



October 25, 2013

Division of Public Health

State of Nebraska
Dave Heineman, Governor

Jerry Eisenhauer, Administrator
Norfolk Veterans Home
600 E Benjamin Avenue
Norfolk, NE 68701-0830

CERTIFIED MAIL

Dear Mr. Eisenhauer:

The enclosed report documents the results of a licensure inspection which includes one or more findings of noncompliance with the licensure regulations for Skilled Nursing Facilities, Nursing Facilities, Intermediate Care Facilities. The report was prepared following the compliance inspection and complaint investigation at your facility completed on October 10, 2013 by Krista Roeber, Social Worker, Brenda Orlovski, Registered Nurse, Patricia Wolfe, Registered Nurse, Janice Hake, Registered Nurse with the Nebraska Department of Health and Human Services, Division of Public Health.

The violations found did not create imminent danger of death or serious physical harm and no direct or immediate adverse effect on the health, safety, or security of residents residing in the facility. Therefore, the Department requests a written statement of compliance be submitted to the Department within 10 working days of receipt of this letter. The statement of compliance must include the following:

- 1) Steps which have been or will be taken to correct each violation;
- 2) The period of time estimated to be necessary to correct each violation; and
- 3) Signature of responsible staff.

If you fail to submit and implement a statement of compliance, the Department may initiate disciplinary action against the facility license in accordance with 175 NAC 4-008.

Thank you for the assistance and cooperation during the inspection.

If there are any questions regarding this correspondence, you may contact this office.

Sincerely,

A handwritten signature in cursive script that reads 'Dan Taylor RN'.

A small handwritten mark or initials in the left margin, possibly 'EL'.
Eve Lewis, RNC, Program Manager
Office of Long Term Care Facilities
Licensure Unit, Division of Public Health
Department of Health and Human Services
(402) 471-3324

EL/kr

Enc: Compliance Inspection and Complaint Investigation Report

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
LICENSURE UNIT

Compliance Inspection and Complaint Investigation Report

Facility Name & Location: Norfolk Veterans Home
600 E Benjamin Avenue
Norfolk, NE 68701-0830

Investigation/Inspection Dates: October 8, 2013-October 10, 2013

Surveyors: Krista Roeber, Social Worker
Brenda Orłowski, Registered Nurse
Patricia Wolfe, Registered Nurse
Janice Hake, Registered Nurse

175 NAC 12-006.09 Care and Treatment

The facility is responsible for ensuring the physical, mental and psychosocial needs of all residents are met in accordance with each resident's individualized needs and physician orders.

Based on observations, record review and staff interview; the facility failed to provide and to monitor the administration of oxygen for Resident 3 as ordered and in accordance with the resident's care plan. Observations throughout the survey revealed Resident 3 did not have oxygen in place as ordered and no assessments were completed regarding the resident's oxygen saturation (measure of the percentage of hemoglobin in the bloodstream occupied by oxygen). Facility census was 137.

Findings are:

Review of facility policy entitled "Oxygen Administration" with revision date of 10/2010 revealed the following: Before administering oxygen, and while the member (resident) is receiving oxygen therapy assess the following:

- Signs or symptoms of cyanosis (blue tone to the skin and mucous membranes)
- Signs and symptoms of hypoxia (rapid breathing, rapid pulse rate, restlessness and confusion)
- Vital signs
- Lung sounds
- Oxygen saturation

Review of Resident 3's Physician Orders dated 6/1/13 revealed the following:
-Oxygen at 2-4 liters (L) per nasal cannula to keep oxygen saturation above 93%.

Review of Resident 3's care plan dated 7/12/13 indicated the resident was at risk for alteration in respiratory function related to history of smoking and diagnosis of chronic obstructive pulmonary disease. Care plan interventions included;

- Provide oxygen at 1-5 L /minute to maintain oxygen saturations above 90%
- Refer to physician if having respiratory distress
- Check oxygen saturations and listen to lung sounds
- Elevate head of bed if respiratory distress noted

Review of Medication Administration Record (MAR) for 10/13 for Resident 3 revealed the following orders:

- O2 on at 1-5 L/minute to keep O2 saturations greater than 90% as needed for decreased oxygen saturations
- O2 saturations as needed

175 NAC 12-006.09D7 Accidents

The facility must identify and implement standards of care and treatment to prevent resident accidents.

