

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: June 10, 11, 12, 13, and 16, 2014.</p> <p>Facility number: 000411 Provider number:155384 AIM number: 100275100</p> <p>Survey team: Terri Walters RN TC Amy Wininger RN Sylvia Scales RN</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payor type: Medicare: 6 Medicaid: 52 Other:13 Total: 71</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 18, 2014 by Jodi Meyer, RN</p>	F000000	Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility set forth. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 Programs. We would like to request a desk review. Thank you Julie Pennington	
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT			

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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	<p>ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure allegations of</p>	F000225	What corrective action(s) will be accomplished for those residents found to have been affected by	07/16/2014	

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	<p>abuse were reported immediately to the Executive Director for 1 of 3 allegations reviewed and/or the facility failed to ensure allegations of abuse were reported immediately to the state agency for 1 of 3 allegations reviewed. Resident #38 Resident #51</p> <p>Findings include:</p> <p>1. A facility "UNUSUAL OCCURRENCE REPORT FOLLOW UP" dated 3/10/14 indicated Resident #51 had reported to CNA #8 that CNA #9, "... had come in the room one day last week and woke him up by grabbing his scrotum. The investigation is underway..."</p> <p>The facility report indicated RN #2 documented at 5:15 A.M. (3/10/14), "...Resident (#51) told CNA #8 that CNA #9 had come in room 1 day last week & woke him up grabbing his scrotum- said she had short blond hair. CNA #8 reported this to me..."</p> <p>Documentation by RN #2 on 3/10/14 at 5:20 A.M., indicated, "I asked (Resident's name) Resident #51 what had happened, he said he didn't remember but she had short blond hair, said she grabbed his scrotum inappropriately, said it happened in the early morning..." "... he</p>		<p>this deficient practice?Any allegations of abuse will be reported to the Executive Director/Designee immediately and within two hours to the law enforcement and ISDH.How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Inservicing will be provided to staff regarding reporting the allegation immediately to the Executive Director/Designee and reporting to the ISDH and law enforcement within two hours. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Audits will be put into place for monitoring the reporting procedure. Audits will be conducted five times a week by the ED/Designee for two months, four times a week for one month, three times a week for one month, two times a week for one month and one time a week for one month. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time monthly in the QAPI meeting for six months or until no more corrective actions are required.</p>				

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	<p>said 'No' I didn't have my light on said he was asleep & she just came in & grabbed him..."</p> <p>The unusual occurrence report indicated the Executive Director had been notified of the allegation on 3/10/14 at 5:15 A.M., on 3/10/14 at 9:00 A.M.</p> <p>On 6/16/14 at 7:44 A.M., the Executive Director was interviewed regarding the reporting of the allegation by the resident on 3/10/14 at 5:15 A.M. to a CNA and then to the Executive Director, 3.75 hours later. The Executive Director at that time indicated 3.75 hours later was not an immediate notification.</p> <p>The facility abuse policy entitled "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property Guideline (Revision 2013) was reviewed on 6/11/14 at 1:30 P.M. The policy included, but was not limited to, "...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violations') are reported immediately to the executive director of the center..."</p>						

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	<p>2. A facility report entitled, "Unusual Occurrence Report" dated 4/21/14, indicated "...Resident name (Resident #38) told the Business Office Manager (BOM #1), that her Power of Attorney had taken her guns and quilt from her home last year. She also stated that the Social Services Director (SSD) took some jewelry last year. Resident name (Resident #38) was admitted to the facility on October 12, 2012..."</p> <p>Facility documentation provided on 6/13/14 at 9:40 A.M., by the Executive Director indicated BOM #1 had been notified of the allegation on 4/21/14 at 3:00 P.M. by Resident #38. The BOM then notified the Executive Director of the allegation on 4/21/14 at 3:30 P.M. Facility documentation indicated the Indiana State Department of Health had been notified on 4/22/14 at 1:54 P.M.</p> <p>On 6/16/14 at 7:44 A.M., the Executive Director was interviewed regarding the notification of the state agency of the 4/21/14 allegation. She indicated at that time the facility policy indicated to report to the State Department of Health within 24 hours. The Executive Director was made aware at that time an allegation should be reported immediately.</p>						

