

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 14, 15, 18, 19, 20 and 21, 2016</p> <p>Facility number: 000255 Provider number: 155364 AIM number: 100273280</p> <p>Census bed type: SNF/NF: 89 Residential: 48 Total: 137</p> <p>Census payor type: Medicare: 3 Medicaid: 86 Other: 48 Total: 137</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on July 25, 2016 by 17934.</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy and to address residents in a respectful manner during the provision of care for 3 of 5 residents reviewed for dignity (Residents #3, #9, and #11).</p> <p>Findings include:</p> <p>On 7/19/16 at 3:46 P.M., Resident #3 was observed during care of her enteral feeding tube. Nurse #2 was observed to pull up resident's gown, expose her abdominal area and disconnect her</p>	F 0241	<p>This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</p> <p><u>F241-Dignity and Respect of Individuality</u> What corrective action(s) will be</p>	08/19/2016

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	<p>Percutaneous Endoscopic Gastrostomy (PEG) feeding tube from the feeding pump tubing. Nurse #2 reached for his stethoscope around his neck and was heard to say "oh (expletive deleted)" when the stethoscope got stuck on his nametag. Nurse #2 then flushed the PEG tube with water. Nurse #2 did not pull the privacy curtain or close the door to the resident's room during the procedure and did not explain to Resident #3 what care was going to be done prior to providing care.</p> <p>On 7/19/16 at 4:06 P.M., Resident #9 was observed during care of his enteral feeding tube. Nurse #2 was observed to pull up the resident's gown, exposing the abdominal area, and disconnect the PEG feeding tube from the feeding pump tubing. Nurse #2 flushed the resident's tube and reconnected the tubing. Nurse #2 did not speak to Resident #9 before, during, or after the procedure and did not close the privacy curtain or door. Following the procedure, Nurse #2 asked COTA (Certified Occupational Therapy Assist) #4 to help pull Resident #9 up in bed. COTA #4 lowered the head and foot of the bed while Nurse #2 went to the opposite side of the bed. COTA #4 and Nurse #2 conversed with each other as they pulled the resident up to the top of the bed and elevate his head.</p>		<p>accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents had the potential to be affected by this practice. All staff who assist residents throughout the day will be educated on Tone and Approach Expectations (Attachment 1-3). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents had the potential to be affected by this practice. All staff will be in-serviced on Byron Health Center's Culture and Resident Credos with emphasis on showing respect and honoring dignity (Attachment 3-4). All staff will be interviewed for knowledge regarding dignity and respect. (Attachment 5).</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>At Byron Health Center we have the highest expectations for all staff to adhere to the Byron Culture and Resident Credos. We discuss the Resident Credos in our interview process, hiring process, orientation process and on an ongoing basis with all staff. Staff are educated on the Culture as well as abuse, neglect, tone</p>	

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	<p>Nurse #2 and COTA #4 did not pull the privacy curtain or close door to the resident's room prior to providing care and did not explain to Resident #9 what care was going to be provided.</p> <p>On 7/19/16 at 4:15 P.M., Resident #11 was observed during care of his enteral feeding tube. Nurse #2 pulled up Resident #9's gown and disconnected the tubing from the feeding pump. Nurse #2 checked placement of the PEG tube by injecting a large amount of air into Resident #11's stomach. Nurse #2 flushed the PEG tube with two cups of water. Both cups of water were pushed quickly into the PEG tube via a syringe and plunger and Resident #11 was observed to flinch. Nurse #2 did not tell Resident #11 what he was doing and did not speak to the resident during the procedure. Nurse #2 then checked Resident #11's blood sugar. Nurse #2 removed the sock on the resident's hand and pricked his finger with a lancet. Resident #11 was observed to flinch and open his eyes. Nurse #2 told the resident what he was doing after his finger was pricked. Nurse #2 did not pull the privacy curtain or close the door to Resident #11's room prior to providing care.</p> <p>The facility Administrator was</p>		<p>and approach at least quarterly. Please specify how the QAA Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?</p> <p>Interviews will be conducted with at least ten residents per week times six weeks, and monthly thereafter to confirm compliance with the facility's policy regarding showing respect and honoring dignity. Any concerns voiced during the resident interviews will be immediately investigated as per facility policy. Results of the interviews and any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted. All staff who are able to administer NG tube treatments will be observed and checked-off for adherence to showing respect and honoring dignity as well as Tone and Approach Expectations.</p> <p>By what date the systemic changes will be completed: August 19, 2016</p>	