12-006.09D7a The facility's environment must be free from hazards over which the facility has control.

12-006.09D7b The facility must establish and implement policies and procedures which address:

- 1. Investigation, including documentation of the accidents to include identification and evaluation of individual resident causal factors;**
- 2. Method for tracking and identification of trends;**
- 3. Development of interventions to prevent the accident from recurring; and,**
- 4. Reevaluation of the effectiveness of the interventions.**

Based on observations, record review and staff interview; the facility failed to assure Resident's 3 and 6 were protected from falls. Fall interventions were not consistently implemented for Resident 3 and staff failed to assure the call light was always accessible for Resident 6. Facility census was 137.

Findings are:

A. Review of facility policy entitled "Fall Risk Program" (revision date 3/4/13) revealed the following:

If a fall occurs;

- An Incident Report is completed after each member (resident) fall by the end of the shift. Interventions are assessed for efficacy and new interventions are initiated.
- Interventions for the reduction of falls are documented on the care plan.

B. Review of Resident 3's Incident Report dated 7/6/13 revealed Resident 3 was found lying on the floor beside the bed at 9:15 AM. A new intervention was initiated for the staff to toilet the resident as soon as the resident leaves the dining room after meals.

Review of Resident 3's care plan dated 7/12/13 indicated the resident was at risk for falls due to occasional confusion, involuntary tremors, history of self-transfers out of wheelchair, anxiousness and restlessness. Care plan interventions included;

- Pressure alarm (an electronic pressure sensitive sensor pad designed for use in chairs or beds which will alarm if a resident tries to get up without assistance) to wheelchair
- Tabs alarm (a personal alarm with a pull string that attaches magnetically to the alarm with a garment clip to the resident. When the resident attempts to rise out of the chair or bed the pull string magnet is pulled away from the alarm which causes the alarm to sound, alerting the care giver) to be on at all times
- High/low bed to be in lowest position whenever resident in bed
- If resident in wheelchair and appears to be sleepy, staff to attempt to lay the resident down
- Attempt to toilet the resident as soon as the resident leaves the dining room after meals

Review of Resident 3's Fall Risk Assessment dated 7/16/13 identified a score of 13. The assessment further indicated a score of 10 or greater indicated the resident was at high risk for falls.

Review of Incident Report dated 10/5/13 revealed Resident 3 was found on the floor at 9:55 AM. Staff found the resident between the resident's wheelchair and a computer desk. Resident had bright red blood draining from a laceration above right eye and bruising was noted to left bicep and right side of face. A new intervention was initiated for the staff to attempt to lay the resident down if sleeping in front of the computer.

Observations of Resident 3 revealed:

- On 10/8/13 at 8:30 AM, 11:03 AM and 11:36 AM, Resident 3 was in wheelchair with tabs alarm in place to back of the chair. No pressure alarm was evident to the resident's wheelchair.
- On 10/8/13 from 1:09 PM to 1:45 PM, the resident was seated in a wheelchair in front of the computer desk in the residents' television lounge. The resident's eyes were closed and head was bent forward indicating the resident was asleep. No pressure alarm was in place to the resident's wheelchair.
- On 10/8/13 from 2:00 PM to 3:30 PM, the resident was lying in bed in room. The resident's bed was not in the lowest position.
- On 10/9/13 at 7:00 AM, Resident 3 was lying in bed and bed was not in lowest position.

