

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2014
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NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal</p>	S9999		
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to implement a protocol to secure razors and ensure the safety involving eleven sampled residents (R21, R23, R26 R31, R34, R35, R36, R37, R38, R39 and R40) that were listed as residents from the behavioral unit with a history of aggressive, homicidal and suicidal behavior. R26 gained access to a razor to self mutilate and cut right arm.</p> <p>Findings include:</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>1.) The Face Sheet documents that R26 was admitted to the facility on 1/7/14 with a diagnosis of schizophrenia and schizoaffective disorder. The Progress Notes dated 4/5/14 at 6:11pm documents that R26 was hearing voices telling him to cause self-harm. R26 was redirected, given an anti-anxiety medication, and monitored throughout the night.</p> <p>The Progress Notes and Incident Report both dated 4/9/14 at 3:18pm documents that R26 approached E8 (Nurse) at the nurse's station with bleeding to the right inner arm. R26 informed E8 that voices told him to do it and the razor was found in a garbage can in the shower room three weeks prior. At 6:22pm, R26 was sent to the hospital with a diagnosis of suicidal ideations and depression.</p> <p>On 5/21/14 at 2:10pm, E8 stated "the resident had a history of saying he wanted to cut himself and I remember him saying that about a month ago and being sent out to the hospital. The interventions in place were 1:1 observations and the resident was not allowed to shave himself. The aides shaved him. The housekeepers clean the shower daily and I have no idea how he got the razor."</p> <p>On 5/22/14 at 11:25am E11 (Behavioral Unit Director) during interview stated "We keep a razor log on the unit and the residents tell staff when they need a razor. The staff signs out the razors and they are responsible for signing the log when the razor is returned. Any residents that are mentally impaired or have suicidal ideations are not allowed to have razors."</p> <p>On 5/22/14 at 11:38am, E11 was unable to find</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>the log used to track the residents' used razors.</p> <p>On 5/22/14 at 11:40 am, E11 stated "We give out razors daily and we have a log that staff signs to track the razors, but I can't find it."</p> <p>On 5/22/14 at 11:45am, E8 stated "One resident asked for a razor today so that he can shave. I didn't log it, but when he returned it I just put it in the sharps container."</p> <p>On 5/22/14 at 11:50am, R31 stated "I ask the nurse for a razor when I need it and I keep them until I'm done, then I put them in the box in the shower room."</p> <p>On 5/22/14 at 11:55am, R10 stated "When I need a razor I get it from the nurse and I keep it in my drawer until I want to use it."</p> <p>On 5/22/14 at 12:00pm three razors were observed in R31's bathroom.</p> <p>The social service department provided the survey team with a list of residents from the behavioral unit with a history of aggressive, homicidal and suicidal behavior. R21, R23, R31, R34, R35, R36, R37, R38, R39 and R40 were listed among the 55 residents on the unit with these types of behavior during the time of the survey.</p> <p>The facility's policy on Regulated Medical Waste documents that sharps will be placed directly into impervious, rigid, leak proof and puncture-resistant containers to eliminate the hazard of physical injury.</p> <p>(A)</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>300.610a) 300.1010h) 300.1210b) 300.1210d)1 300.1210d)2 300.3220f) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a</p>	S9999		

