

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E244	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN46218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0000	<p>This visit was for Investigation of Complaints IN00098562 and IN00099488.</p> <p>Complaint IN00098562 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00099488 - Unsubstantiated. Allegation did not occur.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: November 16 & 17, 2011</p> <p>Facility number: 000388 Provider number: 15E224 AIM number: 100454140</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census bed type: NF: 41 Total: 41</p> <p>Census payor type: Medicaid: 41 Total: 41</p> <p>Sample: 10</p>	F0000	<p>This plan of correction is to serve as Rural Health Care's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Rural Health Care or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>We are in full compliance as of 12/08/2011 and respectfully request paper review.</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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F0164 SS=D	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/23/11 by Jennie Bartelt, RN.</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review, and interview, the facility failed to ensure</p>	F0164	F164 483.10(e) PRIVACY AND CONFIDENTIALITY	12/08/2011	

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	<p>privacy to a resident, in that when a resident required total care for incontinent care, the nursing staff failed to provide visual privacy for the resident while providing care, and the resident continued to attempt to cover self during 1 of 2 observations for incontinent care in a sample of 10. [Resident "H"].</p> <p>Findings include:</p> <p>The clinical record for Resident "H" was reviewed on 11-16-11 at 12:15 p.m. Diagnoses included, but were not limited to, dementia, organic brain syndrome, cerebral palsy and convulsions. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 10-14-11, indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care.</p> <p>The resident's plan of care, dated 10-25-11, indicated the following: "The resident is incontinent of bladder and bowel related to poor cognitive skills and inability to communicate need for toileting."</p> <p>"Approaches/Interventions" included, "Toilet at regular intervals, such as</p>		<p>It is the practice of Rural Health Care to ensure the resident's right to privacy and confidentiality of personal and clinical records.</p> <p>I. Resident H is being provided privacy during care and treatment. CNA #11 has been re-educated regarding the provision of privacy during care.</p> <p>II. The facility realizes other residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. The facility's policy regarding privacy was reviewed by the QA Committee. It was not necessary to revise the policy. Nursing personnel have been re-educated regarding the facility's policy to provide privacy during care. Additional systemic changes are being implemented through our quality improvement (QI) program as indicated below.</p> <p>IV. The Director of Nursing Services or her designee is conducting QI audits to further</p>		

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	<p>following meals as indicated up in a.m., after meals, p.m., HS [bedtime] and PRN [as needed].... Provide incontinent/pericare after incontinent episodes."</p> <p>During observation on 11-17-11 at 10:25 a.m., the resident was transported to the shower room, and upon return to room at approximately 11:00 a.m., the resident was placed in a recliner. The resident remained in the recliner through 12:45 p.m. During further observation at 1:10 p.m., Certified Nurses Aide (CNA) #11 exited the resident's room. During this observation, the resident was observed lying in bed.</p> <p>Interview on 11-17-11 at 1:30 p.m. CNA [Certified Nurses Aide] #11 indicated that although she transferred the resident back to bed, she did not have time to "clean" the resident, as she had to attend at meeting in the Director of Nurses office. CNA #11 indicated the resident was incontinent and then proceeded to the resident's bathroom. CNA #11 returned to the resident's bedside donned a pair of gloves and pulled down the bedsheet. The resident was observed with diarrhea stool oozing from the side and bottom of the incontinent brief. In addition the diarrhea stool was observed on the resident's gastrostomy feeding tube,</p>		<p>ensure privacy is being provided. A random sample of 5 staff members are being monitored weekly to ensure privacy is maintained during care and treatment. This QI Audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's QA Committee monthly for additional recommendations if necessary.</p>		

