Concerns are addressed when identified. Any problems or trends are documented and submitted to the Quality Council and a plan of action is developed and implemented as needed</p>		

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F 371	<p>Continued From page 24</p> <p>be changed any time a food preparation task is interrupted by an non-food task including such activities as opening containers, handling...Gloves must be changed between food preparation tasks of different food items..."</p> <p>Reheating of Food in Microwave Observation on 4/20/16 at 8:32 am, the DM reheated a breakfast tray for Resident #13 and placed it on a tray for delivery to the Resident. No food temperature was taken after microwaving. During an interview on 4/20/16 at 8:45 am the DM confirmed, "The temperature of the food had to be monitored after microwaving. I know I should take the temperature. I missed it." No policy was provided for reheating and temperature monitoring of food after microwaving.</p> <p>Food Temping Observation on 4/20/16 at 7:40 am, the DM checked the temperature of potatoes by placing the tip of the thermometer directly touching the bottom of the hot steel tray. With Surveyors' intervention, the DM rechecked the temperature of the potatoes using proper technique and it was only 120 degrees. During an interview on 4/20/16 at 7:40 am the DM confirmed the temperature of the potatoes was too low. Review of facility policy "Cooking Potentially Hazardous Foods" dated 11/2012, revealed, "...5. Insert thermometer in the thickest part of the product which is usually the center."</p>	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		6/5/16	

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F 428	<p>Continued From page 25</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review the facility failed to ensure that a decreased Vitamin D level was addressed in a timely manner for 1 resident (#4) out of 6 sampled residents whose medication regime was reviewed by the pharmacist. Specifically, the pharmacist drug review on 4/15/16 recommended restarting Vitamin D after the resident had been found to have a deficient level of Vitamin D in January 2016. Findings:</p> <p>Record review from 4/19-21/16 revealed Resident #4 was admitted to the facility with diagnoses that included Vitamin D deficiency; chronic kidney disease; ventricular tachycardia; obesity and diabetes.</p> <p>Record review of the "Consulting Pharmacist Notes" written by the Pharmacist, dated 4/15/16, revealed a recommendation "In January [Resident #4] Vitamin D, 25-Hydroxy level was found to be 24ng/ml, a decrease from prior level of 36. [Resident #4] is not currently on any vitamin supplements. Please consider restarting</p>	F 428	<ol style="list-style-type: none"> 1. Actions taken for residents affected by the deficient practice: Resident #4 received an order for Vitamin D 1000 units daily and repeat D level in 3 months. Completed 4/20/2016 2. All residents are potentially at risk 3. Systems and measures to ensure the deficient practice does not recur: Although the lab value was decreased, it was not outside of the reference range for a vitamin D deficiency (normal range is 20-50 per the reference lab). When doing the monthly medication regimen reviews the Pharmacist makes a recommendation when the medication monitoring laboratory value is outside of the normal range or when in the pharmacist's clinical judgment there is a significant change in the value from the previous level. As per our procedure if the pharmacist's judgment deems the change to require immediate attention it will be addressed with the attending physician and/or the medical director. To 		

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F 428	Continued From page 26 [Resident #4] Vitamin D supplement 1000 units daily..." In summary the January 2016 - March 2016 "Consulting Pharmacist Notes" revealed the Resident's low Vitamin D, 25-Hydroxy level was not addressed by the Pharmacist until April, even though the Resident was admitted with a diagnosis which included Vitamin D deficiency and the Resident had a low Vitamin D, 25-Hydroxy level in January.	F 428	enhance currently compliant operations to ensure CP reviews occur monthly and recommendations are acted upon, roster of MRRs is maintained in pharmacy. Completed 5/13/2016 4. To monitor compliance to the deficient practice: Consultant Pharmacists report on MRRs to Pharmacy and Therapeutics committee (a subcommittee of the Quality Council). Any problems or trends are documented and submitted to the Quality Council and a plan of action is developed and implemented as needed		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		6/5/16	

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F 441	<p>Continued From page 27</p> <p>isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: .</p> <p>Based on record review, observation and interview, the facility failed to ensure 1) staff followed accepted standards of practice for contact precaution for infection prevention for 1 resident (#3) out of 3 residents observed receiving care, 2) transported linen to prevent potential cross contamination, 3) laundry was processed in a manner to prevent potential cross contamination, and 4) clean storage of medications and medical supplies. This deficient practice created a risk of cross-contamination and transmission of infection and had the potential to affect all residents residing in the facility (based on a census of 37). Findings:</p> <p>Contact precautions</p> <p>Resident #3</p>	F 441	<p>1. Actions taken for residents affected by the deficient practice:</p> <p>a. Education for staff caring for resident #3 regarding proper use of PPE to include ensuring the ties are tied and not trailing, performing hand hygiene to include wrists and exposed skin if skin becomes exposed during care, not shaking out soiled sheets in the room, and using gloves to carry dirty linen bags to the soiled utility room.</p> <p>b. Education for C NA staff regarding using gloves when transporting soiled linen and trash</p> <p>c. Education for laundry staff on protocol for use of PPE when sorting dirty laundry. Completed 5/12/16)</p> <p>d. Pyxis machines and refrigerators have been cleaned of debris and dust. Completed 5/12/2016</p>		