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S9999	<p>Continued From page 5 meeting.</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to 1) provide necessary care and services to identify, assess, monitor and treat one resident (R5) with a diabetic ulcer reviewed for wound care. This failure resulted in R5 being admitted into hospital with osteomyelitis infection and amputation of right great toes.</p> <p>2) Failed to obtain physicians/pharmacy orders, transcribe and process these orders in a timely manner for one resident (R6) reviewed for</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>physician orders.</p> <p>Failed to assess and document vital signs, blood glucose results, and gastrostomy feeding tube residual for R6. Failed to notify a physician of the death of R6, prior to releasing his body to a funeral home.</p> <p>Findings include:</p> <p>1. R5's was observed with surgical wound on 5-5-14 at 12:30pm. The dressing contained scant, serous drainage, and there was no odor present. The area of R5's right foot at the base of where the toe had been was covered in white tissue that appeared to be slough tissue. R5 was confused during this visit, stating his toe had just gotten this way "all of a sudden". R5 further could not state why his toe was amputated, or what his diagnoses were. R5 stated "I'm going to get a bone marrow transplant today".</p> <p>A facility face sheet document, R5 was admitted to the facility 3-25-14 with diagnoses significant for Diabetes and Schizophrenia.</p> <p>R5's current POS (Physician's Order Sheet dated May 2014 documents new diagnoses of Osteomyelitis and Limb Amputation, Great Toe.</p> <p>R5's MDS (Minimum Data Set) dated 3-31-14 notes R5 was unable to complete the BIMS (Brief Interview for Mental Status), and was assessed by staff as having a memory problem.</p> <p>E8's (Nurse) nursing note dated 3-25-14 at 7:25am documents "noted right great toe opening on outer area 0.3cm (centimeters) X 0.3cm with drainage. Also, open area on upper interior side. Paged MD (Medical Doctor)." There is no follow up note regarding the physician calling back, or</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>giving orders. E8's nursing note dated 3-29-14 at 7:52am documents "After making rounds this morning noted that resident was picking skin off his toe, causing it to bleed. Noted drainage and appears to be slightly swollen. MD (Medical Doctor) called. New orders to start Clindamycin 300mg (milligrams) twice a day noted and carried out". There is a physicians order for this medication noted on that date. Nursing note dated 3-31-14 documents "Resident seen by Wound Care Nurse Practitioner. Nurse Practitioner assessed right great toe and gave orders for resident to be transferred to hospital for signs of infection. Primary nurse made aware. ADON (Assistant Director of Nursing) made aware".</p> <p>R5's care plan dated 10-11-13 documents the focus "R5 has a diagnosis of Schizophrenia which is manifested by low insight into his illness". R5's care plan dated 3-24-14 that documents the nursing intervention "inspect skin daily" and "monitor for signs and symptoms of infection".</p> <p>Hospital records document R5 underwent an amputation of his right great toe 4-1-14, for a diagnosis of Osteomyelitis.</p> <p>E8 stated 5-5-14 at 12:00pm; she first noticed R5's toe was infected on 3-29-14. E8's 3-25-14 nursing note entered at 7:25am, first documents her discovery of R5's wound, as stated above. E8 further stated R5 had been lying in bed 3-29-14, without shoes and socks, and picking on his right great toe. E8 then described R5's right great toe to be red, and have pus coming from it. E8 stated she then asked R5 if it the toe was painful, and he answered "yes". E8 then stated she notified R5's physician, as well as E10 (Treatment Nurse). E8 further stated that after</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>several days, R5 was not improving, and that's when he was sent to the hospital.</p> <p>R5's physician ordered treatment dated 3-29-14 states soak his right great toe and foot in Providine Iodine solution with warm water for 10 minutes daily, and apply Neosporin ointment twice daily.