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F000226 SS=D	<p>The facility abuse policy entitled "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property Guideline (Revision 2013) was reviewed on 6/11/14 at 1:30 P.M. The policy included but was not limited to, "...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violations') are reported immediately to the executive director of the center.</p> <p>Such violations are also reported to state agencies in accordance with existing state law..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the facility abuse policy was implemented in regard to immediate notification of the</p>	F000226	What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?Any allegations of abuse will be	07/16/2014			

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	<p>Executive Director of an allegation of abuse for 1 of 3 allegations of abuse reviewed and/or the facility policy failed to ensure the state agency was notified promptly of an allegation of abuse for 1 of 3 allegations of abuse reviewed. Resident #51 Resident #38</p> <p>Findings include:</p> <p>1. A facility "UNUSUAL OCCURRENCE REPORT FOLLOW UP" dated 3/10/14 indicated Resident #51 had reported to CNA #8 that CNA #9, "... had come in the room one day last week and woke him up by grabbing his scrotum. The investigation is underway..."</p> <p>The facility report indicated RN #2 documented at 5:15 A.M. (3/10/14), "...Resident (#51) told CNA #8 that CNA #9 had come in room 1 day last week & woke him up grabbing his scrotum- said she had short blond hair. CNA # 8 reported this to me..."</p> <p>Documentation by RN #2 on 3/10/14 at 5:20 A.M., indicated, "I asked (Resident's name) Resident #51 what had happened, he said he didn't remember but she had short blond hair, said she grabbed his scrotum inappropriately, said it happened in the early morning..." "... he</p>		<p>reported to the Executive Director/Designee immediately and within two hours to the law enforcement and ISDH. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Inserviceing will be provided to staff regarding reporting the allegation immediately to the Executive Director/Designee and reported to the law enforcement and ISDH within two hours. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be put into place for monitoring the reporting procedure. Audits will be conducted five times a week by the ED/Designee for two months, four times a week for one month, three times a week for one month, two times a week for one month and one time a week for one month. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time monthly in the QAPI meeting for six months or until no more corrective actions are required.</p>	

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	<p>said 'No' I didn't have my light on said he was asleep & she just came in & grabbed him..."</p> <p>The unusual occurrence report indicated the Executive Director had been notified of the allegation on 3/10/14 at 5:15 A.M., on 3/10/14 at 9:00 A.M.</p> <p>On 6/16/14 at 7:44 A.M., the Executive Director was interviewed regarding the reporting of the allegation by the resident on 3/10/14 at 5:15 A.M. to a CNA and then to the Executive director, 3.75 hours later. The Executive Director at that time indicated 3.75 hours later was not an immediate notification.</p> <p>The facility abuse policy entitled "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property Guideline (Revision 2013) was reviewed on 6/11/14 at 1:30 P.M. The policy included but was not limited to, "...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violations') are reported immediately to the executive director of the center..."</p>			

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	<p>2. A facility report entitled, "Unusual Occurrence Report" dated 4/21/14, indicated "...Resident name (Resident #38) told the Business Office Manager (BOM #1), that her Power of Attorney had taken her guns and quilt from her home last year. She also stated that the Social Services Director (SSD) took some jewelry last year. Resident name (Resident #38) was admitted to the facility on October 12, 2012..."</p> <p>Facility documentation provided on 6/13/14 at 9:40 A.M., by the Executive Director indicated BOM #1 had been notified of the allegation on 4/21/14 at 3:00 P.M. by Resident #38. The BOM then notified the Executive Director of the allegation on 4/21/14 at 3:30 P.M. Facility documentation indicated the Indiana State Department of Health had been notified on 4/22/14 at 1:54 P.M.</p> <p>On 6/16/14 at 7:44 A.M., the Executive Director was interviewed regarding the notification of the state agency of the 4/21/14 allegation. She indicated at that time the facility policy indicated to report to the State Department of Health within 24 hours. The Executive Director was made aware at that time an allegation should be reported immediately.</p>						