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	<p>abdomen and the hem of the shirt.</p> <p>CNA #11 turned the resident to the left side, unfastened the brief and folded a section of the brief beneath the resident's hip. The CNA picked up the washcloth, cleansed the resident's rectal area, left buttocks, right buttocks, and the rectal area again. With a towel the CNA dried the resident's buttocks and then rolled the quilted incontinent pad beneath the resident's left hip. The resident was then turned to the resident's back, and stool was observed across the resident's abdomen, along the hem of the resident's shirt and on the gastrostomy feeding tube.</p> <p>CNA #11 removed her gloves and picked up another washcloth, left the resident unattended and walked to the resident's bathroom. While CNA #11 was in the resident's bathroom, the resident pulled on the bedsheet, and attempted to cover self.</p> <p>CNA #11 returned to the bedside, donned a pair of gloves and used the washcloth to wipe the end piece of the feeding tube, and then wiped from the end of the feeding tube to the insertion site. Using the same washcloth CNA #11 cleansed the resident's abdomen.</p> <p>CNA #11 removed the resident's shirt and</p>				

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	<p>placed it at the end of the bed onto the bed linen. CNA #11 removed the gloves, and left the resident unattended, and CNA #11 returned to the resident bathroom. The resident again attempted to pull the bedsheet to cover self.</p> <p>CNA #11 returned to the bedside, donned gloves and positioned the resident's legs apart and wiped the resident's perineum, inside both upper legs/thighs, and again wiped the resident's perineal area. Turning the resident to the right side, CNA #11 pulled the soiled incontinent brief from beneath the resident and placed it into the plastic bag in the trashcan and picked up a new incontinent brief, applied one section of the brief while the resident was positioned to the right side, rolled the resident to [resident] back, adjusted the brief, rolled the resident slightly to the left side, pulled the remainder of the brief to the resident's left side and fastened the tabs. CNA #11 removed her gloves.</p> <p>CNA #11 left the resident's bedside, while the resident remained uncovered, walked to the closet, chose a shirt, returned to the resident's bedside and put the shirt on the resident.</p> <p>3.1-3(p)(4)</p>				

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure staff followed residents' plans of care for incontinent care needs, repositioning every two hours, and safe transfers with the assistance of two staff. The deficient practice affected 2 of 3 residents reviewed who required extensive to total assistance in a sample of 10. [Residents "H" and "I"].</p> <p>Findings include:</p> <p>1. The record for Resident "H" was reviewed on 11-16-11 at 12:15 p.m. Diagnoses included but were not limited to dementia, organic brain syndrome, cerebral palsy and convulsions. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 10-14-11, indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care, and repositioning needs.</p>	F0282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN</p> <p>It is the practice of Rural Health Care to provide services by qualified persons in accordance with each resident's written plan of care.</p> <p>I. The plan of care regarding incontinence care, repositioning, and transfers are being followed for Resident H and I. CNA #11 has been re-educated regarding following the resident care instructions as indicated in the care plan and CNA assignment sheet.</p> <p>II. The facility realizes other residents have the potential to be affected. This is being addressed by the systems described below.</p>	12/08/2011	

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	<p>The resident's plan of care, dated 10-25-11, indicated the following: "The resident is incontinent of bladder and bowel related to poor cognitive skills and inability to communicate need for toileting."</p> <p>"Approaches/Interventions" included Toilet at regular intervals, such as following meals as indicated up in a.m., after meals, p.m., HS [bedtime] and PRN [as needed]." "Administer appropriate cleansing and peri-care after each incontinent episode. Provide incontinent/pericare after incontinent episodes."</p> <p>Another plan of care, dated 10-25-11, indicated the resident was "unable to turn/reposition independently." "Approaches/Interventions" to this plan of care included, " ... reposition at least every 2 hours in <sic> around the clock, never leave the resident in the same position more than 2 hours."</p> <p>Review of the CNA assignment sheet on 11-17-11 at 2:35 p.m., and provided by the Assistant Director of Nurses, indicated the resident required 2 persons for transfer and the resident was incontinent of bowel and bladder.</p> <p>During observation on 11-17-11 at 10:25</p>		<p>III. The facility's policy regarding following care plans was reviewed by the QA Committee. It was not necessary to revise the policy. Nursing personnel have been re-educated regarding this policy. This re-education stressed the importance of incontinence care, repositioning, and following safe transfer instructions. Additional systemic changes are being implemented through our quality improvement (QI) program as indicated below.</p> <p>IV. The Director of Nursing Services or her designee is conducting QI audits to further ensure care plans are being followed. A random sample of 5 nursing personnel are being monitored weekly to ensure the resident's care plan is being followed. This QI Audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's QA Committee monthly for additional recommendations if necessary.</p>		