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	<p>interviewed on 7/20/2016 at 12:35 P.M. During the interview, the Administrator indicated staff cursing in front a resident was not tolerated and did not meet the facility's expectations for how staff should interact with residents. Further, she indicated that staff were expected to show respect and honor dignity during interactions and care of residents.</p> <p>On 7/20/16 at 12:38 P.M., the Administrator provided a copy of training material used to educate staff titled "Tone, Approach and Customer Service Expectations". The training material indicated "...Showing respect and honoring dignity are a part of our Culture as Resident Credos and are of the utmost importance...We should be mindful of speaking around our residents. Most can hear and understand our conversations...speaking only to other staff members may be demeaning to the resident..."</p> <p>3.1-3(t)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders for 1 of 5 residents (#66) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Review of Resident #66's medical records on 5/19/16, at 1:00 P.M. indicated, a physician's order dated 3/11/16 for Glucagon solution, 1</p>	F 0282	<p><u>282- Services by Qualified Persons/Per Care Plan</u></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents who are diabetic had the potential to be affected by this practice. All nursing staff who are expected to follow physician orders will be educated on following the diabetic clinical</p>	08/19/2016

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	<p>milligram injected intramuscularly every 20 minutes as needed for hypoglycemia (low blood sugar) for blood sugar under 50. Resident #66's physician's orders were to have blood sugars checked by glucoscan, four times daily at 7:00 A.M., 11:30 A.M., 4:30 P.M. and 8:00 P.M..</p> <p>Review of the Medication Administration Records (MARs) for June and July 2016 indicated on 8 separate occasions, Resident #66's glucoscans had results of blood sugar under 50: 6/7/16, at 11:30 A.M.(blood sugar 48); 6/11/16 at 11:30 A.M. (blood sugar 49); 6/12/16 at 7:00 A.M. (blood sugar 44); 6/13/16 at 7:00 A.M. (blood sugar 32); 6/20/16 at 11:30 A.M. (blood sugar 33); 7/13/16 at 7:00 A.M. (blood sugar 47); 7/13/16 at 4:30 P.M. (blood sugar 40); 7/14/16 at 11:30 A.M. (blood sugar 36).</p> <p>Physician's orders for Glucagon administration for blood sugar under 50 per glucometer check were not followed on 6/7/16, at 11:30 A.M.(blood sugar 48); 6/11/16 at 11:30 A.M. (blood sugar 49); 6/13/16 at 7:00 A.M. (blood sugar 32); 6/20/16 at 11:30 A.M. (blood sugar 33); 7/13/16 at 7:00 A.M. (blood sugar 47); 7/14/16 at 11:30 A.M. (blood sugar 36).</p> <p>In addition, on 7/10/16, Resident #66's</p>		<p>protocol(Attachment 1). How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents who are diabetic had the potential to be affected by this practice. All nursing staff who are expected to follow physician orders will be educated on following the diabetic clinical protocol and tested for their knowledge with following the diabetic protocol (Attachment 2-3). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurse Managers to audit ten percent of physician orders per month times twelve months to determine compliance with all orders. All newly hired nursing staff will be educated during orientation on the diabetic protocol. Please specify how the QAA Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place? Nurse Managers to audit ten percent of physician orders per month times twelve months to determine compliance with all orders. Any issues identified</p>				

