



PADONA /LTCN

Pennsylvania Association of
Directors of Nursing Administration

DEDICATED TO SERVICE
COMMITTED TO CARING

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PADONA ENews



Dear PADONA Members,

Thank you to the 37 participants in this year's Leadership Development Course! We had a packed four days of material geared toward DON development. The course was very interactive with great comments and questions. It was a pleasure to get to know each of you! A big thank you to Sophie Campbell and Christopher Lucas for their time and the sharing of their expertise!

Our 2019 convention agenda has been released! Our Early Bird rate is in effect until December 1st! Get your registration in before the rate goes up. This year's educational sessions are grouped into two different tracks. When you register, don't forget to select your track! Once you select your track, you will attend the sessions associated with that track on Wednesday and Thursday of the convention. We have programs geared toward Administrative and Clinical topics. You have the opportunity to gear your educational programming toward your professional development needs/goals.

Our new educational program, Survival Skills for LTC Nurses kicks off this month. Becky Flack will be providing attendees with two full days of educational programming geared towards nursing administration in long-term care. This is a great opportunity for new DONs and to assist you in development of your ADON, Nurse Managers, RN Supervisors, RNAC/MDS Coordinators, Staff Development, Quality Assurance, and other members of your nursing team. A special thank you to Terri Gabany and Grove Manor for their hospitality in hosting our two-day workshop! We are grateful!

This month's Mitigate Your Risk series includes presentations on November 13th by Julia Belucci from Premier Therapy with strategies to mitigate your risk in the areas of pressure ulcers, falls, and weight loss. And, then on November 27th, Rob Leffler from PCA Pharmacies will focus on ways to identify and prevent narcotics diversions. Both are topics you won't want to miss!

PADONA is exploring a training partnership with APIC to provide education and training for our members on the Phase III infection control and infection preventionist training requirements in effect November 2019. We understand many of our members were not able to take advantage of the training previously offered by the Department of Health. We aim to provide future training opportunities that are both cost effective and time efficient.

As we enter the season of giving thanks, PADONA is thankful for each of our members and supporters! We are grateful for the opportunity to partner with you in your journey of caring for Pennsylvania's elders! Wishing you and yours a Happy, Safe, and Healthy Thanksgiving!

All the Best,

Candace McMullen
PADONA Executive Director/Board Chair

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Leadership Development Series

Demonstrate Integrity

To act with integrity may sound like an over-reaching goal, but what it really means is to act in honest and trustworthy ways. It means having a strong and unwavering moral compass. It means living according to your values—even when no one is looking. It is a non-negotiable quality for leaders. It is not always easy to do the right thing for the right reasons, no matter the consequences, but that is what is expected of you as a leader.

Let's look at some examples.

1. You and your direct report are best buds outside of work. Your friend/direct report is a solid team player, contributing to the organization in many ways. She takes initiative and offers to serve on committees, generates great ideas to be more efficient, and her work is timely and well done. She and another co-worker on the same team and also one of your direct reports are both being considered to represent the organization at a state-wide event. Only one can be selected. Both coworkers are stellar employees. Your friend co-worker knows that your opinion matters in the selection process and approaches you to ask that you recommend her for the appointment. (After all, you have been friends since high school). A leader with integrity would decline to interject opinion based on friendship and insist on fairness to both candidates. Leaders who demonstrate integrity do the right thing.
2. One of your staff, Andy, mentions that things are going missing from the supply closet. He tells you that he knows another employee, Zoe, is pocketing items and trying to cover for herself. He gives you this information in strict confidence. After further exploration, you have a private talk with Zoe. She wants to know if it was Andy who snitched on her. You say that is not for you to say, and move on to resolving the issue. Maintaining confidentiality is of prime importance as a leader. If you want people to trust you, you must comply with the boundaries and limits of information that you give others without consent. Leaders with integrity understand communication boundaries.
3. You are interviewing for an Activities manager. One candidate, Marta, a musician, explains she also plays at weddings and other events. In small talk, you mention that your daughter will be getting married and is looking around for musicians. Marta says she would be delighted to play for free for your daughter. Marta is not the best of the candidates. Choosing Marta for the position when there are others more suitable, just so you can book free entertainment for your daughter's wedding is an unethical action. In this situation you are making hiring decisions to promote your self-gain instead of the organization.

There are many, many small ways to exhibit integrity in your day to day behavior.

- Keeping a secret when your friend asks you to.
- Mentioning to the sales clerk that she forgot to charge you for an item.
- Making coffee for the break room when you've taken the last cup.



