

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2016
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included a State Residential Licensure Survey.</p> <p>Survey dates: March 28, 29, 30, 31, and April 1, and 4, 2016.</p> <p>Facility number: 001144 Provider number: 155668 AIM number: 200256980</p> <p>Census bed type: SNF: 58 SNF/NF: 74 Residential: 2 Total: 134</p> <p>Census payor type: Medicare: 29 Medicaid: 61 Other: 42 Total: 132</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on April 11, 2016.</p>	F 0000	To the best of my knowledge and belief, as an agent of Diversicare of Providence, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements Preparation and execution of the plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of Federal and state law	

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 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the residents' drug regimen was free from duplicate therapy, had adequate monitoring of behaviors and/or was at the lowest effective dose for 2 of 5 residents reviewed for unnecessary medications. (Residents #46 and #5)</p>	F 0329	<p>F329 Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. Resident #46 has had anxiolytic and antidepressant medications reviewed by the primary physician and psychiatric services.</p> <p>2. Documentation has been</p>	05/02/2016

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	<p>Findings include:</p> <p>1. Review of the clinical record for Resident #46 on 3/29/16 at 12:45 p.m., indicated the resident had diagnoses which included, but were not limited to: depression and anxiety.</p> <p>On 1/15/16, the resident was admitted with an order for Xanax (for anxiety) 0.25 mg (milligrams) - 1 tablet BID (twice daily).</p> <p>On 1/29/16, the physician made a visit and indicated the resident appeared depressed and gave an order for Mirtzapine (Remeron for depression) 15 mg - 1 tablet at night.</p> <p>The 1/29/16 14 Day Admission MDS (Minimum Data Set) assessment indicated the resident's BIMS (Brief Interview Mental Status) score was = 10 - poor long term recall with good orientation to current day, week, month; was restless, feeling tired and had trouble concentrating 2-6 times weekly; and had no behavior issues.</p> <p>On 2/3/16, the resident was seen by the psychiatrist who indicated "Staff reported since admission patient has been anxious and tearful, with poor appetite. Hospital records indicate resident while at home</p>		<p>obtained from physicians documenting the need for more than one antidepressant and need for medication changes ordered for Resident #46.</p> <p>3.Resident #5 has had her anxiolytic and antidepressant discontinued.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1.The Pharmacist has completed an audit of residents on psychotropic medications, to include anxiolytics, antidepressants and antipsychotics, to check for duplicate therapy, last dose reductions attempts and non-use of PRN medications.</p> <p>2.If changes were indicated, orders have been requested.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <p>1. Social Services has developed an audit sheet for each resident with orders for psychotropic medications listing medications ordered. (Attachment A)</p> <p>2.This log will be monitored monthly for duplicate therapy, last dose reduction attempts and non-use of medications.</p> <p>3.Education has been completed with the pharmacist regarding</p>	

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	<p>was on Xanax 1 mg BID and Remeron but no dosing was listed for Remeron. Prior to lengthy hospitalization, resident lived independently with grandson. During the evaluation, the resident's chief complaint was feel sad, had been treated by psych in the past for depression. Diagnoses: Major Depression, recurrent; General anxiety disorder, and psychosocial stressors r/t (related to) LTC (Long Term Care). Due to increased s/s (signs/symptoms) of depression, ordered Lexapro 5 mg qd (every day) for increased s/s of depression.</p> <p>On 2/6/16, a new physician order was received to increase the resident's Xanax from 0.25 mg BID to 0.5 mg TID (3 times daily) for anxiety.</p> <p>The 3/14/16 Quarterly MDS assessment indicated the resident's BIMS score = 9 - moderate cognitive impairments with poor recall to both long and short term memory; had trouble concentrating and was restless 2-6 days a week; and had no behavior issues.</p> <p>Review of the Interdisciplinary Progress Notes and MAR (Medication Administration Record)/Behavior Logs between 1/15/16 and 3/31/16 failed to indicate the resident was experiencing episodes of anxiety or depression which</p>		<p>expectations of documentation on duplicate therapy, dose reduction attempts or why attempts are not ordered and checking for non-use of psychotropic PRN medications.</p> <p>4. Physicians have been provided our guidelines and expectations regarding documentation on duplicate therapy, dose reduction attempts or why attempts are not ordered and checking for non-use of psychotropic PRN medications</p> <p>5. Order changes and new orders for psychotropic medications will be monitored at clinical start-up meeting for duplicate therapy. (Attachment B)</p> <p>6. Education has been completed with nursing team members on the Behavior Documentation form to include the relevance to ordered psychotropic medications and gradual dose reductions.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>1. The psychotropic medication log will be audited monthly continuously by social services for duplicate therapy, last dose reduction attempts and non-use of medications.</p> <p>2. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting monthly.</p>				