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F 441	<p>Continued From page 28</p> <p>Record review on 4/19-21/16 revealed Resident #3 was readmitted to the facility on 1/5/15 and had diagnoses that included: obesity; dermatitis to skin folds; knee wound and methicillin-resistant staphylococcus aureus (MRSA) infection (a type of staph bacteria that's become resistant to many antibiotics and can survive on skin and objects in the environment).</p> <p>Review of the "Resident Daily Care Plan" updated 4/13/16, revealed "Contact Precautions: MRSA in wound to pannus [a large abdominal fold]."</p> <p>Observation during morning care on 4/19/16 at 6:15 am, revealed Certified Nurse Assistants (CNA) #2 and #6 donned masks, face shields, gowns and gloves upon entering Resident #3's room. CNA #3 did not tie the strings in the back of the gown, the long strings trailed into the garbage that contained soiled dressings, and then rubbed onto her clothing potentially contaminating it.</p> <p>Continued observations revealed the CNAs' gloves had not been pulled over the cuff of the isolation gown sleeve, causing their wrists to be exposed while providing personal care to the Resident. Because of the large abdominal pannus, the staff had to lean over the Resident and use their entire forearm and hands to pull back the abdominal fold while cleansing the Resident's groin, causing the CNAs' wrists to rub against the Resident's skin and soiled bedding. When the CNAs performed hand hygiene, they did not cleanse their wrists that had been exposed during personal care.</p> <p>Further observations revealed, CNA #6 shook the</p>	F 441	<p>2. All residents are potentially at risk</p> <p>3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations to ensure a safe, sanitary environment:</p> <p>a. Education for all care staff regarding proper use of PPE to include ensuring the ties are tied and not trailing, performing hand hygiene to include wrists and exposed skin if skin becomes exposed during care, not shaking out soiled sheets in the room, and using proper PPE when transporting dirty linen and trash bags to the soiled utility room.</p> <p>b. Education for all laundry staff regarding protocol for use of PPE when sorting dirty linens Completed 5/12/16</p> <p>c. PPE stocked in the soiled utility rooms, to include gloves, gowns eye and face protection.</p> <p>d. Explore alternatives to the current gowns we are using with the goal to find one that will not create a gap of bare skin on caregivers' arms.</p> <p>e. Unannounced hand hygiene audits each shift to include nursing, kitchen and laundry weekly x 4 and a minimum of quarterly on-going. On the spot coaching as needed.</p> <p>f. Dedicated Infection Preventionist position filled May 15. Completed 5/15/2016</p> <p>g. Environmental rounds at least quarterly to include all departments completed by IP, DON, SS Dir QI or designee(s)</p> <p>h. Pyxis machine cleaning protocol and schedule developed and maintained by pharmacy. Completed 5/12/16</p> <p>4. To monitor compliance to the deficient</p>		

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F 441	<p>Continued From page 29</p> <p>sheet into the air over the bed increasing the risk of transmitting multidrug resistant organisms throughout the room.</p> <p>After completing care for Resident #3, CNA #3 picked up the plastic bags that contained soiled linen and trash with both bare hands and carried it to the soiled utility room for disposal.</p> <p>A review of the facility policy, revised 12/15, revealed: "Contact Precautions-are indicated when resident/patient has a epidemiologically important organism that can be transmitted by direct contact with the resident/patient or with environmental surfaces or resident patient care items in the resident/patient's room...after removing gloves and handwashing, be careful not to touch potentially contaminated environmental surfaces or items in the resident's room or environment...remove gown before leaving room and be careful your clothing does not contact potentially contaminated environmental surfaces in the room..."</p> <p>During an interview on 4/20/16 at 12:45 pm, LN #4 stated the orientation handbook and CDC guidelines were to be followed by all staff for hand hygiene practice, proper gowning and transport of garbage and linen. In addition, the LN stated shaking the sheets contaminated other surfaces and people in the room and CNAs are to wear gloves when transporting soiled linen and garbage.</p> <p>Review of facility job description on 4/21/16, revised 5/10 revealed: "Certified Nursing</p>	F 441	<p>practice: Hand hygiene and environmental audits to the IP and QI. Any problems or trends are documented and submitted to the Infection Control Committee and the Quality Council and a plan of action is developed and implemented as needed</p>		