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	<p>a.m., the resident was transported to the shower room, and upon return to room at approximately 11:00 a.m., the resident was placed in a recliner. The resident remained in the recliner through 12:45 p.m.</p> <p>During further observation on 11-17-11 at 1:10 p.m., Certified Nurses Aide (CNA) employee #11 exited the resident's room. During this observation, the resident was observed lying in bed. During nterview on 11-17-11 at 1:30 p.m. CNA #11 indicated that although she transferred the resident back to bed, she did not have time to "clean" the resident, as she had to attend at meeting in the Director of Nurses office.</p> <p>During interview on 11-17-11 at 1:30 p.m., CNA #11 indicated the resident was incontinent and then proceeded to the resident's bathroom. CNA #11 returned to the resident's bedside donned a pair of gloves and pulled down the bedsheet. The resident was observed with diarrhea stool oozing from the side and bottom of the incontinent brief. In addition the diarrhea stool was observed on the resident's gastrostomy feeding tube, abdomen and the hem of the shirt.</p> <p>2. The record for Resident "I" was reviewed on 11-16-11 at 1:50 p.m. and</p>				

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	<p>then again on 11-17-11 at 9:10 a.m.</p> <p>Diagnoses included, but were not limited to, Huntington's chorea, altered mental status, dementia, and delusional disorder. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 09-16-11, indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care, and repositioning needs.</p> <p>The resident's plan of care, dated 09-27-11, indicated the resident "presents with a functional deficit in ADL [Activities of Daily Living] self skills and requires extensive to total assist with ADL's."</p> <p>"Approaches/Interventions" to this plan of care included "gather and provide necessary materials/equipment, (soap, shampoo, washcloth, towel ... clothing etc.) Make sure materials/equipment are clean and functioning appropriately."</p> <p>An additional plan of care, dated 09-27-11, indicated the resident was "incontinent of bladder and bowel." "Approaches/Interventions" included Toilet at regular intervals, such as following meals as indicated up in a.m.,</p>				

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	<p>after meals, p.m., HS [bedtime] and PRN [as needed]." "Administer appropriate cleansing and peri-care after each incontinent episode. Provide incontinent/pericare after incontinent episodes." "Use incontinent products i.e. pads and briefs as indicated."</p> <p>A plan of care, dated 09-27-11, indicated the resident was "unable to turn/reposition independently." "Approaches/Interventions" to this plan of care included, " ... reposition the resident at least every 2 hours in <sic> around the clock. Never leave the resident in the same position more than 2 hours."</p> <p>Review of the CNA assignment sheet on 11-17-11 at 2:35 p.m., and provided by the Assistant Director of Nurses, indicated the resident required 2 persons for transfer and the resident was incontinent of bowel and bladder. In addition the CNA assignment sheet prompted the nursing staff in bold type,"gait belts are to be used with every assisted transfer."</p> <p>Observation on 11-17-11 at 10:25 a.m., the resident was observed seated in a gerichair while being transported to the dining room by CNA employee #11. The resident remained in the gerichair through the noon meal and at 12:45 p.m. the resident was transported back to [resident]</p>				

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	<p>room. The resident remained seated in the gerichair until 1:45 p.m., when CNA employee #11 indicated she was preparing to place the resident back to bed.</p> <p>CNA employee #11 removed the tray that was positioned in front of the resident, and moved the resident's trunk to the edge of the seat. CNA #11 placed both arms around the resident, and in one motion transferred the resident from the gerichair to the bed.</p> <p>CNA #11 positioned the resident to the middle of the bed and began to remove the resident's slacks. While the resident was positioned onto back, CNA #11 unfastened the tabs on each side of the incontinent brief. During this observation the brief was observed saturated with urine and stool. CNA #11 pushed the soiled brief between the resident's legs. During this observation the resident had indentations across the upper thighs and buttocks. The resident's perineum and buttocks were slightly reddened.</p> <p>3.1-35(g)(2)</p>				