- Not getting involved in gossip—neither listening to nor spreading it.
- Touting your staff's accomplishments to the board/upper management and playing down your own.
- Being mindful of the organization's supplies, and not using them for your own personal use.
- Not parking in handicapped designated spaces—even if you think you'll only need a minute or two to take care of your business.
- Keeping your staff informed/up to date with what needs to be done, priorities, and future plans.
- Refusing to do anything that is against the organization's policies or your professional ethics.
- Admitting your errors and saying "I'm sorry, I got that wrong."

A strong work ethic serves as a role model to co-workers and staff and demonstrates that you care about your reputation and the reputation of your organization. Demonstrating integrity is what great leaders do, and in doing so, they gain the trust of their staff. Practice it daily and reap the rewards.

-Anne Weisbord

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Anne Weisbord, president of Career Services Unlimited, has been a communications/leadership consultant for over 20 years. She has worked with health care professionals in a wide range of settings helping them become more compelling, confident, and articulate speakers and leaders. She has been a keynote speaker and presenter at senior care facilities, nursing organizations, and in staff development in hospitals. She has had personal experience working closely with long term care staff. www.awlearningconsultants.com.

Clinical Pearls

MORE FLUOROQUINOLONE WARNINGS!.....What Next? Are we being Proactive?

Nick Zaksek Pharm D. Infectious Disease Pharmacist.

The FDA has required changes in the labeling of all systemic (i.e. tablets, capsules and injectable) fluoroquinolone antibiotics to strengthen warnings about the risk of severe hypoglycemia and mental health effects associated with their use.

Quinolones are antibiotics used extensively for UTI, skin infections, and Respiratory infections, especially in nursing homes. An FDA review identified 67 cases of hypoglycemic coma associated with fluoroquinolone use, 22 of which resulted in death or disability. Most cases occurred in patients with risk factors such as diabetes, older age, or renal insufficiency. Patients taking a fluoroquinolone (especially those with risk factors) should be counseled about the symptoms of hypoglycemia and monitored for blood glucose disturbances.

Warnings over the years about fluoroquinolones:

2008, FDA added a warning for the increased risk of tendonitis/tendon ruptures.

2011, FDA added a warning for risk of worsening symptoms in those with Myasthenia gravis.



2013, FDA required updated labels to reflect the potential for irreversible peripheral neuropathy.

2016, FDA enhanced warning about the disabling and potentially permanent side effects involving tendons, muscle, joints, nerves and the CNS.

2018, FDA adds new label warnings for mental health side effects such as disturbances in attention, disorientation, agitation, nervousness, memory impairment, and delirium. Additionally, the blood glucose disturbance section of the label now must explicitly reflect the potential risk for coma with hypoglycemia.

FDA-Approved Fluoroquinolones For Systemic Use	
Generic Name	Brand Name
moxifloxacin	Avelox
delafloxacin	Baxdela
ciprofloxacin	Cipro
gemifloxacin	Factive
levofloxacin	Levaquin
ofloxacin	Floxin

Other adverse effects associated with systemic fluoroquinolones include tendonitis/ tendon rupture, C. diff infection & (except for delafloxacin) QT-interval prolongation & torsade de pointes.

The FDA recommends avoiding use of fluoroquinolones in patients with uncomplicated UTI, acute sinusitis, or acute exacerbation of chronic bronchitis, except when no alternative treatment options are available because the risks outweigh the benefits in these patients.

Many nursing homes are focusing on using less quinolones and doing an amazing job of decreasing their fluoroquinolone use. We need to be proactive and vigilant to create and sustain a campaign to use fluoroquinolones wisely.



Vendor Spotlight

PADONA's November Vendor Spotlight is **Brockie Pharmatech**! We are so grateful to **Brockie** for their ongoing **support of so many of our PADONA initiatives! Brockie is a premier sponsor of our annual convention hosting the infamous Martini Bar at our gala reception. In 2019, they are also sponsoring the gift cards for our door prize giveaways! Mitch Haines, a Brockie representative, dedicates his time in service on our Board of Directors and Chair of our Vendor Advisory Committee. Mitch is very dedicated to PADONA initiatives and always looking for ways to support our success!**

On Behalf of The PADONA Board of Directors...We Express our Appreciation and Thanks to Mitch and Brockie Pharmatech's Contributions to our Success!



Brockie Pharmatech
(888) 276-2543

We are a family owned pharmacy provider that understands the importance of providing the most comprehensive level of customer service available in today's economy. A top-notch pharmacy provider specializing in high touch, high tech medication fulfillment for residents in nursing homes, personal care/assisted living, and group home settings. With a business model that locates our pharmacies within one hour of our clients, we are able to support our commitment of being "always at your service!"