-On 10/9/13 at 8:30 AM, Resident 3 was seated in wheelchair in the dining room. Resident's eyes were closed and head was bent forward indicating the resident was asleep. No pressure alarm was observed to the resident's chair.
-On 10/9/13 at 8:57 AM, the resident was seated in wheelchair in the residents' television lounge. The resident's eyes were closed and head was bent forward indicating the resident was sleeping. No pressure alarm was observed to the resident's chair.
-On 10/9/13 at 10:57 AM, Resident 3 was seated in wheelchair in the hallway outside of the dining room. The resident had eyes closed and head bent forward indicating the resident was sleeping. No pressure alarm was observed to the resident's chair.
-On 10/9/13 from 1:30 PM to 2:30 PM, the resident was lying in bed in room. The resident's bed was not in the low position.

During interview on 10/9/13 from 2:35 PM to 2:47 PM, Registered Nurse (RN)-T confirmed Resident 3 was at risk for injuries related to falls. RN-T further indicated Resident 3 was to have a tabs and a pressure alarm to bed, wheelchair and recliner at all times. RN-T also confirmed the facility staff was to attempt to lay the resident in bed if found sleeping in the wheelchair and resident was to have high/low bed in the lowest position whenever the resident was in bed.

C. Review of Resident 6's Medication Administration Record (MAR) dated 10/2013 indicated the resident was admitted to the facility 9/9/10 with diagnoses of depression, hypertension, congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease and cognitive dysfunction.

Review of Resident 6's current Plan of Care with a review date of 1/9/14 indicated the resident had a decline in mobility related to dementia and generalized weakness, and was dependent on staff for transfers and wheelchair mobility. Nursing interventions included restorative therapy for range of motion (ROM) and strengthening 1 to 5 times weekly, use of mechanical lift and 2 assist for all transfers, placing the electric recliner controls in the pocket of the recliner to prevent the resident from raising the chair and sliding out, and use of a tabs alarm at all times. The Plan of Care did not address the use of a call light to alert staff of need for assistance.

Review of Resident 6's Fall Risk Assessment dated 10/3/13 revealed a score of 11, which indicated the resident was at high risk for falling. The Fall Risk Assessment revealed Resident 6 had a history of falling on 8/13/13.

During observation of nursing care on 10/9/13 from 2:41 PM until 2:48 PM, Resident 6 was observed lying in bed. The tabs alarm was attached to the resident. The resident's call light cord was hanging down on the wall behind the head of the bed and not within reach of the resident. RN-O and Medication Aide (MA)-F provided treatment to the resident's buttocks and repositioned the resident in bed. The resident was left resting in bed. The call light cord remained hanging down on the wall behind the head of the bed and not within reach of the resident.

During interview on 10/10/13 from 8:15 AM until 8:25 AM, the Director of Nursing (DON) verified Resident 6's call light should be accessible to the resident at all times.

During observations on 10/10/13 at 8:48 AM, 10:30 AM and 2:00 PM, Resident 6 was observed lying in bed, and the resident's call light cord was hanging down on the wall behind the head of the bed and not within reach of the resident.

During interview on 10/10/13 at 2:03 PM, MA-D, Nursing Assistant (NA)-R and RN-S verified Resident 6's call light cord was "always" put on the resident's pillow for accessibility while the resident was in bed.

175 NAC 12-006.17B, 12-006.17D Prevention of Cross-Contamination

The facility must prevent cross-contamination between residents in provision of care, sanitation of equipment and supplies, and cleaning of resident's rooms.

Based on observations, record review and staff interview the facility failed to: 1) perform hand hygiene in

accordance with standards of practice during the provision of incontinence cares for Residents 11, 5 and 3 and during a dressing change for Resident 5; 2) clean an oximeter (a sensor device used to check pulse and oxygen saturation) in accordance with facility policy; 3) provide a covering for an elimination product stored in Residents 3 and 5's bathroom to prevent cross contamination; 4) store and maintain respiratory equipment to prevent cross contamination for Resident 11 and an insulin pen (device used to inject insulin for the treatment of diabetes) for Resident 15 to prevent the spread of infection; and 5) sanitize a hydraulic sit-to-stand mechanical lift (a device used to support the weight of the resident during transfers) and a hydraulic sling mechanical lift between resident uses, which had the potential to affect 20 residents (4, 18, 19, 20, 28, 6, 22, 23, 3, 5, 24, 25, 26, 27, 29, 30, 31, 32, 11 and 28) who were identified as using the lifts on a routine basis. Facility census was 137.