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	<p>blood sugar per glucoscan check at 7:00 A.M. was 58 and Glucagon was administered.</p> <p>An interview with LPN #5, on 7/19/16 at 2:40 P.M. stated if Resident #66's blood sugar is under 50 and she is alert, she gives her a drink of Med Pass 2.0 or Mighty Shake (both dietary supplements) and recheck the resident's blood sugars. LPN #5 stated if Resident #66's blood sugar was under 50 and she was not alert she was given Glucagon.</p> <p>An interview with the Director of Nursing (DN) on 7/20/16 at 12:36 P.M. indicated the physician's orders for Resident #66 for administration of Glucagon for blood sugars under 50 should have been followed by nursing staff.</p> <p>A current policy was provided by the DN on 7/20/16 at 12:30 P.M. titled Administering Medications, revised December 2012. Under Policy Interpretation and Implementation #3: "Medications must be administered in accordance with the orders."</p> <p>3.1-35(g)(2)</p>		<p>during the audit process will be immediately changed and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly meetings and the plan revised, if warranted.</p> <p>By what date the systemic changes will be completed: August 19, 2016</p>	

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F 0322 SS=D Bldg. 00	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff properly verified placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube) prior to flushing the tube with water for 1 of 3 residents reviewed for feeding tubes (Resident #11). The facility also failed to ensure the proper administration of water flushes for 3 of 3 residents reviewed for feeding tubes (Resident ' s #3, #9, and #11).</p> <p>Findings include:</p>	F 0322	<p><u>F322-</u> <u>NGTreatment/Services-Restore Eating Skills</u> What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? All residents who have a G-tube have the potential to beaffected by this practice. All LPNs and RNs will be retrained and observedthrough the process of a G-tube treatment and checked off for adherence to theG-tube treatment policy and procedure (Attachment 1-3). How other residentshaving the potential to be affect by the</p>	08/19/2016

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	<p>On 7/19/16 at 3:46 p.m., Resident #3 was observed during care of her enteral feeding tube. A physician's order dated 10/4/15 indicated the PEG tube was to be flushed with 225 cc's (cubic centimeters) every 4 hours. Nurse #2 checked placement of the PEG tube by administering a 10 cc air bolus through the PEG tube with a syringe after he placed his stethoscope next to the resident's stoma (where the tube was placed in the stomach area for access to the tube feeding). Nurse #2 poured water into the 60 cc syringe. The water did not flow by gravity into the PEG tube. At this same time, Resident #3 was heard making unintelligible noises and observed to move her head and upper body back and forth. Nurse #2 told Resident #3 to "relax" as the water would not flow down the tube. Nurse #2 then quickly pushed the water down the PEG tube with a plunger. He repeatedly pushed water down the PEG tube with a plunger until 225 cc's of water was administered.</p> <p>On 7/19/16 at 4:06 P.M., Resident #9 was observed during care of his enteral feeding tube. A physician's order dated 12/23/15 indicated the PEG tube was to be flushed with 300 cc's every 4 hours. Nurse #2 checked placement of the PEG tube by administering a 10 cc air bolus</p>		<p>same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents who have a G-tube have the potential to be affected by this practice. All LPNs and RNs will be retrained and observed through the process of a G-tube treatment and checked off for adherence to the G-tube treatment policy and procedure (Attachment 1-3).</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>All nurses will have to perform a skill check-off to ensure compliance with our G-tube treatment policy and procedure (Attachment 4).</p> <p>Please specify how the QAA Committee will monitor this plan of correction, how often, and for how long? If less than six months, how will the facility ensure the plan remains in place?</p> <p>Nurse Managers to observe ten G-tube treatments per month times six months to determine compliance with policy and procedure. Any issues identified during the observation will be immediately corrected and education will be given to staff through one-on-one training. Any corrective actions taken shall be reported to the QAPI Committee during monthly</p>		