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F000371 SS=F	<p>The facility abuse policy entitled "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Resident Property Guideline (Revision 2013) was reviewed on 6/11/14 at 1:30 P.M. The policy included but was not limited to, "...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violations') are reported immediately to the executive director of the center.</p> <p>Such violations are also reported to state agencies in accordance with existing state law..."</p> <p>The facility abuse policy had not included the time period required for the state agency notification.</p> <p>3.1-28(a)</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>						

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	<p>Based on observation, interview, and record review the facility failed to ensure food was prepared under sanitary conditions and/or stored at the proper temperature, in that, staff did not have hair completely contained within a hair restraint during 4 of 5 kitchen observations and the temperature of the walk-in refrigerator exceeded 40 degrees Fahrenheit on 3 of 5 kitchen observations. This had the potential to affect 71 of 71 residents who resided in the facility.</p> <p>Findings include:</p> <p>The following was observed during the initial kitchen tour on 06/10/14 at 9:00 A.M.:</p> <p>1. The CDM (Certified Dietary Manager), DA (Dietary Assistant) #1, DA #2, DA #3, DA #4, and Cook #3 were in the food preparation area with hair not completely contained within a hair restraint.</p> <p>2. The thermometer inside of the walk-in refrigerator indicated the temperature was 44 degrees Fahrenheit.</p> <p>The following was observed on 06/10/14 at 10:45 A.M.:</p>	F000371	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Corrective measures were accomplished as follows: the walk in refrigerator compressor was replaced with a new compressor, staff contained hair in hairnets appropriately and staff ensured the refrigerator door was closed properly to maintain proper temperature controls. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. A new compressor was placed in the refrigerator. The staff will wear hairnets properly while in the food storage area and ensure the refrigerator door is closing properly to maintain the correct temperature in the walkin refrigerator. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Audits will be put into place for monitoring of the walk in kitchen refrigerator, proper usage of hairnets and properly closing the refrigerator door. Audits will be conducted five times a week by the DSM/Designee for two months, four times a week for one month, three times a week for one month, two times a week for one month and one time</p>	07/16/2014			

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	<p>3. The CDM, Cook #1, and DA #1 were in the food preparation area with hair not completely contained within a hair restraint.</p> <p>The following was observed on 06/10/14 at 2:17 P.M.:</p> <p>4. The CDM, Cook #1, Cook #2, and DA #1 were in the food preparation area with hair not completely contained within a hair restraint.</p> <p>5. The thermometer inside of the walk-in refrigerator indicated the temperature was 50 degrees Fahrenheit.</p> <p>During an interview with on 06/10/14 at 2:30 P.M., the CDM indicated the temperature of the walk-in refrigerator had been above 40 degrees Fahrenheit for at least 4 1/2 hours on 6/10/14 due to a mechanical problem.</p> <p>The walk-in refrigerator log provided by the CDM on 06/10/14 at 3:00 P.M. indicated, "...Frigerator (sic) should be 41 or below..."</p> <p>The following was observed on 06/11/14 at 8:00 A.M.:</p> <p>6. The CDM and DA #4 were in the food preparation area with hair not completely</p>		<p>a week for one month. An inservice was provided for staff on the proper usage of hairnets while in the kitchen food preparation area and properly closing the walk in refrigerator door to ensure temperatures remain within state/federal guidelines. How will the corrective action be monitored to ensure the deficient practice does not recur? An audit review will be conducted one time monthly in the QAPI meeting for six months or until no more corrective actions are required.</p>		