Findings are:

A. Review of facility Infection Control policy titled "Hand Hygiene" (dated 2/7/12) indicated staff members were to complete hand hygiene after removing gloves, after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressing. In addition, staff should perform hand hygiene after touching contaminated body sites and before moving to a clean body site during member (resident) care.

B. Review of facility Infection Control policy titled "Cleaning of Multiple Use Items" (dated 2/7/12) revealed multiple use items were defined as those used on more than 1 member. The policy included but was not limited to oximeters. The policy further designated if a multiple use item became visibly soiled, staff were to clean it with soap and water. In addition, staff was to clean all items with a germicidal disposable wipe before removing from the member's room.

C. Review of policy titled "Stand-up Lift, Hydraulic" (revised date 5/15/10) revealed staff were to clean all handles of the lift with a disinfectant wipe before and after member use.

D. Review of policy titled: "Hydraulic Lift" (revised date 12/27/06) revealed staff were to wipe handles of the lift with a disinfectant wipe prior to member use. After the procedure, staff were to wipe all areas on the lift that had member or worker contact.

E. Nursing Assistant (NA)-D was observed to provide Resident 5 assistance with a transfer and incontinent cares on 10/8/13 from 2:40 PM to 3:06 PM. NA-D pushed a mechanical sit-to-stand hydraulic lift from the hallway into the resident's room and positioned the lift directly in front of Resident 5 who was seated in a wheelchair. NA-D did not clean or sanitize the lift prior to securing the resident in the lift. NA-D used the lift to remove the resident from the wheelchair then transported the resident into the bathroom. NA-D obtained a stool riser which had been lying directly on the bathroom floor and positioned the stool riser onto the seat of the resident's toilet before transferring Resident 5 onto the seat. NA-D failed to clean or sanitize the stool riser prior to using for Resident 5. NA-D put on gloves and removed Resident 5's disposable incontinent brief which was soiled with urine. NA-D removed gloves but without washing or cleansing hands retrieved a clean disposable incontinent brief from a storage container in the resident's bathroom and placed on the resident. NA-D then used hand sanitizer, donned clean gloves and proceeded to provide perineal cares for Resident 5. NA-D removed soiled gloves and adjusted the resident's clothing before sanitizing hands. Resident 5 was observed to use left hand frequently throughout incontinence cares to touch perineal and groin area. NA-D cued the resident to use soiled hands to hold onto the handle bars of the lift and transferred the resident back into the wheelchair. NA-D removed Resident 5 from the mechanical sit-to-stand lift and without cleansing or sanitizing the lift placed the lift back into the hallway.

F. Observations on 10/8/13 at 3:13 PM revealed NA-D removed the mechanical sit-to-stand lift from the hallway outside of Resident 5's room and took the lift into an adjoining resident's room.

G. On 10/9/13 from 6:38 AM to 6:48 AM the pressure ulcer treatment to Resident 5's second toe on the right foot was observed. Registered Nurse (RN)-E entered the resident's room, washed hands and donned gloves. RN-E cleansed the wound with wound wash then applied Neosporin Ointment to the tip of gloved finger and rubbed ointment directly on the wound bed. Without removing soiled gloves or washing hands, RN-E applied a clean dressing to the toe wound. RN-E then placed a sock on Resident 5's right foot and adjusted foot pedals to the resident's wheelchair before removing soiled gloves and washing hands.