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	<p>through the PEG tube with a syringe after he placed his stethoscope next to the resident's stoma (where the tube was placed in the stomach area for access to the tube feeding). Nurse #2 then flushed the PEG tube with water. The water was pushed quickly down the PEG tube with a plunger, repeatedly, via a 60 cc syringe for a total of 300 cc's.</p> <p>On 7/19/16 at 4:15 P.M., Resident #11 was observed during care of his enteral feeding tube. A physician's order dated 12/22/15 indicated the PEG tube was to be flushed with 200 cc's every 4 hours. Nurse #2 checked placement of the PEG tube by administering a 60 cc air bolus through the PEG tube with a syringe after he placed his stethoscope next to the resident's stoma (where the tube was placed in the stomach area for access to the tube feeding). Nurse #2 then flushed the PEG tube with water. The water was pushed quickly down the PEG tube with a plunger, repeatedly, via the 60 cc syringe for a total of 200 cc's. Resident #11 was observed to flinch when the water was pushed down the PEG tube and into his stomach.</p> <p>The facility's Education Coordinator was interviewed on 7/20/2016 at 1:35 P.M. During the interview, she indicated PEG tube placement should be checked by</p>		<p>meetings and the plan revised, if warranted.</p> <p>By what date the systemic changes will be completed: August 19, 2016</p>		

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F 0441 SS=E Bldg. 00	<p>administering a 10-20 cc air bolus through the tube with a syringe to verify correct placement of the tube in the stomach. Further, she indicated if a PEG tube becomes plugged or fluids won't flow down the tube per gravity, a syringe and plunger may be used to do "little pumps" to help the tube drain. She indicated that fluids should not be forced down the tube with a plunger.</p> <p>On 7/21/16 at 12:00 P.M., the DON provided a current policy titled "Enteral Tube Feeding via Syringe (Bolus). The policy indicated the following: "...Verify placement of tube: ...3. b. Attach 60 ml syringe containing approximately 10 ml air. c. Auscultate (listen with a stethoscope) the abdomen while injecting the air from the syringe into the tubing. d. Listen for "whooshing" sound to check placement of the tube in the stomach...2...allow feeding to flow by gravity...."</p> <p>3.1-44(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable</p>			

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	<p>environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure staff followed proper handwashing procedures (while providing care) for 4 of 4 residents observed for handwashing. The facility also failed to ensure staff followed infection control practices to</p>	F 0441	<u>F441- InfectionControl, Prevent Spread, Linens</u> What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice? A. All residents had the potential to be affectedby this	08/19/2016

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NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818			
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	<p>prevent cross contamination of wounds when changing a pressure ulcer dressing for 1 of 1 residents being observed for pressure ulcer dressing change.</p> <p>Findings include:</p> <p>1. On 07/18/16 at 1:47 P.M., Nurse #3 was observed washing her hands after completing a blood sugar check on Resident #13. The nurse washed her hands properly and then turned the faucet off with her clean hands.</p> <p>On 7/19/16 at 3:55 P.M., Nurse #2 was observed washing his hands after providing care to Resident #3. Nurse #2 washed his hands properly and then turned the faucet off with the wet paper towel he had dried his hands off with.</p> <p>On 7/19/16 at 4:17 P.M., Nurse #2 was observed wearing gloves to provide care to Resident #11. After care was completed, Nurse #2 left the resident's room wearing his gloves. Nurse #2 then removed the gloves at the medication cart in the hallway. Nurse #2 then walked down the hallway to another medication cart, and opened drawers, touched medication packages and bottles searching for an insulin bottle. He then returned to the medication cart outside of Resident #11's room. Nurse #2 then</p>		<p>practice. All staff will be in-serviced on the proper Handwashing procedure. All staff will be observed for compliance with the proper handwashing procedure (Attachment 1). B. All residents with wounds had the potential to be affected by this practice. All licensed nurses who administer treatments for wounds will be in-services on the proper Wound Care policy and Procedure (Attachment 2-4). How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. A. All residents had the potential to be affected by this practice. All staff will be in-serviced on the proper Handwashing procedure. All staff will be observed for compliance with the proper handwashing procedure (Attachment 1). B. All residents with wounds had the potential to be affected by this practice. All licensed nurses who administer treatments for wounds will be in-serviced on the proper Wound Care policy and Procedure (Attachment 2-3). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A. A. All staff are educated on proper handwashing techniques during quarterly in-services. Going forward we will be doing handwashing education in</p>				

