

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 12,13,14,15, and 16, 2014</p> <p>Facility Number: 000532 Provider Number: 155527 AIM Number: 100267180</p> <p>Survey Team: Karen Lewis, RN, TC Toni Maley, BSW Ginger McNamee, RN Tina Smith-Staats, RN</p> <p>Census Bed Type: SNF: 5 SNF/NF: 39 Total: 44</p> <p>Census Payor Type: Medicare: 6 Medicaid: 34 Other: 4 Total: 44</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora</p>	F000000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under State and Federal Law. Please Accept this plan of correction as our credible allegation of compliance.</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.

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F000309 SS=D	<p>Barth, RN.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure a resident received only the laboratory tests necessary for monitoring the medications he was receiving for 1 of 5 residents reviewed for unnecessary medications. (Resident #22)</p> <p>Findings include:</p> <p>Resident #22's clinical record was reviewed on 5/15/14 at 8:48 a.m. The resident's diagnoses included, but were not limited to, non-valvular atrial fibrillation and hypertension.</p> <p>The resident's current physician's orders were signed but not dated by the physician. The orders included an order</p>	F000309	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under State and Federal Law. Please Accept this plan of correction as our credible allegation of compliance.1. Resident #22 digoxin lab order was discontinued immediately.2. Physicians' orders reviewed, and a complete laboratory audit was conducted to assure any resident with a discontinued therapeutic medication, no longer receives the associated lab test.3. Licensed staff was re-educated (See Attachment A)ensuring when a therapeutic medication is discontinued, the associated</p>	05/30/2014

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F000323 SS=D	<p>for a digoxin level every six months. Review of the resident's medications lacked an order for digoxin [a heart medication.]</p> <p>Review of the laboratory tests indicated the resident had a digoxin level checked on 12/18/14.</p> <p>During an interview on 5/16/14 at 10:55 a.m., with the Assistant Director of Nursing and Director of Nursing additional information was requested.</p> <p>On 5/16/14 at 9:45 a.m., the RN Consultant indicated the digoxin was discontinued in November and the laboratory test was drawn in December. She indicated the test should have been discontinued when the medication was discontinued.</p> <p>On 5/16/14 at 10:15 a.m., the Administrator in Training provided the discontinue order for the digoxin. The medication was discontinued on 10/1/13.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident</p>		<p>laboratory test is also discontinued, to assure residents receive only the laboratory tests necessary for monitoring the medications which they are receiving. The DON and/or designee will monitor physicians orders 5 x weekly to ensure any discontinued therapeutic medication has the associated lab test discontinued(See Attachment A1). Should noncompliance be noted, corrective action shall be taken.4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the QAA committee monthly times 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p>				

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	<p>receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to provide the number of staff required for a safe transfer resulting in a fall for 1 of 3 residents reviewed for falls. (Resident #55)</p> <p>Findings include: The clinical record for Resident #55 was reviewed on 5/14/14 at 8:34 a.m. Diagnoses for the resident included, but were not limited to, seizure disorder, severe mental retardation with developmental disability, non-verbal and urinary retention. An annual Minimum Data Set (MDS) assessment, dated 12/24/13, indicated Resident #55 was severely cognitively impaired and never or rarely made decisions. The MDS indicated the resident needed the extensive assistance of 2 or more staff for transfers. A fall risk assessment, dated 12/24/13, indicated Resident #55 had risk factors including seizure disorder, use of assistive devices, weakness, unsteady gait, and use of medications that may increase the risk for falls. A current health care plan problem, dated 1/3/14, indicated Resident #55 required</p>	F000323	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. 1. Resident #55 plan of care was revised (See Attachment B3), as well as the C.N.A. assignment sheet to assure 2 person assist with all transfers for the safety of the resident (See Attachment B4).2. All residents care plans and assignment sheets reviewed and revised as necessary, to ensure the proper assistance is communicated and provided for safe transfer as recorded on the ADL grid. 3. All staff were re-educated on Fall Management (See Attachment B), to assess all residents for risk factors that may contribute to falls and use of assignment sheets to confirm number of necessary caregivers. The DON and/or designee will monitor by observation 2 resident transfers 5 x weekly for 4 weeks, weekly x 4 weeks, then monthly to assure the appropriate number of staff for safe transfer.(See Attachment B1 & B2) Should non-compliance be observed, corrective action will be taken.4.</p>	05/30/2014