H. NA-F was observed to provide Resident 11 assistance with a transfer and incontinent cares on 10/9/13 from 6:56 AM to 7:10 AM. A mechanical sit-to-stand hydraulic lift was positioned in front of the resident who was seated on the side of the bed. NA-F failed to clean or sanitize the lift prior to positioning and securing the resident into the lift. NA-F used the lift to transfer Resident 11 into the bathroom and removed the resident's disposable incontinence brief which was soiled with urine. NA-F washed hands, donned gloves and proceeded to provide perineal hygiene. NA-F then removed soiled gloves, adjusted the resident's clothing, transferred the resident and positioned the resident in a wheelchair then placed fall alarms to the back of the resident's wheelchair before returning to the bathroom and washing hands. NA-F exited the resident's bathroom and without washing or cleansing the mechanical sit-to-stand hydraulic lift, removed the lift from the resident's room and placed the lift in the hallway.

I. Observations on 10/9/13 at 7:27 AM revealed NA-F removed the mechanical sit-to-stand hydraulic lift from the hallway outside of Resident 11's room and moved the lift into a resident's room across the hall.

J. During observation on 10/9/13 at 7:36 AM, Resident 11's nebulizer (a machine used to administer medication in the form of a mist into the lungs) machine was sitting directly on the arm of the resident's bedside recliner. The tubing from the machine was draped across the resident's bedside table and the end of the tubing was lying directly on the bare floor.

K. NA-F was observed to provide Resident 3 assistance with a transfer on 10/9/13 from 9:06 AM to 9:25 AM. NA-F pushed a mechanical sit-to-stand hydraulic lift from the hallway into the resident's room, directly in front of Resident 3 who was seated in a wheelchair. NA-F failed to clean or sanitize the lift prior to securing the resident into the lift. NA-F used the lift to transfer Resident 3 out of a wheelchair, toileted the resident and then transferred the resident back into the wheelchair. NA-F failed to clean or sanitize the lift after removing from the resident and placing the lift into the hallway outside of the resident's room.

L. During observation on 10/9/13 at 1:24 PM, Resident 11's nebulizer machine was atop a shelf of a corner cupboard in the resident's room. The tubing from the machine was draped onto the floor, and the end of the tubing was lying directly on the floor.

M. During interview on 10/10/13 from 6:12 AM to 6:35 AM the Director of Nursing (DON) verified facility staff should sanitize the mechanical sit-to-stand hydraulic lift and the mechanical hydraulic lift before and after resident use. The DON further indicated staff should store stool risers in a basin and not directly on the bathroom floor and staff should follow facility policy for washing hands and for storage and cleaning of respiratory equipment.

N. During observation of nursing care on 10/8/13 from 11:16 AM until 11:37 AM, NA-A and RN-B transferred Resident 4 from bed to wheelchair using a full mechanical hydraulic lift. NA-A and RN-B failed to disinfect the mechanical lift prior to use or following the transfer of Resident 4. The mechanical lift was stored in the hallway outside Resident 4's room after use.

O. During observations on 10/9/13 from 6:35 AM until 7:09 AM the following was observed:

-MA-M entered Resident 16's room and checked the resident's pulse by placing an oximeter on the resident's finger. MA-M failed to clean the oximeter after removing the oximeter from Resident 16's finger. MA-M indicated the oximeter would be used to check 7 resident's pulses that day.

-MA-M entered Resident 15's room to assist and monitor the resident who completed an accu-check (A lancet is used to obtain a drop of blood from a fingertip. The blood is placed on a test strip which is then inserted into a meter device which displays the blood sugar result). Resident 15 completed the accu-check and proceeded to self-administer insulin with an insulin pen. After self-administering the insulin, Resident 15 handed the insulin pen to MA-M. MA-M placed the insulin pen in a basket filled with clean lancets. MA-M indicated the lancets in the basket were used for all residents who needed accuchecks.

P. During interview on 10/10/13 at 7:10 AM, the DON indicated the oximeter was to be cleaned between each resident use.

CAP

Issue Identified: **Care and Treatment**—Facility failed to provide and monitor the administration of oxygen for Member 3 as ordered and in accordance with the Member’s care plan. Observations throughout the survey revealed Member 3 did not have oxygen in place as ordered and no assessments were completed regarding the Member’s oxygen saturation.