A Review of Real Life "Immediate Jeopardy" Citations from 2018

Sometimes it is helpful to review citations from other nursing homes to better assist you with understanding where your opportunities might be for process and performance improvement. A sampling of actual deficiencies cited in Pennsylvania where immediate jeopardy to residents was identified is included below. The information contained below was obtained from the Full Text of 2567 Statements of Deficiencies available on the CMS Five Star website.

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html>

FTAG 0925 S/S: L

Facts of Citation:

- On initial tour of the kitchen there were 14 live cockroaches and two dead stink bugs observed in the dish area and one dead stink bug by the steam table. There was one small live bug on the steam table.
- The facility contracted with a Pest Control company and recommendations on the 11/14/17 invoice included to clean food debris under and behind equipment, on stainless steel counters, in corners, and advise that all cracks and crevices be eliminated.



- Observation of the kitchen during survey in January 2018 revealed that the floors under and behind the equipment and in corners were dirty with food items, leaves, and dirt. There were two leaking pipes in the dish area creating wet conditions under/on top of equipment. The red buckets used for sanitizing the counters were on the floor containing brownish water and used towels. The kitchen's walls and containers on the walls had a brown/black substance on them. There was an unknown/offensive odor in the dish area. The ventilation hood had a brown/black substance on it. The opening of the outside plastic packages for two loaves of bread was lying on a rug with brown/black areas. Cracks and crevices were observed in the corners and in the flooring underneath the equipment.
- The kitchen area had a weekly cleaning schedule with a spreadsheet that was to be initialed when each daily cleaning task was completed. When reviewing the spreadsheets, it was determined that each monthly spreadsheet was missing a significant number of initials of the staff members completing the cleaning tasks. An interview with the Dietary Manager confirmed that the weekly cleaning schedule was not being followed and cleaning tasks were not getting done.

Immediate Jeopardy (IJ) was identified in the kitchen because of 14 live cockroaches in the dish area and one small live bug on the steam table.

FTAG 0658 S/S: K

Facility failed to ensure nursing services provided met professional standards of quality regarding medication administration as set forth in the Pennsylvania code Title 49. Professional and Vocational Standards, Section 21.145 (b) Functions of the Licensed Practical Nurse for 17 of 38 residents.

- The facility Agency Orientation policy indicated that the Agency staff must meet Pennsylvania requirements for working in Long Term Care. As defined in the 28 Pa. Code Long Term Care Facilities Licensure Guidelines 201.3 (i), a Nurse Aide (NA) is an individual providing nursing or nursing-related services to residents in a facility who does not have a license to practice professional or practical nursing in the Commonwealth.
- The Pennsylvania code Title 49 - Professional and Vocational Standards, Section 21.145 (b) Functions of the Licensed Practical Nurse notes that the LPN (licensed practical nurse) administers medications and carries out therapeutic treatment prescribed as ordered for the patient.

Facts of Citation:

- Review of information submitted by the facility to the PA Department of Health revealed that Agency Employee was a NA and passed medications to residents.
- The Medication Administration records revealed that Agency NA administered medications to 17 of 38 residents. The facility investigation revealed that Agency NA Employee did not identify themselves as an NA and did not inform anyone that they were not a Licensed Practical Nurse (LPN).
- Investigation revealed that it was unknown if NA Employee wore a name badge.
- Agency NA Employee credentials were not verified prior to working.

FTAG 0607 S/S: K

Facility failed to ensure that residents were protected from neglect when they failed to ensure all staff received mechanical lift and abuse training and one of three residents reviewed was transferred without assist or a mechanical (Hoyer) lift, as per physician's orders. This placed residents in the facility in an Immediate Jeopardy situation.



Facts of Citation:

- Review of an Electronic Report sent to required agencies regarding this resident revealed that an agency Nurse Aide (NA), working in the facility, transferred a Resident from the bed to her wheelchair without assist of other staff or a mechanical lift, as outlined in the resident's care plan and physician orders. This action resulted in the Resident incurring a laceration to her right leg, and uncontrolled bleeding from the wound, which required a transfer to the hospital. At the hospital, the Resident received 9 sutures to close the wound.
- Review of NA written statement revealed that she put resident in the chair after changing her brief from being soiled. "The resident asked for a necklace, so I gave her the box and she choose one and we proceeded to go out the door. When we got to the door blood started to run and drop on floor. I then alerted nurse. I checked her bed and room and no blood anywhere else. "
- The NA in question had no documented training on the facility's abuse policy, and the identification of and proper implementation of the resident's transfer status.
- Review of the facility files for all agency staff who have provided resident care in the facility revealed 32 agency staff who had no documentation of education on the transfer/mechanical lift policy, that included 2 Registered Nurses, 5 LPN's, and 25 Nurse Aides.

