

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/18/2012
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713
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R0000	<p>This visit was for a Residential State Licensure Survey. This visit included the Investigation of Complaints IN00115504, IN00115054, and IN00113388.</p> <p>Complaints: IN00115504 Unsubstantiated due to lack of evidence. IN00115054 Substantiated. State Residential Findings related to the allegation are cited at R144. IN00113388 Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: September 10, 11, 17, 18, 2012</p> <p>Facility Number: 011274 Provider Number: 011274 AIM Number: N/A</p> <p>Survey Team: Barbara Fowler, RN TC Diane Hancock, RN Vickie Ellis, RN</p> <p>Census bed type Residential: 89 Total: 89</p> <p>Census payor type: Other: 89</p>	R0000		

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>Total: 89</p> <p>Sample: 7 Supplemental Sample: 5</p> <p>These Residential State Findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 9/25/12 by Suzanne Williams, RN</p>			

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R0029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation and interview, the facility failed to treat the residents with dignity and respect related to call lights and resident care for 1 of 5 sampled residents who currently resided in the facility, in a total sample of 7 and 2 of 5 supplemental sampled residents. (Residents # 59, # 20, #19)</p> <p>Findings include:</p> <p>1. Resident #59 was observed in her room on 9/11/12 at 8:55 a.m., seated in an electric wheelchair. She indicated she needed her urinary catheter drainage bag emptied and had pulled her call light "a long time ago." The call light was checked and it indicated it had been activated. The call light was turned off and reactivated. Fifteen minutes passed. At 9:12 a.m., the control panel was observed at the nurses' station. Resident #59's room was not indicated on the panel. The Director of Nurses [DoN] was interviewed at that time and he indicated the call light should show up on the computer screen, indicating what room needed assistance. It also beeped on the</p>	R0029	<p>R029 All residents have the potential to be affected. 1.) The repeater that signals the nurses' call station was found to be defective. All other repeaters were checked and are in working order. The defective repeater was replaced and the call lights are all in working order. The repeaters for all floors will be checked by the maintenance team. Monthly results will be forwarded to administrator. Any defective repeaters will be replaced. Residents that are affected by faulty repeaters will be given a desk type bell to ring and staff will check on those residents every fifteen minutes until repairs are made. 2.) Nursing staff will be in-serviced on incontinence care along with cleaning of other soiled surfaces. The staff will be observed and audited by DON or his designee, on complete incontinence care of residents. Weekly times 4, monthly times 4, and then Quarterly times four. Results will be forwarded to QA. Completed by 10/30/2012 Three out on 91 residents have the potential to be effected. 3.) The call light string was immediately lengthened to reach</p>	10/30/2012			

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	<p>CNA beepers, telling them where to go.</p> <p>The DoN was observed in Resident #59's room at 9:15 a.m. He indicated he had reset the call light and activated it again. The computer screen at the nurse's station was checked and the room was indicated at that time.</p> <p>2. An observation was made on 9/17/12 at 10:05 a.m. of CNA #1 giving incontinent care to Resident #20. After washing her hands and gloving, CNA #1 assisted the resident to a standing position with a walker and pulled the resident's saturated pants down around the resident's ankles. The CNA left the urine saturated brief on the resident. CNA #1 then assisted the resident back into her wheelchair wearing the saturated brief. CNA #1 removed Resident #20's pants from around the ankles and put a clean brief and clean pair of pants on around the resident's ankles. She then stood the resident up with the walker, during this time a</p>		<p>resident #19 while in her recliner. The other two residents have been checked to assure that their call light string is accessible to both bed and chair.</p> <p>To prevent this in the future for any mobile dependent residents, the call light string will be lengthened. Staff will be in-serviced on making sure that the call light is accessible to residents that are mobile dependent.</p> <p>Mobile dependent residents will be audited for call light accessibility by DON or his designee weekly times four, monthly times four and then quarterly times four quarters. Results will be forwarded to QA. Completed by 10/30/2012</p>				

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	<p>urine puddle was visible in the seat of the wheelchair. The CNA tore the sides of the saturated brief and removed the brief. CNA #1 then pulled the clean brief and clean pants up on the resident and sat the resident back in the wheelchair which had the puddle of urine in it. CNA #1 removed her gloves and exited the room leaving the resident sitting in a wheelchair soaked with urine.</p> <p>3. Resident #19 was observed on 9/11/12 at 9:15 a.m. sitting in her recliner with a tabs alarm attached to her robe. The resident indicated she had a headache. The resident's call light cord was observed to be attached to a stuffed animal laying on the resident's bedside table which was across the room and out of the resident's reach. Interview of the DoN [Director of Nursing] on 9/18/12 at 11:47 a.m., indicated the resident would not be able to reach her call light but the cord could be lengthened so the resident could have the cord in her recliner. The DoN indicated the facility had been wanting to move the resident closer to the nurse's station but did not have a room available.</p>				