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	<p>the assistance of up to two staff to assist with Activities of Daily Living (ADLs). One of the interventions for this problem was to "provide assist with ADLs as resident requires."</p> <p>A fall investigation report, provided by the Director of Nursing on 5/14/14 at 8:53 a.m., indicated Resident #55 was lowered to the floor by CNA #4 during a transfer from a shower chair to the bed on 3/1/14 at 12:38 p.m. The report indicated CNA #4 was transferring the resident and further indicated the resident was not a two person assist with transfers.</p> <p>During an interview with the Administrator in Training (AIT), who was the previous Director of Nursing (DoN), on 5/14/14 at 2:38 p.m., she indicated Resident #55 was care planned for 1 to 2 staff assistance when providing care. The AIT indicated there was not a tool/method for the staff to use to determine if 1 or 2 staff assistance was needed when the resident was care planned for 1 to 2 staff assistance. She indicated the resident had been an assist of 1 to 2 at the time of the incident on the CNA assignment sheet. She further indicated the CNA assignment sheet had</p>		<p>The DON and/or designee will report the findings of the transfer monitoring and any corrective actions taken to the QAA committee monthly x 3 months and then quarterly thereafter, and revisions made to the plan, if warranted.</p>	

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	<p>the assistance the resident required.</p> <p>During an interview with CNA #5 on 5/14/14 at 2:43 p.m., she indicated if the CNA assignment sheet indicated a resident was a staff assist of 1 to 2 she would use one person for assistance if she felt safe. If she did not feel safe she would have another staff help her provide care for the resident.</p> <p>During an interview with CNA #6 on 5/14/14 at 2:59 p.m., she indicated if the CNA assignment sheet indicated a resident was a staff assist of 1 to 2 she would ask the resident how they are feeling and how much help they think they will need when staff was providing care.</p> <p>During an interview with CNA #4 on 5/15/14 at 10:54 a.m., she indicated if the CNA assignment sheet indicated a resident was a staff assist of 1 to 2 she would ask another CNA that had been at the facility longer what the resident would need when providing care.</p> <p>Review of the current facility policy, dated 2/2005, titled "FALL MANAGEMENT PROCEDURE," provided by the AIT on 5/14/14 at 3:09 p.m., included, but was not limited to, the following:</p>			

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F000371 SS=F	<p>"PURPOSE: To assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team... ...PROCEDURE:...</p> <p>...3. The interdisciplinary health care plan team will determine which interventions are most appropriate for reducing the risk of falls..."</p> <p>3.1-45(a)(2)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure food was distributed and served under sanitary conditions. This deficient practice had the potential to impact 44 to 44 residents who were served food in the facility.</p> <p>Findings include:</p> <p>During the dining observation on 5/12/14 at 11:44 a.m., the Assistant Director of Nursing (ADoN) was observed serving and assisting residents in the main dining</p>	F000371	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. 1. There was no adverse affect noted to the resident that was served the bread with jelly, using bare hands. The ADON was	05/30/2014

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	<p>room with meal set up. The ADoN removed a slice of bread from a wax paper bag and laid it in the palm of her bare hand. She spread jelly on the bread and then placed the bread on the resident's plate. The ADoN was not wearing gloves and handled the bread with her bare hands.</p> <p>During an interview on 5/14/14 at 12:39 p.m., the Dietary Manager indicated food should not be handled with bare hands. A policy for the proper handling of food during dining was requested.</p> <p>Review of the current facility policy, dated 11/12/2008, "Glove Use & Meal Service", was provided by the Dietary Manager 5/15/14 at 2:38 p.m., included but was not limited to the following:</p> <p>"Policy: In an effort to protect food products from contamination, all products should be served using utensils.</p> <p>Procedure: ...</p> <p>... 4. Employees may not touch ready-to-eat foods with bare hands, gloves must be worn.</p> <p>... 6. Employees should use utensils such as spatulas, scoops, forks and tongs to serve food. ..."</p>		<p>re-educated (See Attachment C) to the proper procedure for food distribution and service under sanitary conditions.2. All residents have the potential to be affected. All staff were re-educated as to the proper procedure to ensure food is distributed and served under sanitary conditions (see attachment C1). 3. All staff were re-educated (See Attachment C1) as to the proper procedure to ensure food is distributed and served under sanitary conditions. The Administrator and/or designee will observe meal service 5 x weekly x 1 month, then weekly x 1 month then monthly thereafter to assure proper food handling during food distribution. (See Attachment C2) Should non-compliance be observed, corrective action shall be taken.4. The Administrator will report the findings of the meal service monitoring and any corrective actions taken to the QAA committee monthly x 3 months and then quarterly thereafter, and revisions made to the plan, if warranted.IDR Rationale for F371 (SS=F) F371 requires the facility adhere to the following: 483.35(i) <i>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</i> The facility must - (1) <i>Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</i>(2) <i>Store,</i></p>				