An Immediate Jeopardy situation was identified to the Nursing Home Administrator and the Director of Nursing related to lack of training agency staff on the facility's abuse policy and the resident transfer policy. Without the proper training, staff may not know what constitutes abuse and neglect. Without the proper transfer training, including the identification of the residents' transfer status, staff would not know the correct method of transferring the residents, resulting in additional harm to the residents.

FTAG 0689 S/S: K

The facility failed to ensure the resident's environment was free of accident hazards and harm, for 6 of 71 residents identified as cognitively impaired, when the physical therapy room was left unlocked and unattended with an unlocked hydrocollator holding hot steaming water, measuring 161.4 degrees Fahrenheit (F), placing the residents at risk for harm and the residents at the facility in Immediate Jeopardy.

Facts of Citation:

- Observation revealed both entry doors of the therapy room were unlocked. A hydrocollator was in the therapy room, turned on, and full of fluid and steam packs. The hydrocollator had a lid with a handle, which was easy to open. The hydrocollator used by the facility measures 33 inches tall and 20 inches wide making it easy for anyone sitting in a wheelchair to lift the lid, lean into the area of steam and hot water with their head, or reach into the hot water with their hand(s). A chain and lock were hanging on the side of the unit and was not in use.
- The facility did not have a policy for safety and storage of the hydrocollator.
- Additional observation revealed an unlocked wound care cart in the hall of resident care unit. All drawers were accessible by pulling on them. Inside the top drawer were a pair of scissors and a hemostat.

FTAG 0943 S/S: K

The facility failed to provide an effective employee training program for freedom of resident abuse, neglect, exploitation and misappropriation of resident property related to identification of activities or incidents that constitute abuse, neglect and exploitation; and reporting of incidents that constitute abuse, neglect, and exploitation, as determined by the Facility Assessment and staff need. This failure resulted in actual harm to four residents and constituted Sub-standard Quality of Care (SQC) and an Immediate Jeopardy.



Facts of Citation:

- Review of resident incident report noted they accidentally dropped a cup of coffee down the front of the resident resulting in blistered areas on the abdomen and bilateral (both sides) inner thighs. The lid on the resident's coffee cup was on, but the liquid poured out of the spout of the sippy cup (two-handled safety mug with secured lid).
- Further review revealed no documentation of witness statements from any staff members who were present at the time of the incident OR documentation of an interview with the resident who was assessed as being cognitively intact.
- Interview with the dietary supervisor stated that the incident occurred in the resident's room at lunch time and indicated that this resident had her own sippy cup in her room that she preferred to use and that after the lunch tray was delivered to the resident, a nursing assistant poured the resident's coffee from the one handled facility's mug into the resident's personal two-handled mug. Upon assessment of the mug and lid, it was noted that the lid did not fit properly on the resident's two-handled mug and was too small.
- Review of a prior incident nurse's note revealed that resident accidentally dropped a cup of coffee down the resident's front resulting in blistered areas on the abdomen and bilateral inner thighs, that the lid was in place on the resident's coffee cup, but the liquid poured out of the spout of the sippy cup. The resident's physician was notified of the incident and ordered treatment to the burned areas along with an order to consult with a facility contracted wound care specialist.
- The nurse's note indicated burn areas were noted to mid abdomen measured 12.0 centimeters (cm) long by 5.0 cm wide by 0.1 cm in depth; right upper inner thigh measured 8.0 cm long by 7.0 cm wide with no depth documented; left upper inner thigh measured 8.0 cm long by 3.5 cm wide with no depth documented; and pubic area (pelvis) measured 2.0 cm long by 1.5 cm wide with no depth documented.
- Review of a Certified Registered Nurse Practitioner (CRNP) wound consult report revealed this resident was seen in follow up for wound management for FTW (full thickness wound - wound that extends below the top layer of skin and may also involve muscle and supporting areas). The wound consult report indicated the resident was alert, ate orally, and was quadriplegic requiring total care. The wound consult report went on to document the four burned areas as follows: full thickness ulceration of the mid abdomen measured 12.0 cm long by 9.5 cm wide by 0.1 cm in depth; full thickness ulceration of the right upper inner thigh measured 12.5 cm long by 9.3 cm wide by 0.1 cm in depth; full thickness ulceration of the left upper inner thigh measured 11.5 cm long by 12.0 cm wide by 0.1 cm in depth with some blistered areas; and full thickness ulceration of the pubic area measured 7.2 cm long by 2.5 cm wide intact clear fluid filled blister.
- Further interview with Dietary Manager revealed that:
 - The coffee was brewed by facility staff in the dietary kitchen and emerges from the coffee maker at 200 degrees Fahrenheit.
 - Immediately after brewing, staff pours the coffee into one-handled mugs. Staff allows the poured coffee to rest for approximately 20 minutes, then plastic lids with a slit are placed on top of each mug, mugs are loaded onto the food carts, and carts are delivered to the units for distribution.
 - Hot liquids are served to residents in the main dining room on the first floor at 175 degrees Fahrenheit and hot beverage temperatures do not exceed 175 degrees Fahrenheit at point of service (moment the cup is served to a resident for consumption).
- Further review of the facility's food temperature record indicated that the facility's serving temperature standard for hot liquids was 170 degrees Fahrenheit (five degrees Fahrenheit less than the 175 degrees Fahrenheit as established in interview with The Dietary Manager).
- The food temperature record documented food/beverage temperatures upon service to the residents: between 172-190 degrees Fahrenheit.
- There was no evidence of education provided to staff on what safe hot beverage/liquid foods serving temperatures were and when staff was to monitor hot beverage/liquid foods temperatures.