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	<p>required 2 anti-depressants and an increase in the resident's Xanax to be ordered..</p> <p>The February and March 2016 Behavior Monitoring logs for "Increased anxiety" indicated the resident experienced only 1 episode of anxiety: "March 6 - re-direction and 1-1 provided but behavior remained unchanged."</p> <p>During an interview with Social Worker #1 on 4/1/16 at 11:00 .a.m., she indicated that the way it was explained to her was when the physician visited, she thought the resident was depressed over being in the NH (Nursing Home) and her health and ordered the Remeron. Then the Psychiatrist came in and saw that the resident was still experiencing increased depression and ordered the Lexapro to be given. The Social Worker indicated that she could only guess the doctors wanted to given both of them together but they should have documented it if that was the case.</p> <p>She also indicated it should be documented on the MAR or the behavior monitoring sheets whenever the resident was experiencing episodes of anxiety. She indicated Therapy also reported that when the resident was first admitted, she was very anxious and crying every time</p>			

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	<p>they went into her room. That was when the physician increased her Xanax. The daughter also had made the request for her Xanax to be increased close to what it was at home.</p> <p>During an interview with the Director of Nursing on 4/4/16 at 3:30 p.m., she indicated the resident was experiencing more episodes of anxiety than what was documented and that it should have been no matter how many times it occurred.</p> <p>2. A Quarterly Minimum Data Set (MDS) assessment indicated the resident had a BIMS (Brief Interview for Mental Status) of 06 out of 15 indicating the resident was cognitively impaired. The resident's functional status indicated extensive assistance with a two person physical assistance. The resident was frequently incontinent of bladder and always incontinent of bowel.</p> <p>The review of the Care Plan on 03/30/2016 at 1:15 p.m., indicated " I am having thoughts of death/dying with no intent of harm to myself or others and feelings of sadness and hopelessness at times. The goal is I will seek help when thoughts of death/dying are present." The Interventions indicated, but was not limited to, "Refer me to a psychological counseling/mental health specialist as needed. Encourage me to share my</p>			

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	<p>thoughts and be empathetic to my feelings, and observe for changes in my mood status."</p> <p>The clinical record review on 03/30/16 at 1:15 p.m., of Resident # 5's diagnoses indicated, but was not limited to, heart failure, chronic obstructive pulmonary disease, hypertension, major depressive disorder, anxiety disorder, insomnia, osteoarthritis, and arthropathy.</p> <p>The review of the Physician's orders on 03/30/16 at 1:15 p.m., indicated "The resident may be seen by Psychiatric Services as needed. Lexapro 10 mg [milligrams] daily by mouth and behavior monitoring every shift."</p> <p>During a clinical record review on 03/31/2016 at 7:47 p.m., the eMar (electronic medication administration record) from October 2015 to March 2016, the resident had one behavior episode of screaming on January 18, 2016. The resident was repositioned and received one on one care. The resident stopped screaming. No medication was given.</p> <p>During an interview with the Director of Nursing (DON) on 03/31/2016 at 10:44 a.m., she indicated, "I am not sure how often we are suppose to do a GDR</p>			

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	<p>[Gradual Dose Reduction]. I will have to ask our pharmacist to make sure."</p> <p>On 3/31/16 at 11:45a.m., during an interview with the DON, she indicated, " I talked to our pharmacist and she indicated she did not write a GDR because psychiatric services makes the decision, if a resident is to be on a medication and why a GDR should not be done. The DON pointed out on the clinical record: A trial dose reduction of the psych medications are contraindicated secondary to risk for exacerbation of mood dysregualtion and cognitive impairment.</p> <p>During an interview with the DON on 04/01/2016 at 11:30 a.m., she indicated it was up to the pharmacist if a GDR is done. During a review of the clinical record with the DON she indicated no prior GDR's could be located for the medications Xanax and Lexapro in the resident's clinical record. The records indicated the resident's start date for Xanax 0.25mg was on 12/19/13 and the start date for Lexapro10mg was on 3/15/14.</p> <p>During an interview with LPN (Licensed Practical Nurse) # 1 on 04/01/16 at 1:45 p.m., she indicated for a resident on an antidepressant or anxiety medication, she</p>			