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F0312 SS=D	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview the facility failed to ensure activities of daily living were provided for dependent residents, in that when residents were assessed as requiring total assistance with incontinence care, the facility failed to provide the appropriate services for 2 of 3 residents reviewed for incontinent care and repositioning in a sample of 10. [Residents "H" and "I"].</p> <p>Findings include:</p> <p>1. The record for Resident "H" was reviewed on 11-16-11 at 12:15 p.m. Diagnoses included, but were not limited to, dementia, organic brain syndrome, cerebral palsy and convulsions. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 10-14-11, indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care.</p> <p>The resident's plan of care, dated 10-25-11, indicated the following: "The resident is incontinent of bladder and</p>	F0312	<p>F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>It is the practice of Rural Health Care to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>I. Resident H and I are receiving incontinence care and repositioning as necessary. CNA #11 has been re-educated regarding the provision of assistance with ADL care including incontinence care and repositioning.</p> <p>II. The facility realizes other residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. The facility's policy regarding assistance with Activities of Daily Living was reviewed by the QA</p>	12/08/2011	

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	<p>bowel related to poor cognitive skills and inability to communicate need for toileting."</p> <p>"Approaches/Interventions" included, "Toilet at regular intervals, such as following meals as indicated up in a.m., after meals, p.m., HS [bedtime] and PRN [as needed]," and "Administer appropriate cleansing and peri-care after each incontinent episode. Provide incontinent/pericare after incontinent episodes."</p> <p>Review of the CNA assignment sheet on 11-17-11 at 2:35 p.m., and provided by the Assistant Director of Nurses, indicated the resident was incontinent of bowel and bladder.</p> <p>During observation on 11-17-11 at 10:25 a.m., the resident was transported to the shower room, and upon return to room at approximately 11:00 a.m., the resident was placed in a recliner. The resident remained in the recliner through 12:45 p.m. During further observation at 1:10 p.m., Certified Nurses Aide (CNA) employee #11 exited the resident's room. During this observation, the resident was observed lying in bed.</p> <p>During interview on 11-17-11 at 1:30 p.m., CNA [Certified Nurses Aide]</p>		<p>Committee. It was not necessary to revise the policy. Nursing personnel have been re-educated regarding this policy. This re-education stressed the importance of incontinence care and repositioning. Additional systemic changes are being implemented through our quality improvement (QI) program as indicated below.</p> <p>IV. The Director of Nursing Services or her designee is conducting QI audits to further ensure residents are receiving the necessary assistance with activities of daily living. A random sample of 5 nursing personnel are being monitored weekly to ensure incontinence care and repositioning is being provided. This QI Audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's QA Committee monthly for additional recommendations if necessary.</p>		

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	<p>employee #11 indicated that although she transferred the resident back to bed, she did not have time to "clean" the resident, as she had to attend at meeting in the Director of Nurses office. CNA #11 indicated the resident was incontinent and then proceeded to the resident's bathroom. CNA #11 returned to the resident's bedside donned a pair of gloves and pulled down the bedsheet. The resident was observed with diarrhea stool oozing from the side and bottom of the incontinent brief. In addition the diarrhea stool was observed on the resident's gastrostomy feeding tube, abdomen and the hem of the shirt.</p> <p>CNA #11 turned the resident to the left side, unfastened the brief and folded a section of the brief beneath the resident's hip. CNA #11 picked up the washcloth, cleansed the resident's rectal area, left buttocks, right buttocks, and the rectal area again. With a towel CNA #11 dried the residents buttocks and then rolled the quilted incontinent pad beneath the resident's left hip. The resident was then turned to [resident] back and stool was observed across the resident's abdomen, along the hem of the resident's shirt and on the gastrostomy feeding tube.</p> <p>CNA #11 removed her gloves and picked</p>				

