STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILLS CARE CENTER	403 BIELBY RD LAWRENCEBURG, IN 47025

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00158670 and IN00159547. Complaint: 158670 - Unsubstantiated - due to lack of evidence. Complaint: 159547 - Unsubstantiated - due to lack of evidence. Survey dates: December 1, 2, 3, 4, and 5, 2014. Facility number: 000022 Provider number: 155061 AIM number: 100274510 Survey team: Tammy Forthofer, RN - TC Rita Bittner, RN Josh Emily, RN (12/2, 3, 4, 5, 2014) Jennifer Carr, RN (12/4 & 5, 2014) Census bed type: SNF/NF: 44 Total: 44	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census payor type: Medicare: 4 Medicaid: 38 Other: 2 Total: 44 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12, 2104, by Janelyn Kulik, RN.			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided related to wound care for 1 of 2 residents reviewed for skin conditions (non-pressure related) of the 2 residents who met the criteria for skin conditions (non-pressure related). (Resident #36) Findings include:	F000309	F309 Requires the facility to provide the necessary treatment and services related to wound care. The facility will ensure this requirement is met through the following: 1. Resident #36 wound was healed at the time of the dressing change. Resident #36 other wounds were assessed and no signs and symptoms of infection was noted. 2. All residents have the potential to be affected.	12/19/2014

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	On 12/05/2014 at 8:40 AM, Resident #36 was observed during wound care. The ADON (Assistant Director of Nursing) collected the supplies for Resident #36's care of two wounds. The ADON opened the bottom draw of the treatment cart, pulled her scissors out of her pants pocket, cut two adhesive dressing squares from a box of rolled adhesive dressings, and placed the scissors back in her pocket. The ADON walked into the resident's room, washed her hands, put on gloves, and pulled the scissors out of her back pocket. She then cut the soiled dressing off of the resident's heel and placed the scissors on the resident's bed side table. She then washed her hands and placed on clean gloves. After completing the assessment of the resident's heel, the ADON indicated the heel had improved and no longer needed treatment. An observation of the heel confirmed the ADON assessment. She placed the resident's sock on the foot. The ADON washed her hands and put on a new pair of gloves to start the treatment for the second wound. The resident was rolled to her right side and the soiled dressing was removed from the resident's sacrum/lumbar area. The wound was assessed and soiled packing removed. The wound looked		Residents who currently have skin areas were assessed to ensure their wounds were free from infection. No concerns were noted. See below for corrective measures. 3. The dressing clean technique policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. 4. The DON or her designee will audit at least one dressing change daily to ensure infection control is being maintained. The audits will be completed daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before December 19th, 2014	

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	slightly pink with red and yellow drainage on the packing gauze. The wound, measured by the ADON, was "0.3 centimeters in diameter and 3.0 centimeters deep". The ADON washed her hands appropriately and put on a pair of clean gloves. She then picked up the scissors from the bed side table, opened the bottle of sterile packing gauze, pulled out 8 to 10 inches of gauze, and cut the packing gauze. The gauze was placed in a medication cup and soaked in a dakins solution. The ADON picked up the soaked gauze and packed the wound using a cotton tipped applicator to advance the gauze into the wound. The packed wound was covered with a gauze pad, taped, and dated. The ADON washed her hands, picked up the scissors from the bed side table, then placed the scissors back into her pocket. The scissors were never observed being cleaned prior, during, or after both wound care procedures. During an interview, on 12/05/2014 at 9:11 AM, the ADON indicated she carried her own scissors and since she was, "just doing wound care on one resident, I will clean my scissors with alcohol." When asked about the procedure after removing a soiled dressing, the ADON indicated the scissors needed to be cleaned between			

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	dressing changes. The ADON indicated "I should have cleaned the scissors before cutting the packing dressing". The clinical record was reviewed for Resident #36. The Care plan, dated 12/01/2014, for the open area located on the sacrum indicated the goal was for the wound to decreased in size. The interventions were to provide treatment as ordered, assess weekly, and observe for signs and symptoms of infection such as redness, warmth, and odor. Under interventions there was a note to consult with the previous back surgeon. The "On Going Assessment of Non-Pressure related skin condition" form addressed the sacral wound. The assessment dated 09/11/2014 indicated wound measurements to be "Partial thickness wound measuring 0.2 by 0.2 centimeters with 0.2 centimeters depth." The assessment dated 11/28/2014 indicated wound measurements to be "Full thickness wound 0.4 by 0.4 centimeters with 4.2 centimeters depth. A wound culture of the coccyx report, dated 09/04/2014, indicated under item #1. "gram negative rod light growth", and under item #2. "Diptheroid Bacillus heavy growth".			