</p> <p>Z3 (Nurse Practioner) stated 5-6-14 at 12:30pm states upon her visit to examine R5 on 3-31-14, she found his right great toe to have an odor, and necrotic tissue. Z3 further stated this toe looked infected, and was warm and painful to touch. Z3 then stated she ordered R5 to be sent to the hospital for evaluation. Z3 also stated he ordered Vancomycin 1 gm (gram) IVPB (Intravenous Piggy Back) every 12 hours to be infused. Z3 further stated she had never seen R5 as a patient before. Z3 also stated she gave R5 the diagnosis of Cellulitis, questionable Osteomyelitis. Z3 also ordered lab work and a Bone Scan of R5's right foot to rule out Osteomyelitis, in case he refused to go to the hospital, due to his mental illness. Z3 stated 5-19-14 at 12:30pm, she's not sure how long R5's toe had been infected when she first saw him 3-31-14, but it was obviously not an acute injury. Z3 then stated nursing staff should be performing daily skin checks for residents. Z3 further stated it is especially important to monitor a diabetic resident's skin, and particularly his feet, as a small wound can quickly progress into necrotic tissue or become infected.</p> <p>E9 (CNA-Certified Nursing Assistant) stated 5-6-14 at 1:51pm, R5 is confused at times, and sometimes has hallucinations and delusions; for example, R5 thinks the other residents are his family members or his children. E9 further stated</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>R9 showers and dresses himself. E9 further stated staff does not have the opportunity to view R5's feet, as he showers and dresses himself. E9 then stated if R5 is asked if he needs help, he becomes defensive, saying "What, are you trying to look at me? "</p> <p>E2 (Director of Nursing) stated 5-20-14 at 9:40am, residents receive a shower twice weekly. E2 further stated CNA's are to fill out "shower sheets" after every resident shower.</p> <p>Surveyor requested a copy of all R5's shower sheets from January 2014 through May 2014. Shower sheets dated 1-13-14, 1-20-14, 1-22-14, 2-10-14, 2-15-14 and 2-20-14 do not indicate the condition of the right great toe</p> <p>Facility policy titled "Shower Day Worksheet" states, in part "Once a week on resident bath/shower day obtain a Shower Day Worksheet. During bath/shower if the CNA notes any skin abnormality place an "X" where you notice abnormality or change in color on the shower day worksheet. The nurse will assess all areas where the CNA has indicated a change on the Shower Day Worksheet, and determine if there is a treatment, whether the current treatment if effective. If not, a change treatment as ordered by MD".</p> <p>Facility policy titled "Change of Condition" states, in part "Attending physician or physician on call/ Nurse Practitioner and responsible party will be notified of all changes in condition</p> <p>Facility policy titled "Diabetes Management" states, in part "General guidelines for assessment may include, but are not limited to skin: color, temperature, irritation, abrasions, open areas,</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>turgor, pruritus, and condition of feet".</p> <p>2. R6 was admitted to the facility 3-27-14 from a sub-acute hospital, arriving at 2:00pm, according to nursing notes. R6 had diagnoses significant for Quadriplegia, Hypertension, Diabetes, Cognitive Deficits due to Cerebrovascular Disease, and Intracerebral Hemorrhage, according to facility Admission Record.</p> <p>There was no documentation of R6's vital signs recorded from 3-27-14 at 11:00pm through 3-28-14 3:00pm. There was no documentation of R6 receiving a blood glucose test from 3-27-14 11:00pm through 3-28-14 at 7:00am. There is no documentation of R6's gastrostomy tube feeding residual for the entire time he was at the facility.</p> <p>Nursing note dated 3-29-14 at 1:36am, documented as a late entry: 3-28-14 at 9:25pm states "Family member alerted the writer to resident condition. The writer immediately rushed into the room with team 1 nurse. Resident found unresponsive. CPR (Cardio Pulmonary Resuscitation) initiated 911 and code blue called for assistance. Paramedics arrived and confirmed resident dead at 9:35pm with family member present".</p> <p>Nursing note dated 3-29-14 at 8:24pm documents: "MD was paged in regards to resident had expired on 3-28-14. Medical Director (Z2) was notified about resident at 5:20pm. Z4 returned call at 8:30pm and was informed about resident". E4 stated 5-8-14 at 4:20pm that when she tried to call Z4 approximately 3:00pm on 3-29-14 and again before 5:00pm, and got no response. E4 then called Z2 at 5:20pm, stating nurses need to inform the Medical Director after two attempts are</p>	S9999		