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	<p>up another washcloth, left the resident unattended and walked to the resident's bathroom. CNA #11 returned to the bedside, donned a pair of gloves and used the washcloth to wipe the end piece of the feeding tube, and then wiped from the end of the feeding tube to the insertion site and then used the same washcloth to cleanse the resident's abdomen.</p> <p>CNA #11 returned to the bedside, donned gloves and positioned the resident's leg apart and wiped the resident's perineum, inside both upper legs/thighs, and again wiped the resident's perineal area.</p> <p>CNA #11 picked up a new incontinent brief, applied one section of the brief while the resident was positioned to the right side, rolled the resident to [resident] back, adjusted the brief, rolled the resident slightly to the left side, pulled the remainder of the brief to the resident's left side and fastened the tabs. CNA #11 removed her gloves.</p> <p>2. The record for Resident "I" was reviewed on 11-16-11 at 1:50 p.m. and then again on 11-17-11 at 9:10 a.m. Diagnoses included, but were not limited to, Huntington's chorea, altered mental status, dementia, and delusional disorder. These diagnoses remained current at the time of the record review.</p>				

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	<p>The resident's Minimum Data Set Assessment, dated 09-16-11, indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care.</p> <p>The resident's plan of care, dated 09-27-11, indicated the resident "presents with a functional deficit in ADL [Activities of Daily Living] self skills and requires extensive to total assist with ADL's."</p> <p>"Approaches/Interventions" to this plan of care included, "Gather and provide necessary materials/equipment, (soap, shampoo, washcloth, towel ... clothing etc.) Make sure materials/equipment are clean and functioning appropriately."</p> <p>Another plan of care, dated 09-27-11, indicated the resident was "incontinent of bladder and bowel." "Approaches/Interventions" included, "Toilet at regular intervals, such as following meals, as indicated, up in a.m., after meals, p.m., HS [bedtime] and PRN [as needed]." "Administer appropriate cleansing and peri-care after each incontinent episode. Provide incontinent/pericare after incontinent episodes." "Use incontinent products i.e. pads and briefs as indicated."</p>				

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	<p>Review of the CNA assignment sheet on 11-17-11 at 2:35 p.m., and provided by the Assistant Director of Nurses, indicated the resident was incontinent of bowel and bladder.</p> <p>During observation on 11-17-11 at 10:25 a.m., the resident was observed seated in a gerichair while being transported to the dining room by CNA #11. The resident remained in the gerichair through the noon meal and at 12:45 p.m. the resident was transported back to [resident] room. The resident remained seated in the gerichair until 1:45 p.m., when CNA #11 indicated she was preparing to place the resident back to bed.</p> <p>CNA #11 donned gloves, removed the tray that was positioned in front of the resident, and moved the resident's trunk to the edge of the seat, placed both arms around the resident, and in one motion transferred the resident from the gerichair to the bed. The resident was positioned to the middle of the bed, and CNA #11 began to remove the resident's slacks. While the resident was positioned onto the back, CNA #11 unfastened the tabs on each side of the incontinent brief. During this observation the brief was observed saturated with urine and stool. CNA #11 pushed the soiled brief between the</p>			

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	<p>resident's legs.</p> <p>CNA #11 donned gloves, turned the resident to the right side, and using one end of the wet bath towel, cleansed the resident's rectal area, both buttocks and cleansed the rectal area again. CNA #11 reached between the resident's legs and in one motion cleaned the resident's perineum. During this observation the resident had indentations across the upper thighs and buttocks. The resident's perineum and buttocks were slightly reddened.</p> <p>CNA #11 failed to completely cleanse by separating the labia, washing the urethral area, or wash between and outside labia.</p> <p>CNA #11 turned the resident onto the resident's back and then slightly to the left side, removing the soiled incontinent brief and quilted incontinent pad and placed a new incontinent brief under the resident's left hip, and rolled the resident from side to side positioning the incontinent brief on the resident.</p> <p>3. Review of facility policy on 11-17-11 at 2:30 p.m., and titled "Perineal Care," undated indicated the following:</p> <p>"Assist Resident to Supine Position."</p> <p>"Place waterproof pad under resident's</p>				

