

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey Completed on June 15, 2015.</p> <p>Survey dates: July 27, 28 and 29, 2015.</p> <p>Facility number: 000274 Provider number: 155810 AIM number: 100271660</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 2 Medicaid: 75 Other: 1 Total: 78</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law. Plan of Compliance is effective: August 17, 2015</p>	
F 0441 SS=D Bldg. 00	<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 environment and to help prevent the</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(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	
	<p>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 infection control practices were followed during personal care for 1 of 1 residents reviewed for infection control. (CNA #1& CNA #2; Resident # 21)</p>	F 0441	<p>F 441 Infection Control</p> <p>Corrective action for affected resident:</p> <p>Head to toe assessment</p>	08/17/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
	<p>Findings include:</p> <p>An observation of personal care for Resident #21 was done on 7/28/15 at 2:53 p.m., with the following concerns:</p> <p>CNA #1 applied a glove to her right hand only, leaving her left hand bare. She opened Resident #21's brief and turned him onto his side with CNA #2's assistance. Resident #21 was found to be incontinent of both bowel and bladder. With her right hand, CNA #1 began to wipe away the bowel movement from the resident with a disposable wipe while holding his left buttock with her left ungloved hand. She then proceeded to fold the wipe onto her ungloved left hand and place the wipe into a trash bag sitting on the floor to her left. This was repeated three more times. CNA #1 removed the brief from under the resident and folded it closed. She then placed the brief under her right arm for a moment, and then placed it in the trash bag on the floor to her left. CNA #1 opened a new brief, and began to place it under Resident #21. CNA #1 placed the brief onto the bed to her left. CNA#1 tapped brown particles located on the draw sheet with her left ungloved hand, turned her hand palm up, rubbed the particles with her thumb, and patted the particles onto the draw sheet. CNA #1 used her left index fingernail to</p>		<p>completed on Resident #21 with no signs or symptoms of infection or skin breakdown noted.</p> <p>Identification of others at risk:</p> <p>Head to toe assessments completed on residents assigned to CNA #1 with no signs or symptoms of infection or skin breakdown noted.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>An additional three day re-orientation was completed with CNA #1, including skills validation by return demonstration. Additionally, skills validation by return demonstration was completed a third time with the Director of Nursing. Re-orientation and return demonstration focused on providing infection control practices during personal care.</p> <p>Directed in-servicing on hand washing and glove use was provided to all nursing staff. Skills validation by return demonstration on hand washing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2015	
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992			
(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			
	<p>pick the brown particle off of Resident #21's right upper buttock, which fell onto the draw sheet. She then swept the particles on the draw sheet into a pile with her left ungloved hand. CNA #2 folded the draw sheet under Resident #21's buttocks. CNA #1 tucked her hair behind her left ear using her left hand and picked up the clean brief with her right hand. She pulled the draw sheet back out from under the resident's buttocks and wiped her forehead with the back of her left hand. She then tucked the draw sheet back under the resident's buttocks and placed the clean brief under the resident. Both CNAs turned Resident #21 onto his back and closed the brief. Resident #21's perineal area was not cleansed during the episode of care. CNA #1 picked up a wet washcloth, with a quarter-sized area of pink liquid on it, with her right hand and handed it to CNA #2. CNA#1 applied a glove to her left hand. She did not wash her hands. CNA #1 indicated to CNA #2 that she was going to use the washcloth on Resident #21's face. This surveyor intervened at this time.</p> <p>CNA #2 indicated the washcloth should be replaced and both CNAs should wash their hands before proceeding with Resident #21's care.</p> <p>Resident #21's clinical record was</p>		<p>and glove use was completed for all nursing staff. Re-orientation and return demonstration focused on providing infection control practices during personal care.</p> <p>All new hire nursing staff will receive in-servicing and skills validation by return demonstration on hand washing and glove use during orientation.</p> <p>Monitoring of corrective action:</p> <p>Managers, or designees will observe hand washing techniques and glove use while staff provide resident care on 10 staff per week times 4 weeks, 5 staff per week times 4 weeks, 3 staff weekly times 4 weeks and monthly thereafter for 6 months.</p> <p>The audit results will be discussed in morning meeting and in the monthly Quality Assurance Committee meeting for further recommendations.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
---	---

(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
	<p>reviewed on 7/28/15 at 10:20 a.m. Resident #21's diagnoses included, but were not limited to, cerebral palsy, profound intellectual disability, and aphasia.</p> <p>Resident #21 had a, 4/7/15, quarterly, Minimum Data Set assessment, which indicated the resident was cognitively impaired, made poor daily decisions requiring cues and supervision, and was totally dependent on staff for ADLs and mobility.</p> <p>During an interview with the Administrator and Director of Nursing (DON), on 7/28/15 at 3:30 p.m., they both indicated gloves should be worn on both hands and hand washing should be completed after providing perineal care. The DON indicated CNA #1 attended an in-service on hand washing and glove use on 7/7/15. The Administrator indicated new hire skills check offs were completed during CNA #1's orientation by CNA #3.</p> <p>During an interview, on 7/28/15 at 4:07 p.m., CNA #3 indicated she had completed CNA #1's orientation check off sheet, which included perineal care.</p> <p>Review of CNA #1's "CNA Employee Skills Checklist", provided by the DON</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(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	
	<p>on 7/28/15 at 4:15 p.m., indicated, "Provide Perineal Care ...Monitor appropriate technique and hand hygiene" The checklist was dated as having been completed between 6/27/15 and 6/30/15 and was signed by CNA #1 and CNA #3.</p> <p>Review of a document, titled, "Procedural Guideline 17-1 Perineal Care", provided by the DON on 7/28/15 at 4:26 p.m., indicated the following:</p> <p>"...Wear gloves during perineal care because of the risk of contacting infectious organisms present in fecal, urinary, or vaginal secretions"</p> <p>Review of a document, titled, "Plan of Correction-7/2015 Post Test", completed by CNA #1 on 7/7/15, provided by the DON on 7/28/15 at 4:26 p.m., indicated the following:</p> <p>"...Staff must wash hands before putting on gloves and after removing gloves" CNA #1's answer indicated this statement was true.</p> <p>3.1-18 (l)</p>				