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F 441	<p>Continued From page 30</p> <p>Assistant (CNA) RESIDENT CARE...Sequence for putting on personal protective equipment (PPE)...Gown-fully covered...arms to wrist...secure ties...gloves-extend to cover wrist of isolation gown...perform hand hygiene...after removal of gloves."</p> <p>Soiled linen transport</p> <p>Continuous observations on 4/19/16 from 9:40 am-10:03 am in the North unit, soiled utility room revealed, multiple CNA's transporting soiled linen and garbage to the soiled utility room without gloves.</p> <p>CNA #7 carried an opened bag of soiled linen with a blanket hanging from the top of the bag to the soiled utility room with ungloved hands. The CNA put the opened bag into the bin labeled "dirty." The bin was full of soiled laundry bags. The CNA, ungloved and not gowned, leaned over the dirty bin and stuffed the soiled blanket into the soiled laundry bag.</p> <p>CNA #8 carried 1 bag of soiled laundry into the soiled utility room and put the bag in the dirty bin without wearing gloves.</p> <p>CNA #1 carried a bag of soiled laundry into the soiled utility room, opened the door (holding it open with her body) and threw the soiled linen bag across the room towards the dirty bin. The bag landed on the rim of the bin. The CNA went into the room, walked to the dirty bin and put the bag into the bin. The CNA was not wearing gloves to transport the soiled linen.</p> <p>CNA #9 carried 1 bag of soiled laundry to the soiled utility room without wearing gloves.</p>	F 441			

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F 441	<p>Continued From page 31</p> <p>Review of nursing protocol on 4/21/16, updated 5/14 revealed: "Providence Transitional Care Center Protocol...key points for monitoring...hand cleansing between care/contact with each patient...one glove may be worn to carry a laundry or trash bag...gloves and PPE, used as appropriate."</p> <p>PPE Laundry</p> <p>Observation on 4/19/16 at 10:30 am in the central laundry room revealed: Laundry Staff (LS) #1 removed dirty laundry from a laundry bin and placed it in the washing machine. The LS was not wearing a personal protective gown to protect her clothing while handling dirty laundry. The LS was then observed removing clean laundry from the dryer and placing it in a laundry bin.</p> <p>During a second observation on 4/20/16 at 9:35 am, in the central laundry room LS #1 placed dirty laundry into the washing machine without a protective gown to protect her clothes.</p> <p>During an interview on 4/21/16 at 9:08 am, the Infection Control Coordinator (ICC), stated staff should be wearing gloves when transporting bagged linen and trash. Gowning and transferring of linen should be performed per policy and procedure.</p> <p>Review of the orientation manual "PECC and PTCC booklet-Good things to Know" revealed the "Instruction...use Caution when handling laundry...PPE, such as gloves, gown...are worn to prevent exposure during handling or sorting of laundry."</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>Medication Storage</p> <p>Observation on 4/21/16 at 8:40 am of the North Pyxis (an electronic machine/cabinet that contains residents' medications and medical supplies), had significant dust and clumps of debris in cabinets 4, 8, 12 and 16.</p> <p>Observation on 4/21/16 at 8:45 am of the South Pyxis had significant dust and clumps of debris in cabinets 4, 8, 12 and 16.</p> <p>Further observation on 4/21/16 at 8:50 am revealed both units had refrigerators attached to the Pyxis system. The refrigerator gaskets had a buildup of grey substance. There were multiple biologicals (ie, vaccines) and medications located in both Pyxis refrigerators.</p> <p>Interview on 4/21/16 at 8:40 am with LN #11, when asked about the maintenance of medication storage of Pyxis cabinet, refrigerator/ gaskets and cleaning schedule, she stated she was not aware of any schedule nurses were to follow, but that the pharmacy technicians or nurse manager may know of one.</p> <p>A second interview on 4/21/16 at 8:50 am, LN #5 stated she did not know who cleaned and maintained the Pyxis, but thought a supervisor or pharmacy would know.</p> <p>During an observation and interview on 4/21/16 at 11:00 am, the Pharmacist stated she was not aware of a cleaning schedule or policy for the Pyxis cabinets and refrigerators. In addition, she confirmed the cabinets and refrigerator gaskets were dirty in both the North and South units.</p>	F 441			