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	<p>hips."</p> <p>"Drape Resident."</p> <p>"Fill wash basin with warm water and have resident check water temperature."</p> <p>"Put on gloves."</p> <p>"Assist resident spread legs and lift knees if possible."</p> <p>"Wet and soap folded washcloth."</p> <p>"Wipe from front to back and from center of perineum to thighs. Change washcloth as necessary. For females: separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke."</p> <p>"Change water in basin. With a clean washcloth, rinse area thoroughly in the same direction as when washing."</p> <p>"Gently pat area dry in same direction as when washing."</p> <p>"Assist resident to turn onto side away from you."</p> <p>"Wet and soap washcloth."</p>				

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	<p>"Clean anal area from front to back, rinse and pat dry thoroughly."</p> <p>"Remove pad, assist resident to turn onto back and undrape resident."</p> <p>"Remove gloves."</p> <p>3.1-38(a)(3)(A) 3.1-38(b)(6)</p>				

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F0441 SS=D	<p>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> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure the proper handling and disposal of soiled linens and gloving/handwashing, in that when a CNA [employee #11] provided</p>	F0441	F441 483.65 (a)(1) INFECTION CONTROL	12/08/2011	

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	<p>incontinent care to dependent residents, the staff member failed to follow the facility policy in regard to the handling of soiled linens and gloving/handwashing during 2 of 2 observations. This deficient practice occurred during observation of incontinent care provided for 2 of 3 residents reviewed for incontinent care in a sample of 10. [Residents "H" and "I"].</p> <p>Findings include:</p> <p>1. The record for Resident "H" was reviewed on 11-16-11 at 12:15 p.m. Diagnoses included, but were not limited to, dementia, organic brain syndrome, cerebral palsy and convulsions. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 10-14-11, indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care.</p> <p>During interview on 11-17-11 at 1:30 p.m. CNA [Certified Nurses Aide] employee #11 indicated that although she transferred the resident back to bed earlier, she did not have time to "clean" the resident, as she had to attend at meeting in the Director of Nurses office. CNA #11 further stated the resident was</p>		<p>It is the practice of Rural Health Care to 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>I. Resident H and I are receiving incontinence care with adherence to infection control practices. CNA #11 has been re-educated regarding infection control including and handwashing, glove use, and handling soiled linens.</p> <p>II. The facility realizes other residents have the potential to be affected. This is being addressed by the systems described below.</p> <p>III. The facility's policy regarding handwashing and handling soiled linens was reviewed by the QA Committee. It was not necessary to revise the policy. Nursing personnel have been re-educated regarding this policy. This re-education stressed the importance of handwashing and glove use during incontinence care as well as the handling of soiled linens. Additional systemic changes are being implemented through our quality improvement</p>		

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	<p>incontinent and proceeded to the resident's bathroom. CNA #11 returned to the resident's bedside, donned a pair of gloves and pulled down the bedsheet. The resident was observed with diarrhea stool oozing from the side and bottom of the incontinent brief. In addition the diarrhea stool was observed on the resident's gastrostomy feeding tube, abdomen and the hem of the shirt.</p> <p>CNA #11 turned the resident to the left side, unfastened the brief and folded a section of the brief beneath the resident's hip, picked up the washcloth, cleansed the resident's rectal area, left buttocks, right buttocks, and the rectal area again. With a towel CNA #11 dried the resident's buttocks and then rolled the quilted incontinent pad beneath the resident's left hip.</p> <p>CNA #11 placed the soiled washcloth at the end of the bed onto the bed linen, then turned the resident onto [resident] back and stool was observed across the resident's abdomen, along the hem of the resident's shirt and on the gastrostomy feeding tube.</p> <p>CNA #11 removed her gloves and picked up another washcloth, left the resident unattended and walked to the resident's bathroom. Upon return to the resident's</p>		<p>(QI) program as indicated below.</p> <p>IV. The Director of Nursing Services or her designee is conducting QI audits to further ensure the facility's policies regarding handwashing, glove use, and soiled linens are followed. A random sample of 5 nursing personnel are being monitored weekly during incontinence care for provision of handwashing and soiled linen disposal. This QI Audit is being completed weekly for 30 days; then every other week for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's QA Committee monthly for additional recommendations if necessary.</p>				