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	3.1-21(i)(3)		<p><i>prepare, distribute and serve food under sanitary conditions</i> Per the 2567, page 6: "This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was distributed and served under sanitary conditions. This deficient practice had the potential to impact 44 to 44 residents who were served food in the facility." "Findings include: During the dining observation on 5/12/14 at 11:44a.m., the Assistant Director of Nursing ADoN was observed serving and assisting residents in the main dining room with meal set up. The ADoN removed a slice of bread from a wax paper bag and laid it in the palm of her bare hand. She spread jelly on the bread and then placed the bread on the resident's plate. The ADoN was not wearing gloves and handled the bread with her bare hands."</p> <p>The facility concurs that the ADON was not following facility policy in regard to assisting the resident with her bread/butter/jelly; however, the facility does not concur that food was served in an unsanitary condition such that 44 of 44 residents who were served in the facility had the potential to be impacted.</p> <p><u>Relevant Facts:</u> The ADON had washed her hands prior to the initiation of food service (see</p>		

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F000441 SS=D	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 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		statement provided by ADON, Attachment C3). The ADON assisted the resident as stated as observed on the 2567; however, no further observations and/or breach in serving food under sanitary conditions were observed/cited on the 2567. Not all residents of the facility are served in the dining room, nor did the ADON assist all residents in the dining room by assisting to butter their bread, etc. (see statement provided by the ADON, Attachment C3 and witness statements Attachment C4). The facility respectfully requests the review of this citation, specifically the accuracy of the single observed/documented practice having the "potential to impact 44 to 44 residents who were served food in the facility," when the ADON did not come in contact with those residents consuming meals in areas other than the dining room.		

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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff washed their hands appropriately for 1 of 2 observations of PICC [Peripherally Inserted Central Catheter] line flushing and medication administration. [Resident #18]</p> <p>Findings include:</p> <p>An observation was made of RN #1 on 5/13/14 at 9:29 a.m., administering medication through Resident #18's PICC</p>	F000441	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. 1. Resident # 18 had no adverse reactions. RN # 1 was re-educated on proper hand washing during medication</p>	05/30/2014

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	line. She entered the resident's room and washed her hands. She turned off the faucet with a paper towel and continued to use the same paper towel to finish drying her hands. She exited the room and returned to the medication cart to retrieve the medications and supplies. She placed the items on a paper towel on the over the bed table. She told the resident she needed to give her hands a quick rinse. She used her bare hands to turn on the faucets and placed her hands in the stream of water. She rubbed them together twice and dried her hands. No soap was used. RN #1 returned to the resident and donned gloves. RN #1 flushed Resident #18's PICC line and removed her gloves. She exited the room and went to the medication room. RN #1 returned to the resident's room with new tubing and medication. She washed her hands, donned gloves, and proceeded to mix the medication and placed the tubing in the pump. She told the resident she had to give her hands a quick rinse again. She removed her gloves and used her bare hands to turn on the faucets. She ran her hands under the water quickly and dried them. She used the same towel to dry them that she had used to turn off the faucets. No soap was used. She returned to the resident and completed the procedure.		administration through a PICC line (See Attachment D).2. As any resident with a PICC line could be affected, Licensed staff re-educated on proper hand washing during medication administration through a PICC line. (See Attachment D1) The DON and/or designee will monitor PICC line medication administration 5 x weekly x 4 weeks, weekly x 4 weeks, then monthly thereafter.(See Attachment D2) Should non-compliance be observed, corrective action shall be taken.3. Licensed staff re-educated on proper hand washing during medication administration through a PICC line. (See Attachment D1) The DON and/or designee will monitor PICC line medication administration 5 x weekly x 4 weeks, weekly x 4 weeks, then monthly thereafter. (See Attachment D2) Should non-compliance be observed, corrective action shall be taken. 4. The DON and/or her designee will report the findings of Medication administration through a PICC line observations and any corrective actions taken to the QAA committee monthly x 3 months and then quarterly thereafter, and revisions made to the plan, if warranted.		