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S9999	<p>Continued From page 12</p> <p>made to reach a resident's attending physician.</p> <p>E13 (Nurse) stated 5-6-14 at 4:20pm she received resident upon admission 3-27-14 at 2:00pm, in stable condition, with stable vital signs. E13 also stated R6 was non-verbal, had tracheostomy and a gastrostomy tube. There is no documentation of R6's blood glucose level upon admission. E13 further stated she worked until 3:00pm that day, so only did resident's initial assessment, and endorsed R6's admission to E4 (Nurse). Nursing Initial Assessment dated 3-27-14 at 5:29pm document R6's bowel sounds as "absent".</p> <p>E4 stated 5-8-14 at 4:20pm she cared for R6, 3-27-13 from 3: pm to 11:00pm; however, E14 (Nurse) completed his admission, as there was multiple admissions that day on her shift. E4 also stated E14 would have called R6's physician for admitting orders, as well as faxing those orders to pharmacy. E4 further stated she did not recall receiving a blood glucose result when she received report from E13. E4 also stated she doesn't recall taking blood glucose, vital signs, or R6's gastrostomy tube feeding residual on her shift. There are no nursing notes for 3-27-14 for the 3:00pm through 11:00pm shift. There is no documentation of R6's gastrostomy tube residual amount.</p> <p>E14, during interview stated 5-8-14 at 5:08pm, that he admitted R6 3-27-14, receiving report from E13 at 3:00pm. E14 did not recall receiving a blood glucose result given to him in report. E14 stated it took him "awhile" to review R6's chart from the subacute hospital he was transferred from. E14 also stated he called Z4 (Attending Physician) three times between 7:00pm and</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2014
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NAME OF PROVIDER OR SUPPLIER ALDEN PRINCETON REHAB & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 255 WEST 69TH STREET CHICAGO, IL 60621
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S9999	<p>Continued From page 13</p> <p>9:00pm, then finally reached him approximately 9:00pm to get admission orders for R6. E14 then stated it took him "awhile" to transcribe and fax R6's medication orders to pharmacy, and he faxed then 3-28-14 at 12:36am. E14 further he did not check R6's blood glucose test. POS dated March 2014 contains the order for blood glucose monitoring every six hours, with sliding scale coverage using Regular Insulin. E14 further stated he did not check R6's gastrostomy feeding tube residual.</p> <p>E12 stated 5-6-14 at 1:12pm, he cared for R6 on 3-28-14 from 3:00pm until his death at 9:35pm. E12 stated R6's medications had been delivered on his shift from pharmacy. E12 also stated at 9:15pm, R6's family member came rushing out of his room, and came to find him. E12 then stated that upon entering R6's room, he found R6 to be unresponsive, with brown liquid that appeared to be gastrostomy tube feeding coming out of his mouth. E12 then stated a Code Blue and 911 was called, and he and E5 (Nurse) performed CPR (Cardio Pulmonary Resuscitation). R12 also stated that after R6 was pronounced dead by CFD (Chicago Fire Department) paramedics at 9:35pm, he paged Z4 (R6's attending Physician) at 9:45pm, but got no response. E12 also stated he stayed until "sometime after 1:00am" 3-29-14 to complete his charting, and endorsed to E26 (Nurse) that Z4 still hadn't called back. E12 stated he did not call the coroner's office to notify them of R6's death. E12 stated R6's family called a funeral home, which picked up R6's body. No medical doctor was aware of R6's death, or gave authorization for his body to be released to a funeral home.</p> <p>E12 stated he endorsed to E26 to follow up with physician notification regarding R6's death, when</p>	S9999		
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Illinois Department of Public Health