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	<p>would look for drowsiness, sweating, confusion, or a change in behavior.</p> <p>During a review of the Long Term Care Facility Pharmacy Services and Procedures Manual on 04/03/16 at 5:13 p.m., indicated the facility should encourage Physicians/Prescribers or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber interventions, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendations were rejected. Evaluate facility documentation related to behavior and adverse effects monitoring for medications. Evaluate appropriate utilization and documentation of non-pharmacologic interventions, either instead of, or in conjunction with, appropriate medication therapy. Provide quarterly reports reflecting facility-level drug utilization and clinical management trends, with corresponding recommendations to improve clinical care delivered and potential savings using preferred drug management and</p>			

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F 0441 SS=E Bldg. 00	<p>formulary compliance.</p> <p>A review of the Diversicare Policy and Procedure indicated attempted tapering was one way to determine whether a specific medication was still indicated, and whether target symptoms and risks can be managed with a lesser dose of a medication. As noted, many medications in various categories can be tapered safely. During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility should attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated.</p> <p>3.1-48 (a) (2) 3.1-48 (a) (3) 3.1- (b) (2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an</p>				

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	<p>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> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to perform handwashing and incontinence care per facility policy to 4 of 5 observations of incontinence, catheter and wound care</p>	F 0441	<p>F441 Corrective actions accomplished for those residents found to have been affected by the deficient practice: 1.Handwashing and</p>	05/02/2016

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	<p>(Residents # 176, 80, and 134).</p> <p>Findings include:</p> <p>1. The observation of CNA (Certified Nursing Assistant) # 1, providing incontinence care on Resident # 176, on 03/31/16 at 9:25 a.m., indicated the CNA performed handwashing first, rubbing hands together for 5 seconds with a total handwashing time of 26 seconds. After applying gloves the CNA used the same side of a wet wipe to clean the left and right creases to each side of the labial area. The resident had a bowel movement prior to the start of care. The front labial area was cleaned first dragging the wipe from front to back into the area of the stool. The resident was rolled over and wet wipes were used to clean the stool from the anal area. The stool on the mid leg was drug from mid leg to the anal area twice, using the same side of the wipe. The CNA did not dry the resident and a clean brief was placed under the resident. The CNA performed handwashing, rubbing hands together for 14 seconds with the total handwashing time of 25 seconds.</p> <p>During an interview with CNA # 1, on 03/31/16 at 9:34 a.m., she indicated when handwashing, she would first turn on the water to test the temperature. Then apply</p>		<p>incontinence care are being provided per guidelines for Residents # 176, 80 and 134.</p> <p>2. Identified team members were educated immediately on appropriate hand hygiene and incontinence care for Residents #176, 80 and 134.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. All residents had the potential of being affected by the handwashing practice.</p> <p>2. The residents receiving incontinence care had the potential to be affected by the incontinence care practice.</p> <p>3. Team members have been educated on appropriate hand hygiene and incontinence care guidelines.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <p>1. Education has been completed with a return demonstration for nursing team members on appropriate hand hygiene guidelines.</p> <p>2. Education has been completed with a return demonstration for nursing team members on incontinence care guidelines.</p> <p>3. A skills checklist has been utilized with return demonstrations for both hand hygiene and incontinence care.</p>	

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	<p>soap and rub hands together for 15-20 seconds or sing the ABC song twice. Rinse until the soap is off. Dry with paper towels, and use paper towels to turn off the water.</p> <p>2. On 03/31/16 at 9:39 a.m., CNA # 2, provided incontinence care on Resident # 80, who was in contact isolation for ESBL (Extended spectrum beta-lactamase) [enzymes capable of breaking down penicillins, broad-spectrum cephalosporins and monobactams of the urine]. The CNA did not wash her hands prior to care. She applied applied PPE (personal protective equipment) [gloves and gown]. The resident was placed into bed using a hoier lift. The resident's brief was unfastened and using a wet wipe, the CNA rubbed over the entire front labial area in circular motions. The resident had a prior bowel movement and the back anal area was wiped using the same area of the wet wipe. The CNA did not dry the resident and a clean brief was placed under the resident and fastened. The CNA removed her gown, touching her hair to move it out of the way of the ties, then removed her gloves. The CNA washed her hands, then turned off the water with her bare hands, instead of using a paper towel. The hoier lift was pushed into the hall without cleaning it.</p>		<p>(Attachment C) 4. Random audits of hand hygiene and incontinence care will be conducted by the Director of Nursing Services or designee. How the corrective actions will be monitored to ensure the deficient practice will not recur: 1. The Assistant Directors of Nursing, Clinical Educator or designee will perform audits of hand hygiene and incontinence care for 25% of C.N.A.'s on each shift daily for one week, weekly for four weeks and then monthly continuously using the skills checklist. 2. The Assistant Directors of Nursing, Clinical Educator or designee will perform audits of hand hygiene and incontinence care for 25% of nurses on each shift daily for one week, weekly for four weeks and then monthly continuously using the skills check list. 3. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting monthly.</p>	