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F000520 SS=D	<p>During an interview with the RN consultant on 5/16/14 at 9:45 a.m., she indicated RN #1 should have used soap every time she washed her hands. She indicated the nurse did not follow the facility's hand washing procedure.</p> <p>RN Consultant provided the undated "Handwashing Procedure" on 5/15/14 at 12:59 p.m. The procedure indicated the following:</p> <p>"...2. Turn on faucet with paper towel.... 3. Apply soap to hands from the dispenser. 4. ...Wet hands and wrists. Rub vigorously for at least 15 seconds....7. Pat dry with paper towel. 8. Turn off faucets with paper towel and discard towel immediately in waste receptacle."</p> <p>3.1-18(I) 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155527		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/16/2014	
NAME OF PROVIDER OR SUPPLIER PINEKNOLL REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N MIDDLE SCHOOL RD WINCHESTER, IN 47394			
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	<p>appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility's Quality Assurance Committee failed to identify and address the need for a tool/method for staff to determine the assistance needs of residents when care planned for assistance of 1 to 2 staff to prevent falls. (Resident #55)</p> <p>Findings include:</p> <p>The clinical record for Resident #55 was reviewed on 5/14/14 at 8:34 a.m. Diagnoses for the resident included, but were not limited to, seizure disorder, severe mental retardation with developmental disability, non-verbal and urinary retention.</p> <p>A fall investigation report, provided by the Director of Nursing on 5/14/14 at 8:53 a.m., indicated Resident #55 was lowered to the floor by CNA #4 during a</p>	F000520	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. 1. Corrective actions as described in the Plan of Correction were taken for all residents relative to the need for developing a tool to determine a method for the assistance needs of the residents' when care planned for assistance of 1 or 2 staff members. 2. As all residents could be affected, the following corrective actions have been taken. The Administrative staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not be limited to the need for developing a tool to</p>	05/30/2014			

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	<p>transfer from a shower chair to the bed on 3/1/14 at 12:38 p.m. The report indicated CNA #4 was transferring the resident and further indicated the resident was not a two person assist with transfers.</p> <p>During an interview with the Administrator in Training (AIT), who was the previous Director of Nursing (DoN), on 5/14/14 at 2:38 p.m., she indicated Resident #55 was care planned for 1 to 2 staff assistance when providing care. The AIT indicated there was not a tool/method for the staff to use to determine if 1 or 2 staff assistance was needed when the resident was care planned for 1 to 2 staff assistance. She indicated the resident had been an assist of 1 to 2 at the time of the incident on the CNA assignment sheet. She further indicated the CNA assignment sheet had the assistance the resident required.</p> <p>During an interview with the Administrator and AIT on 5/16/14 on 12:17 p.m., the Administrator indicated falls were reviewed daily. She further indicated the need for a tool/method for the staff to determine the amount of staff required for safe transfers when the resident was care planned for 1 to 2 staff assistance had not been identified.</p> <p>3.1-52(b)(2)</p>		<p>determine a method for the assistance needs of the residents' when care planned for assistance of 1 or 2 staff members. 3. Administrative staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not limited to the need for developing a tool to determine a method for the assistance needs of the residents' when care planned for assistance of 1 or 2 staff members. Additional areas of concern if identified during morning meetings shall also be addressed relative to potential training and monitoring for compliance to be implemented in an effort to promote quality assessment and performance improvement. 4. As a means of Quality Assurance, The DON and/or designee shall report findings of aforementioned audits and immediate corrective actions taken via identification of need for quality assurance and performance improvement to the QAA Committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next QAA meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement</p>		

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			appropriate plans of actions to correct identified quality deficiencies.	