Corrective Action Plan for those Members Identified	How facility will identify other Members who have the potential to be affected by this deficient practice	Measures that will be put into practice to ensure that the deficient practice will not recur	How facility plans to monitor its performance to make sure that solutions are sustained (QA)	Date/s when corrective action will be completed
<p>1. Will evaluate Mbr #3 each shift to note whether he is exhibiting any S&S of lethargy, increased confusion, asking for momma, shortness of breath. If any of these symptoms occur, oxygen sats will be obtained. If sats below 90%, will apply oxygen per physician’s order.</p> <p>2. Documentation of oxygen saturation level results will be placed in the vital sign section of the medical record.</p>	<p>All members who have physician orders for oxygen administration will be reevaluated for oxygen need.</p>	<p>--Mbr oxygen orders will be reviewed and audited using criteria below:</p> <ul style="list-style-type: none"> • Each current Mbr with oxygen order will have oxygen sats and physical symptoms (cyanosis, shortness of breath, cognition, etc.) will be monitored and documented in nurses progress notes tid x 1 week; • Results of individual Mbr oxygen sats and physical symptoms will be evaluated by physician/APRN; • Individual Mbr oxygen orders will be written or discontinued based on Mbr assessment/need. 	<p>Physician/APRN will evaluate Mbr with 60 day progress note to ensure all mbrs who are receiving oxygen and/or have orders based on individual needs.</p> <p>--ADON’s/Designee will complete initial audit of oxygen administration with results submitted to QA 12/2013 for analysis and trending with changes in plan as indicated;</p> <p>--Results of Physician/APRN evaluation with 60 day progress notes will be submitted to QA quarterly by ADON or his/her designee for analysis and trending Adjustments will be made to CAP as indicated.</p>	<p>by 12/9/13</p>

Corrective Action Plan for those Members Identified	How facility will identify other Members who have the potential to be affected by this deficient practice	Measures that will be put into practice to ensure that the deficient practice will not recur	How facility plans to monitor its performance to make sure that solutions are sustained (QA)	Date/s when corrective action will be completed
		<p>--Mbrs newly admitted to the facility will have respiratory status evaluated by physician/APRN.</p> <p>--Emergency standing order for Mbr. will be re-evaluated by physician/APRN for continued use with orders written based on individual assessment/need.</p> <p>-- Education will be provided to nursing staff related to proper provision and monitoring/documentation on TARS of O2.</p>		

CAP

Issue Identified: **Accidents**—Facility failed to assure Member’s 3 and 6 were protected from falls. Fall interventions were not consistently implemented for Member 3 and staff failed to assure call light was always accessible for Member #6.

Corrective Action Plan for those Members Identified	How facility will identify other Members who have the potential to be affected by this deficient practice	Measures that will be put into practice to ensure that the deficient practice will not recur	How facility plans to monitor its performance to make sure that solutions are sustained (QA)	Date/s when corrective action will be completed
<p>--Mbr 3 had fall prevention alarms evaluated and appropriate alarms initiated based on individual needs. Pressure pads have been dc'd and TABs alarm on at all times. Care Sheet and care plan updated to reflect TABs alarm while in bed and chair. Bed will be placed in lowest position possible when mbr is in bed. This has been added to his current plan of care. Will provide rest periods in a.m. and p.m. for member in bed.</p> <p>--Will evaluate mbr falls at weekly risk mtgs. to note that interventions were implemented and care plan was updated.</p> <p>--Mbr 6 has call light within reach while in room. Member’s cognitive ability and inconsistent ability to utilize call light has been added to current plan of care.</p>	<p>-- Complete initial audit of all member’s in facility to identify which members are assessed to be at risk for falls.</p> <p>--All Mbrs, unless refused, will have access to call light.</p>	<p>-- Incident reports and care plans will be reviewed weekly at risk management team meetings to assure that appropriate interventions are in place</p> <p>--Audit will assure they have appropriate measures in place to prevent falls and call light is accessible.</p> <p>--Education will be provided to nursing staff related to fall intervention processes and call light accessibility.</p>	<p>--MDS Nurses and/or Designee will complete evaluation of call light placement, access and fall preventions implementation by interdisciplinary team with each care plan review</p> <p>--Facility audit results will be reported by ADON or designee to QA 1/1/14 for review and trending.</p> <p>-- Results of Incident reports and care plans reviewed will be submitted by ADON’s to QA for analysis and revision as necessary to assure appropriate interventions are in place.</p>	<p>1/1/14</p>