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	<p>bedside CNA #11 donned a pair of gloves and used the washcloth to wipe the end piece of the feeding tube, and then wiped from the end of the feeding tube to the insertion site. Using the same washcloth CNA #11 cleansed the resident's abdomen and then placed the soiled washcloth onto the bed linen at the end of the bed.</p> <p>CNA #11 removed the resident's shirt and placed it at the end of the bed onto the bed linen, removed the gloves, and left the resident unattended, and returned to the resident bathroom.</p> <p>CNA #11 returned to the bedside, donned gloves and positioned the resident's legs apart and wiped the resident's perineum, inside both upper legs, and again wiped the resident's perineal area. Turning the resident to the right side, CNA #11 pulled the soiled incontinent brief from beneath the resident, placed it into the plastic bag in the trashcan and then removed the soiled quilted incontinent pad from beneath the resident and placed it at the end of the bed onto the bed linen.</p> <p>2. The record for Resident "I" was reviewed on 11-16-11 at 1:50 p.m. and then again on 11-17-11 at 9:10 a.m. Diagnoses included, but were not limited to, Huntington's chorea, altered mental status, dementia, and delusional disorder.</p>						

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	<p>These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 09-16-11 indicated the resident was incontinent of bowel and bladder and required total assistance from the nursing staff for incontinent care, and repositioning needs.</p> <p>Observation on 11-17-11 at 10:25 a.m., the resident was observed seated in a gerichair wile being transported to the dining room by CNA employee #11. The resident remained in the gerichair through the noon meal and at 12:45 p.m. the resident was transported back to the resident's room. The resident remained seated in the gerichair until 1:45 p.m., when CNA employee #11 indicated she was preparing to place the resident back to bed.</p> <p>CNA #11 removed the tray that was positioned in front of the resident, and moved the resident's trunk to the edge of the seat, placed both of her arms around the resident, and in one motion transferred the resident from the gerichair to the bed.</p> <p>The resident was positioned to the middle of the bed and CNA #11 began to remove the resident's slacks. While the resident was positioned onto back, CNA #11</p>				

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	<p>unfastened the tabs on each side of the incontinent brief, and the brief was observed saturated with urine and stool. CNA #11 pushed the soiled brief between the resident's legs.</p> <p>CNA #11 left the resident unattended, entered the resident's bathroom, and returned to the bedside with a bath towel, donned gloves, turned the resident to the right side and using one end of the bath towel, cleansed the resident's rectal area, both buttocks and cleansed the rectal area again. CNA #11 reached between the resident's legs and in one motion cleaned the resident's perineum.</p> <p>Upon completion of the care provided CNA #11 placed the soiled bath towel at the end of the bed onto the bedspread and then turned the resident onto the resident's back and then slightly to the left side, removing the soiled incontinent brief and quilted incontinent pad and placed both items at the end of the bed onto the bedspread.</p> <p>CNA #11 took the end of the bedspread and pulled it up and covered the resident.</p> <p>3. Review of facility policy on 11-17-11 at 2:30 p.m., and titled "Handling Soiled Linen," undated indicated the following:</p>				

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	<p>"Purpose - To prevent contamination of healthcare worker, to prevent contamination of surfaces, clean linen, to provide satisfactory pick-up and laundering of soiled linen, and provide proper temporary storage of soiled linen."</p> <p>"Use gloves to remove waste materials from linens soiled with feces. Place urine, feces soiled linen in soiled line <sic> barrel."</p> <p>"Strip linen carefully, with least agitation (shaking) as possible. Fold linen from outer edges toward center of bed. Roll into a lose bundle."</p> <p>"Place directly into bag or barrel in resident room. Remove gloves and wash hands. Contain linen in a manner that prevents the linen bag from opening or busting during transport. It is also acceptable to bring the soiled linen hamper to the door of the residents room and place the soiled linen directly into the barrel."</p> <p>"Do not place soiled linen on furniture, floor, and other surfaces."</p> <p>3.1-18(l) 3.1-19(g)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E244	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1747 N RURAL ST INDIANAPOLIS, IN46218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	