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	<p>contained within a hair restraint.</p> <p>The following was observed on 06/13/14 at 8:10 A.M.:</p> <p>7. The CDM, Cook #3, DA #1, and DA #2 were in the food preparation area with hair not completely contained in a hair restraint.</p> <p>8. The walk in refrigerator door was completely open from 8:10 A.M. through 8:29 A.M. (19 minutes)</p> <p>9. The MS (Maintenance Supervisor) #1 was in the food preparation area with an uncovered beard.</p> <p>10. The walk in refrigerator door was not fully shut and the thermometer indicated the inner temperature of the refrigerator was 46 degrees Fahrenheit. During an interview, at that time, the CDM verified the inner temperature of the refrigerator was 46 degrees Fahrenheit.</p> <p>During an interview on 06/13/14 at 9:00 A.M., the Dietary Consultant indicated the initial temperature problem on 06/10/14 with the walk in refrigerator was a mechanical problem, but since the unit was repaired on 06/11/14 the temperature problem was because the door not being shut completely.</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
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	<p>During an interview on 06/13/14 at 9:10 A.M., the CDM indicated the temperature of the walk in refrigerator should be 40 degrees Fahrenheit or lower. The CDM further indicated, at that time, the walk-in refrigerator door should be shut tightly.</p> <p>During an interview on 06/13/14 at 10:00 A.M., the Dietary Consultant indicated the staff sometimes left the walk-in refrigerator door open longer than they should. The Dietary Consultant then indicated all staff should have hair completely contained when in the kitchen.</p> <p>The Policy and Procedure for Dining Services Employee Hair Guidelines provided by the HFA (Health Facilities Administrator) on 06/13/14 at 10:30 A.M. indicated, "...Dining Services employees must wear hair restraints, such as hair coverings or nets, and beard restraints. These hair restraints must be designed and worn to effectively keep hair from contacting exposed food, equipment, utensils and unwrapped single-service ware...Hairnets or disposable ...caps must cover all hair completely...all staff (whether a Dining Services employee or not) in the preparation area ...must wear appropriate hair restraint covering all hair..."</p>			

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F000431 SS=D	<p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>			

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	<p>dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to properly label medication stored in 1 of 3 medication rooms observed, in that, an open multi use vial of an injectable medication did not have an open date. This deficient practice affected 1 of 3 medication rooms. (200 Medication Storage Room)</p> <p>Findings Include:</p> <p>The 200 unit medication room was observed on 6/16/14 at 11:27 A.M., with LPN #1. During the observation an open multi dose vial of Tuberculin aplisol 5GU/0.01ml (tuberculin purified protein derivative) was found in the refrigerator. The bottle did not have an open date. LPN #1 confirmed there was no open date on the bottle.</p> <p>On 6/16/14 at 11:30 A.M., The Assistant Director of Nursing (ADON) was interviewed, he indicated, the bottle of Tuberculin purified aplisol should have been marked with an open date. He further indicated the medication was good for thirty days after it was opened.</p> <p>On 6/16/14 at 12:50 P.M., the Director of Nursing (DON) provided the facility policy titled. "Medication Storage in the</p>	F000431	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?The tuberculin multi dose vial was removed and destroyed from the 200 Unit medication storage room.How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. We also checked the 100 and 400 unit medication rooms to ensure there were no undated tuberculin multi dose vials and none were found.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Education will be provided to the nurses to ensure tuberculin multi dose vials are dated upon opening. Audits will be conducted on units 100, 200 and 400 medication storage rooms to ensure no undated tuberculin multi dose vials are present. Audits will be conducted by the ADNS or designee five times weekly for two months, four days a week for one month, three days a week for a month, two days a week for a month, and one day a week for a month. How will the corrective actions be monitored? The audit results will be monitored through the</p>	07/16/2014	

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F000441 SS=D	<p>Facility" dated 5/12, it included on Page 3, paragraph E, "...When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration..., the expiration date of the vial or container will be 30 days..."</p> <p>3.1-25(o)</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 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</p>		monthly QAPI process for six months or until corrective action is no longer needed.	

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	<p>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 (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 interview, observation and record review, the facility failed to ensure a facility policy was implemented and/or an effective disinfectant detergent had been utilized to effectively clean an isolation room which housed a resident with the pathogen Clostridium Difficile (C.diff) for 1 of 1 resident reviewed with Clostridium Difficile. Resident #70</p> <p>Findings include:</p> <p>On 6/16/14 at 12:25 P.M., Resident #70 was observed sitting in her wheelchair in her room. An orange sign outside her</p>	F000441	<p>What corrective action will be accomplished for residents found affected by the deficient practice? Room #70 was cleaned properly by the housekeeping staff.How will other residents having the potential to be affected by the alleged deficient practice cited be identified?The facility recognizes that all residents have the potential to be affected by the deficient practice.The housekeeping supervisor will be informed in the morning meeting of any resident(s) in isolation. Isolation signs are posted at resident doorways for identification. What</p>	07/16/2014