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S9999	<p>Continued From page 14</p> <p>he left after 1:00am of 3-29-14. E26 made no documentation on R6's chart for the entire shift she worked (11:00pm 3-28-14 through 7:00am 3-29-14).</p> <p>E13 stated 5-6-14 at 4:20pm she worked 3-29-14 from 7:00am to 3:00pm. E13 further stated R6's body had already been removed when she came on duty. E13 stated she attempted to call Z4 at 8:37am, 10:27am, 11:39am, and 2:41pm, but was unable to reach him. Nursing notes dated 3-29-14 document these attempts. E13 further stated she endorsed to E4 (Nurse) at 3:00pm that Z4 had not yet called back, and was still unaware of R6's death.</p> <p>Z4 stated 5-19-14 at 12:50pm the facility has his cell phone number, as well as his answering service number. Z4 further stated sometimes his cell phone is not working, due to loss of service. Z4 further stated that as soon as he got the message from his answering service 3-29-14 to call the facility, he did so within the hour. Z4 then stated when he called E4 3-29-14 at 8:30pm, she informed him of R6's death. Z4 further stated nursing should monitor the vital signs on a newly admitted resident every shift for 72 hours, and should check a resident's gastrostomy tube feeding residual every shift. Z4 further stated that if a resident expires and the nurse is unable to contact him within 4 to 5 hours, she/he should notify the Medical Director (Z2). Z4 further stated a physician needs to make the decision of whether to release a resident's body to a funeral home, or if the medical examiner's (coroner's) office should be called. Z4 further stated nurses should call the attending physician for orders one to two hours after the resident is admitted, and those orders should be faxed to pharmacy within two to three hours after they have been received.</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>Z2 (Medical Director) stated 5-19-14 at 1:28pm a resident's nurse should notify him of a resident's death after two hours of attempting to notify the resident's attending physician. Z2 further stated a physician must be notified of a resident's death, and is the one to decide whether the body can be released to the funeral home, or if the coroner's office should be called.</p> <p>Z7 (former Administrator), who was administrator at the time; stated 5-6-14 at 1:05pm there is no facility policy as to when to call the medical examiner/coroner. Z7 further stated a physician needs to make the decision of whether to release a resident's body to a funeral home, or to call the medical examiner/coroner.</p> <p>E2 (Director of Nursing) stated 5-5-14 at 4:02pm stated the attending physician should be notified for orders on a newly admitted resident as soon as the nurse is through assessing the resident and obtaining vital signs. E2 stated 5-19-14 at 10:45am newly admitted residents are to have their vital signs taken and documented every shift for 72 hours. E2 further stated all residents having a gastrostomy tube should be checked for gastrostomy residual every shift. E2 also stated all residents having a tracheostomy with oxygen should have their oxygen saturation monitored every shift.</p> <p>Pharmacy records note R6's admitting orders were faxed to them 3-28-14 at 12:36am. R6 arrived at the facility 3-27-14 at 2:00pm. Z5 (Pharmacy Representative) stated 5-6-14 at 3:38pm R6's medications left the pharmacy at 11:30am 3-28-14, and arrived at the facility at 3:14pm 3-28-14. Pharmacy Delivery Manifest dated 3-28-14 confirms this. Z8 (Pharmacy</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>Technician) stated 5-19-14 at 11:00am deliveries for the facility leave daily at 11:30am and 11:30pm, seven days/week. Z8 also stated that orders faxed to the pharmacy at 12:36am would leave the pharmacy on the 11:30am delivery. Z8 further stated the cut off time to send faxes to pharmacy for the 11:30pm delivery is by 8:30pm.</p> <p>Facility policy titled "Death of a Resident" states, in part "Notify primary MD of death. Follow Medical Examiner policy, if applicable."</p> <p>Facility policy titled "Code Blue/Medical Emergencies" states, in part "Code Blue will be announced for medical emergencies if additional staff is needed to respond. 911 will be notified, if indicated. First aid will be administered. The attending physician on call/nurse practitioner and responsible party will be notified".</p> <p>(A)</p>	S9999		
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Imposed Plan of Correction