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	<p>The CNA joined another CNA to assist the care to another resident.</p> <p>During an interview on 03/31/16 at 9:50 a.m., following the incontinence care on the resident with ESBL, the DON (Director of Nursing) indicated the facility policy was to clean the hoyer lift, after use on a resident in contact isolation, using antimicrobial wipes.</p> <p>3. On 03/31/16 at 2:33 p.m., CNA # 3 and CNA # 4 provided suprapubic catheter care to Resident # 134. Both CNAs entered the resident's room and applied gloves without washing their hands. The resident's brief was unfastened and peeled down. The washcloth was wettened at the sink, no rinse soap was applied and the same area of the washcloth was used on the entire penectomy area of the catheter insertion site, using circular motions around the tubing. Once the tubing was cleaned and the area was dried, the brief was refastened. The CNAs removed their gloves. CNA # 4 performed handwashing, rubbing her hands together for 15 seconds. CNA # 3 ran water over her hands for 2 seconds and without using soap, pulled paper towels to dry her hands and turn off water.</p> <p>During an interview on 03/31/16 at 2:40</p>			

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	<p>p.m., CNA # 4 indicated when handwashing she would turn on the water, wetten and soap the hands, dry with paper towels and turn off the water with the paper towels, either the paper towels used or clean ones. She indicated to rub the soapy hands together for 15-30 seconds.</p> <p>4. On 04/01/16 at 9:30 a.m., the observation of the wound care on Resident # 134 by LPN (Licensed Practical Nurse) # 1 and CNA # 4 indicated both entered to resident's room and without handwashing, applied gloves, after the LPN placed supplies onto the nightstand. The supplies were opened and the LPN performed handwashing, rubbing her hands together for 10 seconds with a total handwashing time of 30 seconds. The glove box was empty, so the LPN left the room and returned with gloves. She applied clean gloves without rewashing and applied normal saline to a gauze. The gauze was rubbed across the wound using a back and forth motion, then dried with a fresh, dry gauze. The LPN removed her gloves and performed handwashing, rubbing her hands together for 24 seconds for a total handwashing time of 35 seconds. The LPN applied clean gloves. Silvasorb gel was applied to the wound, using a cotton swab. A border bandage was placed over</p>			

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	<p>the wound. The resident started to have a bowel movement, which got on the bandage. The LPN removed her gloves and performed handwashing, rubbing her hands together for 18 seconds for a total handwashing time of 30 seconds. The LPN obtained clean supplies from the cart in the hall. The CNA cleaned the stool from the resident's anal area. The LPN applied clean gloves without washing her hands. The soiled bandage was removed. The CNA performed handwashing, rubbing her hand together for 8 seconds with a total time of 28 seconds. The CNA applied fresh gloves. The LPN cleaned the wound was with normal saline on a gauze rubbing in a back and forth motion. She patted the wound dry with a dry gauze. The LPN removed her gloves and performed handwashing, rubbing her hands together for 15 seconds for a total handwashing time of 32 seconds. She applied clean gloves. Silvasorb gel was applied to a swab and applied to the wound. A border bandage was placed over the wound. The LPN removed her gloves and performed handwashing, rubbing her hands together for 12 seconds for a total handwashing time of 20 seconds. The CNA removed her gloves and performed handwashing, rubbing her hands together for 12 seconds for a total handwashing time of 30 seconds.</p>			

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	<p>During an interview with the DON on 04/01/16 at 10:47 a.m., the DON indicated there was no certain time for handwashing on the facility policy. Upon retrieving the policy the DON surprised to see the time on the policy and indicated it stated handwashing should be more than 15 seconds. The DON indicated the facility performed handwashing in-services monthly, or more often if needed.</p> <p>The DON indicated the facility policy for incontinence care did not indicate to clean the stool first, when performing incontinent care. The DON indicated the staff should use a front to back cleaning motion when performing incontinence care. She also indicated staff should fold wipes between swipes and not use the same side of the wet wipe.</p> <p>On 03/29/16 at 11:15 a.m., the Administrator provided a copy of the facility Hand-Hygiene Technique which indicated, but was not limited to, the following: When washing hands with soap and water: Wet hands first with water Apply an amount of product recommended by the manufacturer to hands</p>			