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	A wound culture of the coccyx report, dated 09/23/2014, indicated "gram negative rod moderate growth". A wound culture of the coccyx report, dated 10/11/2014, indicated under item #1. "gram pos cocci light growth", and under item #2. "Gram negative rod rare growth". A wound culture of the coccyx report, dated 11/01/2014, indicated "diptheroid Bacillus heavy growth". A current policy and procedure titled, "Clean Dressing Procedure", was provided by the DON, on 12/05/2014 at 11:00 AM, The policy and procedure indicated: To protect open wounds from contamination, to absorb wound drainage and to promote wound healing. Prepare equipment, dressings, gloves, cleaning solution, wound medication as prescribed, disposal plastic bag for waste materials. 4. Prepare clean area for needed equipment. 3.1-18			

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F000371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review the facility failed to store and prepare foods in a sanitary manner. This had the potential to affect 43 of 44 residents served from the kitchen. Findings included: 1. An observation and interview was conducted during the initial tour of the kitchen, on 12/01/2014 at 10:29 AM, with the Dietary Manager. Several rust colored stains were noted on the ceiling of the dry storage room. The freezers and refrigerators were also located in the dry storage room. Several dry, rust colored drip stains were noted running down the walls from the ceiling to the floor. The Dietary Manager indicated the room was located directly under the porch and, " nothing was dripping on the food products " . 2. In the kitchen, the duct work near the ceiling, located above the aisle way between the steam table and grill, had multiple areas of peeling, cracking, paint	F000371	F371 Requires the facility to procure food from sources approved considered satisfactory by Federal, State or local authorities and to store,prepare distribute and serve food under sanitary conditions. The facility will ensure this requirement is met through the following: 1 The walls and the ceiling in the dry storage area have been cleaned sealed and painted. The light fixture has been removed and a cover installed. 2. All loose paint and debris has been removed from the kitchen above the aisle way between the steam table and the grill area and around duct work. 3. In-serviced and educated staff to monitor for water seepage in the food storage area. Also, monitoring for loose debris in the food prep area. Attached monitoring tool for F371 in addendum The above corrective measures will be completed on or before December 23rd, 2014	12/23/2014

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	around an access panel located on the side of the duct work. During an interview and record review with the Dietary Manager, on 12/05/2014 at 8:41 AM, the cleaning schedule for the kitchen equipment was obtained for the current week and the previous week. Walls in the dish room were on the schedule to be cleaned but no other walls were noted on the schedule/calendar. 3. An observation and interview was conducted on 12/05/2014 at 11:29 AM. with the Dietician. Seventeen spots on the ceiling were noted in the food storage room. The spots ranged in size from one inch to palm size and were a brown, rust color. A brown, rust colored stain was noted around the base of a light fixture located in the center of the ceiling. The glass globe on the light fixture had a rust colored fluid within the globe. The Dietician indicated the stains were from the porch drainage. She also indicated she and the dietary manager could not do anything about it. An interview was conducted on 12/05/2014 at 1:53 PM with the Maintenance Contractor. He indicated staff fill out a maintenance request for work that needs to be done. He indicated he did floor inspections daily and works			

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	with other contractors and service support providers for the facility. He indicated Maintenance and Administration were currently working on preventative maintenance upkeep. He indicated he did not have any outstanding work requests for painting but was currently painting all doors and door jams. He indicated he was currently working on "some numbers" for the administration to take to corporate for repairs to stop the water from coming in to the food storage room. He indicated only during a real hard rain over several days, some condensation may form and run down the wall, but no standing water had been noted on the floor in the six months he had worked at the facility. He indicated the light fixture was checked and confirmed there was fluid standing in the globe. No power was to that light following the installation of new lighting fixtures. He did not know when the new lighting fixtures were installed. He indicated no quotes had been requested nor received to fix the drainage issue. The contractor he planned on using was currently out of the country. Nothing was stored directly under the light fixture. 3.1-21(i)(3)			

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to ensure medications were properly labeled. This deficient practice affected 1 of 3	F000431	F431 Requires the facility to properly label medications. The facility will ensure this requirement is met through the following: 1. The Adapt Cream,	12/19/2014

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	medication carts and 1 of 3 treatment carts in the facility. Findings include: 1. During an observation of the second floor medication cart, on 12/04/2014 at 6:25 AM, with QMA (Qualified Medication Aide) #3, one opened Levemir insulin pen with 9 units left in the pen was noted. The pen had a black unreadable mark on the side with no resident label. During an interview, on 12/04/2014 at 6:32 AM, QMA #3 indicated the Levemir pen was not clearly labeled. When asked if she could read the black mark, QMA #3 indicated, "I can not read the black mark". 2. An observation of the treatment cart located on the first floor was conducted on 12/04/2014 at 6:48 AM with LPN (Licensed Practical Nurse) #1. An open tube of Calmoseptine that was half full, was not dated nor did it have a resident label. An open tube of Adapt cream that was half full, was not dated nor did it have a resident label. A tube of Convatec stoma adhesive that was 3/4 full was not dated nor did it have a resident label. During an interview on 12/04/2014 at		Levemir and Convatec stoma adhesive was removed from the cart and properly disposed of. 2. All residents have the potential to be affected. Medication carts and treatment carts were audited with no further labeling problems noted. See below for corrective measures. 3. The Drug Label policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the on the above procedure. 4. The DON or her designee will audit at least one cart a day, rotating floors to ensure all treatment and medications are properly labeled. The audits will be completed daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before December 19th, 2014	