Plan of Correction

F 309

This Plan of Correction by Alden Princeton is not an admission that a deficiency exists or that the statement of deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any statements set forth in this 2567.

1. The facility has taken the following actions concerning the deficiency identified on the CMS-2567:

R5's skin was re-assessed for skin impairments and no new impairments were identified.

The facility's shower sheet policy was reviewed to ensure compliance with shower sheets and the skin assessment process.

R5's care plan was reviewed and interventions were implemented as appropriate per the plan of care.

R6 is no longer at the facility

E9 was re-educated on ensuring that residents who are independent with bathing still require a skin inspection on their scheduled shower days.

E8 is no longer employed by the facility.

E13 was re-educated on ensuring documentation is completed post 72 hours for new admission/readmission every shift.

E13, E4, E14 were re-educated on checking residual q shift and prior to medication administration.

E13, E4 and E14 were re-educated on ensuring physician has been made aware of the death of a resident prior to release of the body to a funeral home.

2. The facility has conducted a review to determine if any other resident would be potentially affected by the alleged deficient practices, and there were no residents determined to be affected.

3. To ensure that proper practice continues:

Appendix

All nurses were re-educated on the importance of ensuring completion of skin assessments on shower days.

All CNA's were re-educated on the importance of completing shower sheets as per facility policy.

All nurses and CNA's were re-educated on ensuring interventions are carried out as per the resident's care plan.

All nurses were re-educated on obtaining physician/pharmacy orders, transcription and processing of these orders in a timely manner for a new admission/readmission.

All nurses were re-educated on checking the residual prior to medication administration and every shift.

All nurses were re-educated on assessment and documentation of vital signs, blood glucose results and oxygen saturations in the medical record for a new admission/readmission.

All nurses were re-educated on faxing physician orders to the pharmacy in a timely manner for a new admission/readmission.

All Nurses were re-educated on physician notification in the death of a resident prior to releasing the body to a funeral home.

4. A QA/QI tool was developed and initiated by the Administrator and is being utilized to monitor implementation of this Plan of Correction. The results of the monitoring completed under this Plan of Correction will be submitted to the QA/QI Committee for review and further follow up.

5. Completion Date:

20 days from Receipt of Notice

Assent

Impaired Plan of Correction

Alden Princeton – Plan of Correction

F323 J

Submission of this Plan of Correction by Alden Princeton is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency

1. The facility has taken the following action concerning the deficiency identified on the CMS-2567:
 - R26 is no longer a resident at the facility.
 - An immediate sweep of the entire facility was conducted to determine if there were other sharps (hazardous items) accessible to residents. Any hazardous items were secured by administration.
 - R10 and R31 were re-educated on the policy concerning supervision while using sharps
 - R10, R31, R21, R23, R34, R35, R36, R37, R38, R39 and R40 were all reassessed regarding any safety concerns (use of hazardous items).
 - R15 was re-assessed for the use of the floor mats and placement of his call cord
2. The facility took the following actions to identify other residents that could be affected:
 - A review of all other residents with suicidal ideation, homicidal ideation, aggression and/or depression was conducted. Specific residents were re-assessed based on any signs/symptoms of suicidal ideation, homicidal ideation, aggression and/or depression.
 - The plan of care was revised for residents as necessary
 - Other residents were reviewed to determine if their fall prevention interventions were implemented (and they were in place).
3. The facility has taken the following actions to ensure the problem is corrected and will not reoccur:
 - E 11 is no longer employed by the facility
 - E8 is no longer employed by the facility
 - A review and revision of the facility protocol on sharps distribution was completed
 - In-services with staff were promptly conducted on the importance of monitoring residents who show signs/symptoms that may be considered self-injurious/dangerous.
 - Potential for resident self-injurious behavior
 - Proper supervision of sharps
 - Proper disposal of sharps
 - Importance of timely communication of residents who express potentially dangerous behavior

Amend

- Importance of timely communication of residents who actively express potentially dangerous behavior
- Staff was re-educated on the importance of implementing fall prevention interventions (including floor mats and placement of call cords)
- 4. QA Tools have been developed and implemented. The results of the monitoring completed under this POC will be submitted to the QA/QI Committee for review and follow up to determine future monitoring needs.
- 5. Completion Date: 20 days from receipt of Notice

Accepted