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F 441	Continued From page 33 The Pharmacist later confirmed no policy and or procedure for cleaning the Pyxis existed.	F 441			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: . Based on investigations and interview the facility failed to identify potential indicators for use in	F 520	1. Actions taken for residents affected by the deficient practice: The facility utilizes patient council meeting minutes,	6/5/16	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE TRANSITIONAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 910 COMPASSION CIRCLE ANCHORAGE, AK 99504		
(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	
F 520	<p>Continued From page 34</p> <p>their quality program. This failed practice created a risk for an ineffectual program and a failure to identify issues that may have needed further investigation and review by the quality assurance and performance improvement (QAPI) committee. Specifically, the facility failed to: 1) utilize unusual occurrences (incidents); 2) review all resident grievances; 3) review concerns from an outside agency providing resident care; and 4) review all infections as part of their QAPI program. This failed practice had the potential to negatively impact the quality of care and quality life experienced by all the residents (based on a census of 37) residing in the facility and influence systemic change. Findings:</p> <p>Unusual Occurrence (missing money)</p> <p>The facility failed to resolve and respond to 1 grievance in a timely manner for 1 resident (#2) of 1 resident. Specifically, a family member reported a grievance concerning the resident's missing money. The failure to resolve the grievance in a prompt manner denied the resident and family member a prompt resolution to the grievance.</p> <p>Resident Grievances</p> <p>The facility failed to communicate, respond or act upon concerns and/or recommendations brought forth during the past 10 months of the Resident Council Meeting minutes (for 7 of 37 residents that were interviewed).</p> <p>Review of the Resident Council Meeting Minutes, dated June 16, 2015 through April 13, 2016, revealed residents had voiced concerns and/or recommendations in the meeting minutes. The review revealed no documented response,</p>	F 520	<p>resident concern forms and UOR reports of severity C (error occurred that reached patient but did not cause the patient harm) or greater to identify inappropriate care processes. If an occurrence is not addressed in a timely manner, resolution is not achieved and/or resident and/or family member is not notified of resolution in a timely manner, the event will be immediately returned for prompt attention and resolution to the DON or appropriate department leader.</p> <p>The presumed PICC line infection occurred during a period of conversion from a paper MAR to an electronic MAR. The infection was followed up on by the medical provider and did not meet criteria for a line infection. Infections are identified through micro-culture reports from the lab. A report will also be generated through ECS of all new anti-infective medications prescribed. The facility utilizes the McGeers criteria for identification of nosocomial infections. As a part of the conversion process to the electronic MAR, a Quality subcommittee was established to identify and address issues with the electronic documentation system. This committee reports to the QI council. For actions taken for specific residents, see also action plans for deficiencies under tag F166, F244, F 309 and F328</p> <p>Continuation of staff education in High Reliability principles and education regarding tools to enhance communication and increase event and near miss reporting. High Reliability Steering Committee to identify top 3 priorities and draft timeline for</p>		

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F 520	<p>Continued From page 35</p> <p>communication or action(s) taken by administration. Some of the Resident's concerns or recommendations were:</p> <ul style="list-style-type: none"> · Missing clothing; · Would like sugar free cookies; · Can the morning medications be given earlier; · Specific food requests; · Swimming pool; · Gift giving; · North side of the facility is cold; and · Want crackers always put on their trays when they have soup. <p>Concerns from Outside Agency</p> <p>The facility failed to respond to a dialysis center's communication concerns regarding 1 resident (#7) of 1 resident reviewed for dialysis services from an outside dialysis center..</p> <p>Central Line Infection</p> <p>The facility failed to: 1) ensure the electronic medical record was accurate and printed all information on cares specific to medication administration in such a way that a retroactive review could be done for 1 resident (#1) of 3 residents with central lines observed; 2) provide evidence of a central line infection investigation that was diagnosed and treated for 1 resident (#1) of 3 residents diagnosed and treated for a central line infection; and 3) ensure intravenous site cares were documented accurately for 1 resident (#1) of 3 residents.</p> <p>During an interview on 4/21/16 at 10:45 am, the Director of Quality Improvement stated the</p>	F 520	<p>implementation Complete by 6/5/16</p> <p>2. All residents are potentially at risk</p> <p>3. Systems and measures to ensure the deficient practice does not recur: To enhance currently compliant operations to ensure a safe, sanitary environment: A dedicated Infection Preventionist has been hired as of May 15, 2016. Resident concerns and reports from Resident Council meetings will be added to the Quality Council Agenda Event reporting and classification to be reported to the Quality Council to include timeliness of follow up on concerns and events</p> <p>4. To monitor compliance to the deficient practice: problems and trends to be addressed and action plans developed as needed through the Quality Council and Performance Improvement Project process</p>		

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

PRINTED: 07/25/2016
FORM APPROVED
OMB NO. 0938-0391

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F 520	Continued From page 36 Quality committee had not reviewed: 1) a complaint from the family of Resident #1 whose money was missing from the Resident's room; 2) resident council concerns/recommendations; 3) concerns/comments between the facility and the outside dialysis center for the dialysis resident; and 4) had no evidence the cause of the central line infection had been investigated.	F 520			