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	<p>covered his nose with a Kleenex, sneezed, and blew his nose. After he disposed of the Kleenex, Nurse #2 used some alcohol gel on his hands and rubbed them for 15 seconds. Nurse #2 did not wash his hands after removing his gloves or after blowing his nose.</p> <p>On 07/20/16 at 10:04 A.M., Nurse #1 was observed changing a pressure ulcer dressing for Resident #6. Nurse #1 carried in wound care supplies from the medication cart sitting outside of the resident's room in the hallway. Nurse #1 placed the supplies directly on top of an overbed table with no barrier between the table and supplies. The overbed table had a clear liquid substance on the surface that was within one inch of the wound supplies. The nurse then put on non-sterile gloves, closed the room door, pulled the privacy curtain, cranked the bed down and assisted Resident #6 to turn over on their side. The nurse opened a clean wound dressing by pulling the top of the package down and letting it rest on the overbed table. Nurse #1 then opened a package with 2 cotton swabs and placed the swabs on top of the opened wound dressing package. After cleaning the two ulcers, she took a piece of dressing and with one of the cotton swabs pushed the dressing into ulcer #1 to pack the wound. Nurse #1 placed the dirty cotton swab on</p>		<p>the neighborhood or area where staff perform theirwork (Attachment 7).</p> <p>B. B. All nursing staff will have to perform a skillcheck-off to ensure compliance with our wound care treatment policy and procedure(Attachment 5-6). Please specify howthe QAA Committee will monitor this plan of correction, how often, and for howlong? If less than six months, how willthe facility ensure the plan remains in place? A. HandwashingObservation will be conducted with at least tenstaff members per week times six weeks, and monthly thereafter to confirmcompliance with the facility's policy regarding proper handwashing. Any non-compliance with proper handwashing will be corrected at the time ofobservation with one-on-one coaching. Results of the observation and anycorrective actions taken shall be reported to the QAPI Committee during monthlymeetings and the plan revised, if warranted. B. Nurse Managers to observe five wound caretreatments per month times six months to determine compliance with policy andprocedure. Any issuesidentified during the observation will be immediately corrected and educationwill be given to staff through one-on-one training. Any corrective actionstaken shall be reported to</p>	

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	<p>the clean wound dressing package next to the clean cotton swab. Nurse #1 then placed a piece of dressing on top of ulcer #2. Nurse #1 picked up the dirty cotton swab used for ulcer #1 and used it to push the dressing and pack it into ulcer #2. The nurse then removed her gloves and carried the supplies out of the room and placed them onto the medication cart in the hallway outside of Resident #6's room. She assisted the resident to move up in bed and then elevated head of residents bed. Nurse #1 then washed her hands properly then turned the faucet off with the wet paper towel she had dried her hands off with.</p> <p>An interview was conducted with the facility Education Coordinator on 7/20/16 at 1:16 P.M. During the interview, the Education Coordinator indicated hands should be washed prior to providing resident care and before and after wearing gloves. She indicated Nurse #1 should have placed the wound dressing supplies on a clean area of the overbed table. Further, she indicated the nurse should not have placed the dirty cotton swab used for ulcer #1 next to the clean cotton swab and Nurse #1 should not have used the dirty cotton swab to pack the dressing into ulcer #2.</p> <p>A current policy titled</p>		<p>the QAPI Committee during monthly meetings and the plan revised, if warranted. By what date the systemic changes will be completed: August 19, 2016</p>				

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R 0000 Bldg. 00	<p>"Handwashing/Hand Hygiene" dated 8/2012, indicated "...This facility considers hand hygiene the primary means to prevent the spread of infections...5. Employees must wash their hands by rubbing vigorously for at least 20 seconds with antimicrobial or non-antimicrobial soap and warm water under the following conditions: c. Before and after direct resident contact...k. Before and after changing a dressing...o. After blowing or wiping nose...8. The use of gloves does not replace handwashing/hand hygiene...Washing Hands Procedure: 4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.</p> <p>3.1-18(l)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 48</p> <p>Sample: 5</p>	R 0000		

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	Byron Health Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.				