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	<p>Rub hands with water and dry thoroughly with a disposable towel</p> <p>Use towel to turn off the faucet</p> <p>The administrator provided a copy of the PROCEDURAL GUIDELINE 17-1</p> <p>Perineal Care which indicated, but was not limited to, the following:</p> <p>Equipment</p> <p>Washcloths, bath towels, and bath blanket</p> <p>Cleansing product, disposable wipes</p> <p>Laundry bag</p> <p>Wash basin, waterproof pad or bedpan</p> <p>Clean gloves....</p> <p>The Procedural Steps indicated, but was not limited to the following:</p> <p>3. Perform hand hygiene. Apply clean gloves.</p> <p>4. Perineal care for a female....</p> <p>c. Drape patient with bath blanket placed in shape of a diamond. Lift lower edge of bath blanket to expose perineum.</p> <p>d.Wash and dry patient's upper thighs.</p> <p>e. Wash labia majora. Use nondominant hand to gently retract labia fro thigh. Use dominant hand to wash carefully in skinfolds. Wipe in direction perineum to rectum (front to back). Repeat on opposite side using separate section of washcloth. Rinse and dry area thoroughly.</p> <p>f. Gently separate labia with nondominant hand to expose urethral meatus and vaginal orifice. With</p>			

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	<p>dominant hand wash downward from pubic area toward rectum in one smooth stroke....Use separate section of cloth for each stroke. Clean thoroughly over labia minora, clitoris, and vaginal orifice....</p> <p>g. Rinse and dry area thoroughly, using front-to-back method....</p> <p>On 03/31/16 at 11:53 a.m., the DON provided a copy of the Isolation-Categories of Transmission-Based Precautions which indicated, but was not limited to, the following:</p> <p>e. Resident-Care Equipment</p> <p>(1) When possible, dedicate the use of non-critical resident-care equipment itemsto avoid sharing between residents.</p> <p>(2) If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident.</p> <p>c. Gloves and Handwashing</p> <p>(1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room.</p> <p>(2) While caring for a resident, change gloves after having contact with infective material....</p> <p>(3) Remove gloves before leaving the room and perform hand hygiene.</p> <p>(4) After removing gloves and washing</p>			

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R 0000 Bldg. 00	hands, do not touch potential contaminated environmental surfaces or items in the resident's room. 3/1-18 (l)	R 0000	To the best of my knowledge and belief, as an agent of Diversicare of Providence, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of the plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by provisions of Federal and state law.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and			

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	<p>unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview the facility failed to ensure First Aid staff certification of employees for 11 of 11 scheduled dates reviewed.</p> <p>Findings include:</p> <p>The review of the employee schedule on 04/04/16 between 11:00 a.m., and 2:00 p.m., indicated no First Aid certified employees on the schedule to work during the following shifts for 03/29/16, 03/30/16, 03/31/16, 04/01/16, 04/02/16, 04/03/16, 04/04/16, 04/05/16, 04/06/16, 04/07/16, and 04/08/16: 6:30 a.m. to 2:30 p.m. shifts.</p>	R 0117	<p>R 117 Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. Residential residents were affected. A first aid certification course has been held for nursing team members.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. Residential residents had the potential of being affected by the same practice. A first aid certification course has been held for nursing team members.</p> <p>Measures put into place or</p>	05/02/2016			

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	<p>6:30 a.m. to 3:30 p.m. shifts. 6:30 a.m. to 6:30 p.m. shifts. 2:30 p.m. to 10:30 p.m. shifts. 6:30 p.m. to 6:30 a.m. shifts.</p> <p>During an interview with the DON (Director of Nursing) on 04/04/16 at 9:47 a.m., she indicated she did not realize First Aid certification was required any more.</p> <p>On 04/04/16 at 10:05 a.m., the Administrator indicated the nurses do first aid all of the time, so she didn't think training or certification was necessary.</p>		<p>systemic changes made to ensure that the deficient practice does not recur:</p> <p>1.A first aid certification course has been completed by nursing team members.</p> <p>2.A first aid certification course will be completed every two years as required by nursing team members responsible for Residential Residents.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>1.The Clinical Educator will conduct an audit of nursing team members' first aid certifications monthly for three months and then quarterly continuously.</p> <p>2. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting monthly.</p>	