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	6:59 AM, LPN #1 indicated the Convatec stoma adhesive and adapt cream was not labeled with a resident's name. She was unsure whom the cream belong to, but there was only one resident with a stoma on that floor. During an interview on 12/04/2014 at 10:57 AM, the DON indicated "house barrier cream should have a resident's name to individualize". (an example of house barrier cream would be Calmoseptine) A current policy and procedure titled, "Drug Labels", was provided by the DON, on 12/04/2014 at 2:20 PM. The policy and procedure indicated: 1. All prescription labels must state: e. Resident's name and h. date drug is dispensed. 6. Containers with soiled, damaged, incomplete, or illegible labels must be destroyed in accordance with drug destruction procedures. 3.1-25(k)(1)(6)			
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an			

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	Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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. (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 infection control practices and standards were maintained related to equipment cleaning for 1 or 3 dressing	F000441	F441 Requires the facility to ensure infection control practices and standards are maintained related to equipment cleaning. The facility will ensure this requirement is met through	12/19/2014

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	changes observed. (Resident #36) Findings include: On 12/05/2014 at 8:40 AM, Resident #36 was observed during wound care. The ADON (Assistant Director of Nursing) collected the supplies for Resident #36's care of two wounds. The ADON opened the bottom draw of the treatment cart, pulled her scissors out of her pants pocket, cut two adhesive dressing squares from a box of rolled adhesive dressings, and placed the scissors back in her pocket. The ADON walked into the resident's room, washed her hands, put on gloves, and pulled the scissors out of her back pocket. She then cut the soiled dressing off of the resident's heel and placed the scissors on the resident's bed side table. She then washed her hands and placed on clean gloves. After completing the assessment of the resident's heel, the ADON indicated the heel had improved and no longer needed treatment. An observation of the heel confirmed the ADON assessment. She placed the resident's sock on the foot. The ADON washed her hands and put on a new pair of gloves to start the treatment for the second wound. The resident was rolled to her right side and the soiled dressing was removed		the following:1. Resident #36 wound was healed at the time of the dressing change. Resident #36 other wounds were assessed and no signs and symptoms of infection was noted. 2. All residents have the potential to be affected. Residents who currently have skin areas were assessed to ensure their wounds were free from infection. No concerns were noted. See below for corrective measures.3. The dressing clean technique policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure.4. The DON or her designee will audit at least one dressing change daily to ensure infection control is being maintained focusing on equipment cleaning. The audits will be completed daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before December 19th, 2014	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	from the resident's sacrum/lumbar area. The wound was assessed and soiled packing removed. The wound looked slightly pink with red and yellow drainage on the packing gauze. The wound, measured by the ADON, was "0.3 centimeters in diameter and 3.0 centimeters deep". The ADON washed her hands appropriately and put on a pair of clean gloves. She then picked up the scissors from the bed side table, opened the bottle of sterile packing gauze, pulled out 8 to 10 inches of gauze, and cut the packing gauze. The gauze was placed in a medication cup and soaked in a dakins solution. The ADON picked up the soaked gauze and packed the wound using a cotton tipped applicator to advance the gauze into the wound. The packed wound was covered with a gauze pad, taped, and dated. The ADON washed her hands, picked up the scissors from the bed side table, then placed the scissors back into her pocket. The scissors were never observed being cleaned prior, during, or after both wound care procedures. During an interview, on 12/05/2014 at 9:11 AM, the ADON indicated she carried her own scissors and since she was, "just doing wound care on one resident, I will clean my scissors with alcohol." When asked about the			

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	procedure after removing a soiled dressing, the ADON indicated the scissors needed to be cleaned between dressing changes. The ADON indicated "I should have cleaned the scissors before cutting the packing dressing". A current policy and procedure titled, "General Policies", was provided by the DON, on 12/04/2014 at 2:20 PM. The policy and procedure indicated: 1. To provide a sanitary environment for our residents, personnel and visitors. 2. To prevent the spread of communicable disease. 3. To establish guidelines to follow in the implementation of Transmission-based precaution techniques. 4. To interrupt the spread of infection by all routes likely to be encountered. A current policy and procedure titled, "Clean Dressing Procedure", was provided by the DON, on 12/05/2014 at 11:00 AM, The policy and procedure indicated: To protect open wounds from contamination, to absorb wound drainage and to promote wound healing. Prepare equipment, dressings, gloves, cleaning solution, wound medication as prescribed, disposal plastic bag for waste materials.			

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	4. Prepare clean area for needed equipment. 3.1-18			