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	<p>room door indicated to please see the charge nurse before entering the room.</p> <p>On 6/13/14 at 9:05 A.M., Resident #70's clinical record was reviewed. Her diagnoses included, but were not limited to, senile dementia and intestinal infections due to Clostridium Difficile. A lab report dated 5/31/14 was positive for C Difficile Toxin A&B. A physician's order dated 6/2/14 was for Flagyl (an antibiotic) 500 mg three times a day for 10 days to treat C Difficile.</p> <p>On 6/13/14 at 9:15 A.M., Housekeeper staff #1 was interviewed regarding the cleaning of Resident #70's room. Housekeeper #1 indicated Resident #70 was in contact isolation. Housekeeper #1 indicated she cleans Resident #70's room last. She indicated she wears a gown and gloves to clean the room. She indicated she uses a disinfectant cleaner called Neutral to clean bed frames, all furniture and the window sills. Housekeeper #1 indicated she uses a bathroom cleaner to clean the bathroom. She indicated she used the same cleaners to clean the isolation room as the other resident rooms. Housekeeper #1 indicated the chemicals for mopping were stored in the laundry room area.</p>		<p>measures/systemic changes will be made to ensure that the deficient practice does not recur? The housekeeping staff will be inserviced on proper cleaning and identification of residents in isolation rooms. The Housekeeping Supervisor or Designee will conduct audits of isolation rooms during the cleaning process five times a week for two months, four times a week for one month, three times a week for one month, two times a week for one month and one time a week for one month. How will the facility monitor the corrective practice? Audits will be reviewed monthly in the QAPI meeting for six months or until no further corrective action is needed.</p>		

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	<p>On 6/13/14 at 9:25 A.M., Laundry staff #1 was interviewed regarding cleaners used to clean resident rooms. She located a wall dispenser in the laundry room that dispensed cleaners the housekeeping staff used. She indicated the cleaning solution used for mopping of any floor (C. diff room or any room) was QC31 Neutral Cleaner. The other cleaner used by staff was called Ultra Concentrated Acid Bathroom Cleaner (QC91) and was used to clean any bathrooms. Laundry staff #1 indicated housekeeping staff also use a Peroxide Glass & Service Cleaner.</p> <p>On 6/13/14 at 9:32 A.M., the Assistant Housekeeping Laundry Supervisor during interview indicated he was not sure any of the 3 cleaners used by housekeeping staff (QC31 Neutral , Ultra Concentrated Acid Bathroom, or Peroxide Glass) contained bleach.</p> <p>On 6/13/14 at 9:40 A.M., the Housekeeping Laundry Supervisor during interview indicated the same chemicals/cleaners were used to clean all rooms including isolation rooms. The Assistant Housekeeping Laundry supervisor at that time reviewed the Material Safety Data (MSD) Sheet of the 3 cleaners and indicated the cleaners did not contain bleach. The Assistant Housekeeping Laundry Supervisor</p>						

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	<p>indicated at that time he had given bleach to housekeeping staff last Friday. The Housekeeping Laundry Supervisor indicated he had containers of bleach he kept locked up in his office. During interview with the Laundry Housekeeping Supervisor and the Assistant Housekeeping Laundry Supervisor at that time it could not be determined if bleach was being used to clean isolation rooms on a specific schedule.</p> <p>On 6/13/14 at 10:40 A.M., the Laundry Housekeeping Supervisor provided a policy entitled, "Cleaning and Disinfection of Environmental Surfaces (Revision October 2009). The policy included but was not limited to, "... 19. In units with high rates of endemic Clostridium difficile infection or in an outbreak setting dilute solutions of 5.25% -6.15% sodium hypochlorite (e.g., 1:10 dilution of household bleach) will be used for routine environmental disinfection. (Note: Currently, no products are EPA-registered specifically for inactivating C. difficle spores.)" The Housekeeping Laundry Supervisor indicated at that time he thinks C diff rooms should be cleaned with bleach x 7 weekly or daily.</p> <p>3.1-18(b)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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