CAP

Issue Identified: **Prevention of Cross-Contamination**—The facility facility failed to: 1)perform hand hygiene in accordance with standards of practice during the provision of incontinence cares for Members 11, 5, and 3 and during a dressing changed for Member 5; 2) Clean an oximeter in accordance with facility policy; 3)Provide a covering for an elimination product stored in Member 3 and 5’s bathroom to prevent cross contamination; 4) Store and maintain respiratory equipment to prevent cross contamination for Member 11 and an insulin pen for Member 15 to prevent the spread of infection; and 5) Sanitize a hydraulic sit-to-stand mechanical lift and a hydraulic sling mechanical lift between Member users, which had the potential to affect 20 Members who were identified as using the lists on a routine basis.

Corrective Action Plan for those Members Identified	How facility will identify other Members who have the potential to be affected by this deficient practice	Measures that will be put into practice to ensure that the deficient practice will not recur	How facility plans to monitor its performance to make sure that solutions are sustained (QA)	Date/s when corrective action will be completed
<p>Nursing Staff will be educated and competency completed on proper hand washing technique, wound care, glove usage, proper storage of insulin pens, nebulizer tubing and stool risers, cleaning and sanitizing of medical equipment oximetry machines and mechanical lifts. Members 11, 5, and 3 bathrooms will be evaluated for placement of hand sanitizers.</p>	<p>All Members requiring staff assistance with incontinence care, dressing changes, use of stool riser, mechanical lift, receive nebulizer treatments, oximetry monitoring and insulin injections are deemed to be at risk for infection due to cross contamination..</p>	<p>Education and competencies will be completed for nursing staff on these processes by 12/16/2013:</p> <ul style="list-style-type: none"> a. Proper hand hygiene with focus on incontinence cares and dressing changes b. Proper glove usage c. Disinfection of medical equipment used for multiple members (oximetry machines and mechanical lifts) d. Proper storage of nebulizer tubing and removable stool risers when not in use. 	<ul style="list-style-type: none"> 1. ADON’s/ Nurse Supervisors and/or Charge nurses will conduct 2 audits weekly per shift per unit on proper hand washing with incontinence cares, dressing changes, proper use of gloves weekly x 2; biweekly x1 month and monthly x2. 2. ADON’s/Nurse Supervisors will conduct disinfection medical equipment; oximetry and mechanical lifts, 1 time weekly per shift per unit x 2; 	<p>Completion date 1/1/2014</p>

Corrective Action Plan for those Members Identified	How facility will identify other Members who have the potential to be affected by this deficient practice	Measures that will be put into practice to ensure that the deficient practice will not recur	How facility plans to monitor its performance to make sure that solutions are sustained (QA)	Date/s when corrective action will be completed
		<ul style="list-style-type: none"> e. Proper storage and handling of insulin pens. f. Facility will evaluate each members' bathroom for installation of hand sanitizer in units C,D,E,F,G; 	<ul style="list-style-type: none"> biweekly x 1 month and monthly x2. 3. ADON's on each unit will ensure members who are utilizing nebulizer treatments (tubing), insulin pens and/or removable stool riser are stored appropriately. Audits to be completed 2 per shift per week x2 weeks, biweekly x1 month and monthly x2. <p>Results of audits will be submitted to QA for review and analysis of trends.</p>	