FTAG 0684 S/S: K

The facility failed to assess and monitor 10 of 12 residents receiving blood thinning medication causing actual harm to residents who required hospitalization or prompted a delay in treatment related to abnormally elevated blood clotting levels. This failure placed residents receiving blood thinning medication at a high risk for injury and resulted in an Immediate Jeopardy situation.

Facts of Citation:

- The facility protocol for residents taking blood thinners instructed that staff were to ensure that a PT and INR level was drawn twice weekly. The protocol further stated that based on the results of the INR blood test, staff were to use the following instructions as orders given physician:
 - INR of 0-1.49, Increase dosage by 1 milligram (mg);
 - INR of 1.50-1.99, Increase by 0.5 mg;
 - INR of 2.00 -3.00, No Change;
 - INR of 3.01-4.99, HOLD dosage, check levels daily, until level is less than 3, then restart blood thinner minus 0.5 mg of current dosage; and
 - INR of greater than 5, HOLD dosage, call physician, check levels daily until level is less than 3, then restart at the current dosage minus 1 mg.
- The protocol failed to indicate a safe maximum dose (how high a nurse could increase the dosage of based on the protocol) or provide direction to staff with a “do not exceed” dosage indicator.
- This 92-year old resident was on Coumadin for Atrial Fibrillation and aspirin 81mg daily.
- Nursing progress note revealed blood noted in resident’s incontinence brief and added that the blood appeared to come from the resident's penis. The nursing progress note additionally stated that the nurse notified the CRNP of the bleeding.
- Labs were obtained, and PT was greater than 102.0, and INR was greater than 10.17.
- Resident sent to hospital ED and treated with Vitamin K 10 mg IV and required a CT of the head to rule out acute bleeding in the brain or stroke. At the time of noted bleeding, the resident was taking Warfarin 19 mg. The resident returned from the hospital on Warfarin 5 mg.
- There was no written policy or procedure for the use of the facility protocol, no current facility process, or designated staff member, to monitor the PT/INR values for any abnormal trends that could be reported to the facility's Quality Assurance Committee for review and evaluation, no documented evidence available for review that the facility's pharmacy was reviewing any resident's medication regimen, including high alert medication usage, and there was no documentation that the facility's contracted laboratory was reviewing residents on the Protocol for any unsafe range/swing in values.

Based on these findings, Immediate Jeopardy to the health and safety of the residents whose anticoagulation medication was managed based on the Protocol was identified.

FTAG 0689 S/S: K

The facility failed to provide supervision and monitoring of food temperatures related to microwave use on seven of eight nursing units. This failure to monitor food temperatures of food reheated in microwaves put residents at high risk for a burn injury and resulted in an Immediate Jeopardy situation.



