

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155070	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2015
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NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY RD NEW ALBANY, IN 47150
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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00167510.</p> <p>Complaint IN00167510 - Substantiated. Federal/State deficiency related to the allegation is cited at F441.</p> <p>Survey date: March 12, 2015</p> <p>Facility number: 000028 Provider number: 155070 AIM number: 100275370</p> <p>Survey team: Josh Emily, RN-TC Debra Holmes, RN</p> <p>Census bed type: SNF/NF: 99 Total: 99</p> <p>Census payor type: Medicare: 12 Medicaid: 79 Other: 8 Total: 99</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F 000	<p><b>Allegation of Compliance</b> Please accept the following plan of correction for the complaint survey on March 12, 2015. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to the residents in our community. We respectfully request consideration for a desk review and paper compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 441 SS=D Bldg. 00	<p>16.2-3.1. Quality review completed on March 14, 2015 by Cheryl Fielden, RN.</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 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>						

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	<p>(c) Linens 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 demonstrate proper hand washing during the performance of resident care for 1 of 4 residents reviewed for incontinence care. (Resident #D)</p> <p>Findings include:</p> <p>On 3/12/15 at 10:40 A.M., Certified Nursing Assistant (CNA) #2 and CNA #4 were observed performing care on Resident #D. CNA #2 removed a soiled bandage from the coccyx area of the resident's buttocks and requested CNA #4 to find the nurse to replace the removed, soiled bandage. CNA #4 removed her gloves, washed her hands per facility policy and requested the nurse to assist the resident. Licensed Practical Nurse (LPN) #3 entered the resident's room with the needed supplies, donned gloves as she entered the room and did not wash hands prior to donning gloves. LPN #3 opened a foil package of skin prep (used to help bandage adhere to skin), applied the skin prep and applied the bandage to Resident #D's bottom. CNA #2 squeezed barrier cream into the gloved hand of LPN #3 and LPN #3 applied the barrier</p>	F 441	<p>1. Upon review of the alleged incident as cited in the Summary Statement of Deficiencies, no harm was incurred by resident D related to the alleged deficient practice. On 3/16/2015, the associates that failed to follow proper hand washing procedures during resident care was provided counseling on hand washing and glove use.</p> <p>2. Residents that receive incontinence care and dressing changes have the potential to be affected by the same deficient practice.</p> <p>3. On 3/13/2015, the Staff Development Coordinator provided re-education to facility staff regarding the glove use and proper hand washing with return demonstration.</p> <p>4. Director of Nursing or designee will audit resident care for proper glove use and hand washing at least ten (10) times per week for four (4) weeks and continue weekly for no less than two (2) additional months. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The Committee will reevaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing</p>	03/16/2015

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	<p>cream to Resident #D's buttocks. LPN #3 removed her gloves, discarded the gloves into the trash can and washed her hands into the sink in Resident #D's room for 5 seconds. LPN #3 then dried her hands on a paper towel, used the paper towel to turn off the faucet, and exited the residents room.</p> <p>During an interview on 3/12/15, at 11:25 A.M., CNA #1 indicated the proper hand washing time is 2 minutes and CNA #3 indicated the proper hand washing time is 30 seconds.</p> <p>During an interview with LPN #2, at 11:30 A.M., on 3/12/15, LPN #2 indicated the proper hand washing time is 30 seconds</p> <p>During an interview with LPN #3, at 3:45 P.M., on 3/12/15, LPN #3 indicated the proper hand washing time is 30 seconds.</p> <p>A document titled, "Hand Hygiene", was provided by the Assistant Director of Nursing (ADON) at 3:03 P.M., on 3/12/15 and this document was indicated as the policy and procedure currently in use by the facility for hand washing. This document indicated ...3. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction.</p>		<p>audits. The Staff Development Coordinator or designee will complete at least four (4) monthly audits and/or observations of staff for proper infection control practices on an ongoing basis. Plan to be updated as indicated.</p>				

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

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	This Federal tag relates to Complaint IN00167510.  3.1-18(1)				