Facts of Citation:

- During an observation, a dietary worker was observed heating up a pasta entree that was brought in by a resident's daughter. The pasta entree was carried from the food serving pantry and placed in the microwave by the dietary worker. The surveyor noted the cooking time on the microwave to be one minute and twenty-two seconds. After the microwave stopped, the dietary worker removed the plate out of the microwave and placed the plate in front of the resident who proceeded to eat the food. The Dietary worker confirmed that she did not test the temperature of the food after she took it out of the microwave and gave it to the resident to eat.
- Regarding the process and procedures for heating food in the microwave for a resident, an employee reported that when a resident makes a request to have their food heated in the microwave, she heats it up in the microwave until she thinks it is hot enough, and then she gives it to the resident to eat. When asked if she takes the temperature of the food, the employee confirmed that she does not take the temperature. She stated, "There are no thermometers up here. The thermometers are downstairs in the kitchen."
- An interview with the resident's representative revealed that there was a microwave available in the activity room available for use by residents and their families at any time without supervision from facility staff.
- An observation of the activity room after the interview revealed a microwave on the counter that was plugged in and operational. No staff was present in the room at the time of the observation. A staff member then briefly entered the room and stated that, "residents can help themselves to anything in the room."
- A separate observation revealed a door labeled *Pantry* that was open and unattended. No staff was present in or near the Pantry at the time of the observation. Inside the Pantry were two microwaves, one sitting on the counter and the other mounted on the wall, and an oven. Both the microwave on the counter and the oven were able to be activated/turned on by this surveyor. When asked what to do if a family brought in food from outside to be reheated for a resident, she stated that the nurse aide had to heat it up.
- The facility policy, *Use and Storage of Food Brought to Patient/Residents from Outside Guidelines*, stated:
 - If the prepared food must be reheated before service, it may be reheated in a microwave available on the resident's unit. These foods may not be brought into, or reheated in, the Dining Services Department.
 - The FDA Food Code requires that all leftover foods that have been pre-cooked or used as an ingredient, be reheated to 165 degrees F.
 - Thermometers will be available on resident units and must be sanitized between each use.
 - There was no statement about checking the temperature of the reheated food before serving to a resident to avoid burning the resident.
- During an interview with Unit Manager, 14 residents would be able to get to the microwave on their own and considered at risk of getting burned by improper use of the unattended microwaves.

Based on these findings, Immediate Jeopardy to the health and safety of the residents was identified to the Nursing Home Administrator. The facility failed to provide supervision and monitoring of food temperatures related to microwave use on seven of eight nursing units.

FTAG 0689 S/S: K

The facility failed to adequately supervise and maintain each resident's environment to ensure that the residents remained free of accident hazards created by increased temperatures of hot liquids served to residents. One of 48 residents reviewed sustained a hot beverage spill, resulting in actual harm to that resident. This failure placed the residents at a high risk for injury and resulted in an Immediate Jeopardy situation.



Facts of Citation:

- The facility's incident and accident report noted during the breakfast meal service in the main dining room, a resident spilled a cup of coffee onto the right thigh area.
- The nursing staff documented that the resident was experiencing pain in the areas of the blistering on the right thigh.
- The Minimum Data Set assessment indicated that this resident required supervision during eating.
- The occupational therapy assessment also indicated that this resident required supervision during eating due to conditions of abnormal posture and lack of coordination. This assessment also indicated that this resident was always incontinent of bowel and bladder.
- The facility's person-centered care plan indicated that this resident required supervised feeding.
- The facility's investigation report of this incident noted that at 5:00PM, the shift supervisor was called to the resident's room to examine the blistered areas that were found by the nurse aide performing incontinence care for the resident. The resident reported that the coffee spill and burn happened at the breakfast meal that morning.

The facility failed to provide adequate supervision for eating for the resident during the breakfast meal. The coffee spill and burn were not identified until 5:00PM that evening.

- According to the documented report, the burn was not discovered until the nurse aide on the three to eleven nursing shift found the coffee-soaked sweat pants and blisters on the resident's right thigh.
- According to the Nurse Practitioner's assessment, the resident had left-sided paralysis. The wound specialist documented a partial thickness injury of the right proximal knee 2.0 cm by 3.0 cm by .1 cm. The wound base was documented as a ruptured blister. The wound specialist documented another partial thickness injury to the right thigh 3.5 cm by 3.5 cm by .1 cm. The wound base was documented as a ruptured blister. The wound specialist also documented additional partial thickness injuries of the right thigh. The wound base was described with multiple intact serous blisters six blisters with 2 double blisters. The Wound Nurse documentation noted that the wound measured 30.0 centimeters (approximately 12 inches) in length, 7.0 centimeter (approximately 3 inches) in width and had a depth of 0.1 centimeter and had dried exudate.
- The facility's dietary policies and procedures for serving hot liquids revealed that the facility was to serve these liquids at temperatures between 125 degrees Fahrenheit and 155 degrees Fahrenheit.
- **It was determined that the facility's dietary staff was not following their established policies to ensure proper serving temperatures for the residents.** The facility's temperature logs being recorded by the dietary department staff recorded were not within the facility's dietary policy range. The temperatures recorded ranged between 160 degrees to 191 degrees Fahrenheit.
- Interview with the Director of Dietary Services and the Nursing Home Administrator revealed that the facility has a policy to monitor temperatures and hot beverages that are served to the residents. The facility policy indicated that hot beverages were not to exceed 125 to 155 degrees Fahrenheit at the point of service to the resident(s). The facility policy indicated that the Dietary Director and Dietitian would monitor the point of service temperatures of the foods and beverages by conducting periodic tests of them.
- The failure of the facility to adequately monitor hot beverage temperatures to prevent scalding/burning of the residents was confirmed with the Nursing Home Administrator and the Director of Dietary Services, who presented the survey team with point of service temperatures that were substantially above the facility's established policies. The service temperature recorded for coffee ranged between 163-185 degrees Fahrenheit. Although these elevated temperatures were being recorded, the facility's administrative staff had taken no action to correct the problem.

The facility failed to ensure each resident received adequate supervision to prevent accidents and failed to ensure the resident environment remained free of accident hazards related to hot beverages that caused actual harm to one resident and placed other residents at risk for potential harm, identifying an Immediate Jeopardy situation.



FTAG 0600 S/S: J

The facility neglected to monitor and assess a resident for a change in condition, when the resident became unresponsive following a fall and subsequently died. This failure placed the residents at high risk of harm from neglect and placed the facility in an Immediate Jeopardy Situation.

Facts of Citation:

- Review of the facility policy, Neurological Evaluation, revealed that any resident with the potential for head trauma injury or having an acute change in level of consciousness will receive 72 hours of neurological evaluation, following notification of the physician. In addition, the policy indicated that the neurological assessments were to be completed as follows: a. every 15 minutes for the first hour, b. every hour for the next three hours, c. every two hours for the next four hours, d. every four hours for the next sixteen hours and e. every eight hours for the next forty-eight hours.
- Review of facility policy Do Not Resuscitate noted that all residents will be resuscitated without observable signs of life unless they have a Do Not Resuscitate (DNR) order and CPR will be initiated on all residents without observable signs of life unless a DNR order has been obtained.
- Review of facility policy Change in Medical Condition revealed that the facility shall provide notice of changes in medical condition related to but not limited to incidents and other care issues in a timely manner. Continued review of the policy revealed no specific timelines had been developed for physician notification regarding changes in residents' medical condition. The policy indicated that timeliness may be defined based on the severity of situation, time of day and responsible party/designated person/facility expectations.
- Review of the clinical record revealed that the resident had a history of falls and in a period of three days, sustained four falls.
- There was no medical record documentation and no physician orders related to the resident's code status.
- The resident was found lying on the floor near his bed around 11:00PM. Documentation related to the fall revealed that the fall was unwitnessed and that the resident sustained a skin tear and a bruise in the head and knee area as a result of the fall. It was also noted that the cover to the resident's night light had shattered as a result of the fall.
- Following the fall, the resident was transferred into a wheelchair and brought to the nurse's station for staff to monitor. The clinical record revealed that facility staff had contacted the resident's physician regarding the fall and initiated neurological checks as per the facility policy.
- Review of facility documentation related to the resident's fall revealed a completed Neurological Flow Sheet following the resident's fall for 8 hours.
- The resident was found unresponsive at approximately 7:15AM and was subsequently pronounced dead at 7:17AM; however, the completed neurological evaluation form indicated that she had taken the resident's vital signs and completed a neurological evaluation at 7:20AM.
- During interview, the employee admitted that she had not completed the 7:20AM neurological evaluation and that she had falsified the documentation. In further interview, the employee indicated that the remaining neurological evaluations had been completed as documented.
- Observation of the facility's camera footage revealed that following the resident's transfer to the lobby at 11:44PM until 7:00AM, (a period of over seven hours), the employee had not completed any of the scheduled neurological examinations.
- Facility staff had contacted the physician regarding the resident's fall at 12:30AM and were directed to continue monitoring the resident's neurological checks.
- Continued review of facility documentation related to the fall indicated that the resident had remained in the lounge area for the remainder of the night.



- At approximately 7:15AM, the facility's Staffing Coordinator had arrived on the first floor and observed several employees lifting the resident from a reclining chair into a wheelchair. This employee further indicated that she overheard staff say that the resident had died.
- Review of the clinical record revealed no documentation that staff had initiated any resuscitative efforts for the resident.
- Observation of facility camera footage of the first-floor lobby and elevator areas for this time period confirmed staff did not attempt any resuscitative measures upon finding the resident unresponsive.
- Observation of the resident's room at 11:00AM with a representative of the Police Department revealed the presence of a recessed night light on the wall adjacent to the resident's bed. The night light was noted as shattered with multiple missing pieces noted. Continued observation of the resident's room revealed the presence of a large indentation in the wall, adjacent to the night light, measuring approximately twelve inches long by four inches wide.
- Further review of the facility's camera footage revealed that following the resident's transfer to the lobby at 11:44PM until 7:00AM, a period of over seven hours, the employee also neglected to re-attach the resident's scheduled tube feeding, causing the resident to miss six hours of nutritional support.
- Review of facility camera footage revealed that the resident had not been toileted throughout the night nor had the employee checked in with the resident to see if there was anything the resident needed/wanted during the course of the night.
- Interview with an employee who assisted the resident back to bed stated the resident's brief was heavily saturated with urine and feces at the time.

Based on the above findings, Immediate Jeopardy to the health and safety of residents was identified. The facility neglected to complete neurological evaluations as required for one resident following an unwitnessed fall, neglected to toilet the resident throughout the night and neglected to administer the tube feeding as ordered. The facility also failed to respond to an acute change in the resident's medical condition following the fall resulting in actual harm and death to one resident and placed other residents at risk for potential harm creating an Immediate Jeopardy situation.

FTAG 689 S/S: J

The facility failed to adequately supervise and maintain a safe environment for one resident who accessed the roof through an unsecured second floor window resulting in the potential for serious harm. This failure placed the resident at a high risk for injury and resulted in an Immediate Jeopardy situation.

Facts of Citation:

- Review of the information submitted by the facility revealed a resident was observed by an employee to be on the facility's roof from 3:15PM until 3:20PM when the resident then voluntarily reentered the building through their bathroom window.
- The resident's diagnosis included obsessive-compulsive disorder, impulsiveness, recurrent depression, and unspecified intellectual disabilities.
- A Certified Registered Nurse Practitioner (CRNP) progress note revealed the resident had increased anxiety and was pacing the halls with fist doubled up, expressing a desire to be out of the facility.
- Nursing progress notes noted increased agitation and behaviors, using the roommate's computer without permission, banging doors, and being verbally abusive to staff. Nursing progress notes also revealed the resident was seen on the kitchen roof by the staff and that the window in the bathroom was unlocked and able to be opened. After returning into the building from the roof, the resident was threatening harm to staff and then broke into the dining room and called his/her mother on the phone and stated to her he/she was going to jump off the roof.



- The Director of Nursing (DON) stated the facility was unaware of the documentation in the History and Physical stating the resident had a suicide plan to jump out a window but should have been aware of this information.
- The Maintenance Director stated that at the time of the incident, maintenance staff had been notified to check the windows. This resident's room window was not secured and was able to be opened.
- An audit of all the windows was completed and revealed two additional windows on the unit that were able to be opened, which were then secured.
- The Maintenance Director stated that the windows were not routinely checked to prevent roof access and were not checked when this resident was admitted.

The facility failed to ensure each resident received adequate supervision to prevent accidents, and failed to ensure the resident environment remained free of accident hazards related to roof access through unsecured windows with a resident who had suicidal ideations that caused the potential for more than serious harm to one resident, and placed other residents at risk for potential harm, identifying an Immediate Jeopardy situation.

Submitted by:

Candace McMullen, RN, NHA, MHA, CLNC, CNDLTC

PADONA Executive Director/Board Chair

PADONA's 31st Annual Convention

Wednesday, April 3, 2019 through Friday, April 5, 2019

We changed the schedule for our 2019 convention based on the responses to our recent survey.

[Convention Overview Letter](#)

[Register Prior to December 1, 2018 for the Early Bird Pricing](#)

Welcome New Members

- Chelana Crawford - Concordia Lutheran Ministries - Area I
 - Jimi Imm - Clarview Nursing & Rehab Center - Area I
 - Yola Lindo - Phoebe Berks - Area III
 - Angela McCray - Concordia @ Villa St. Joseph - Area I
 - Carrie Ritrovato - Wesley Enhanced Living Main Line - Area III
 - Jennifer Silva - Good Shepherd Rehab Network - Area III
 - Heather Sztobryn - SpiriTrust Lutheran - Area II
 - Richard Tuvell - Inglis House - Area III
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