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R0144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation, the facility failed to ensure a clean, odor-free environment for 2 of 5 sampled rooms and 1 randomly observed room. This affected 3 residents who resided in those rooms. (Room #520, Room #530, Room #314)</p> <p>Findings include:</p> <p>1. During the initial tour, on 9/10/12 at 11:30 a.m., room #520 was observed. There was a container full of urine at the bedside. The floor had an accumulation of black dirt and debris.</p> <p>During an observation on 9/11/12 at 9:10 a.m., there was a strong odor of urine in the hall outside of room #520. During observation of the hall outside of room #520, on 9/10/12 at 9:10 a.m., a strong odor of urine was present.</p> <p>2. During the initial tour, on 9/10/12 at 11:30 a.m., room #530 was observed. The resident was not in the room. There was a strong odor of urine; the carpet was stained dark black in areas.</p>	R0144	<p>R144 All residents with urinary Foley catheters have the potential to be affected.</p> <p>1.) Resident was out at the hospital at the time of the survey. The urinary bottle of the Resident that resided in room 520 customarily empties his nighttime urine in a bedside bottle. The bottle was immediately emptied and resident's floor was cleaned. A urinary drainage bag has been ordered. Resident that resided in room 520 will be instructed on how to change from leg bag to nighttime Foley catheter drainage bag. Staff has been in-serviced on emptying drainage bag in the morning and cleaning up any spillage that may be on the floor. The resident room will be audited by DON or his designee daily business days times two weeks, weekly times four, monthly times four, then quarterly times four. Results will be forwarded to QA Completion date 10/30/2012 The four residents that have carpet have the potential to be effected.</p> <p>2.) The carpet in room 530 has been cleaned. This carpet will be replaced with linoleum tile. All other rooms that have carpet have been checked</p>	10/30/2012			

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	<p>3. On 9/17/12 at 10:00 a.m., room #314 was observed. The bathroom floor had an accumulation of soil, dirt and debris. The shower floor was soiled with dirt and debris. The toilet seat extender was soiled with brown and yellow substances. The room floor was soiled with an accumulation of dirt and debris.</p> <p>This state finding relates to Complaint IN00115054.</p>		<p>for odors and no odors found. The housekeepers will be in-serviced on doing a room to room walk through to check for odors. When odors are noted the source of the odor will be eliminated. A random room audit will be done by the Administrator or her designee daily business days times two weeks, weekly times four, monthly times four and then quarterly times four. Results will be forwarded to QA. Completed by 10/30/2012 All residents have the potential to be effected. 3.) Room #314 has been cleaned. The housekeeping staff will be in-serviced on doing a room to room walk through in the morning to check for any unusually soiled rooms that need immediate attention by housekeeping. A random room audit will be done by the Administrator or her designee, daily business days times two weeks, weekly times four, monthly times four and then quarterly times four. Results will be forwarded to QA. Completed 10/30/2012</p>				

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R0148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility failed to ensure it was free of potential hazards that may affect the welfare of the residents or the public for 1 of 4 resident floors, in that tools and hazardous equipment were left unattended. This had the potential to affect 24 residents who resided on the 6th floor.</p> <p>Findings include</p> <p>During an observation on 9/11/12 at 10:10 a.m. of the 6th floor, a blow torch and box cutter with the blade exposed were laying between Rooms #604 and #605 with no one in</p>	R0148	<p>R148 Twenty four residents that reside on the 6 th floor had the potential to be effected. 1.) The blow torch and box cutter were immediately removed after notification of their existence. The contracted laborers were educated on leaving their tools unattended. The contracted laborers are finished with their work; however' any new contracted laborers will be educated on not leaving tools unattended before they will be allowed to start work in the facility. A form has been implemented for contracted laborers to educate them on not leaving tools unattended.</p>	10/30/2012			

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	<p>attendance.</p> <p>On 9/11/12 at 10:45 a.m., the blow torch and exposed-blade box cutter were observed laying outside of Room #604 with no one in attendance.</p> <p>Interview of the Administrator on 9/11/12 at 12:30 p.m., indicated an outside contractor was working on the 6th floor and was probably not aware they should not leave the items unattended, and they would be notified immediately.</p>		<p>Each contracted laborer will sign that they understand and that they may be dismissed from their job if they do not remain compliant to facility practice.</p> <p>Maintenance will notify the Administrator when outside contractors are needed. The signed forms will be forwarded to Administrator.</p> <p>The Administrator or designee will randomly audit contracted laborers work sight for unattended tools. If the contractor's tools are left unattended the contractor laborers will be dismissed.</p> <p>Completed 10/30/2012</p>		

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R0216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed for self administration of medication assessments, in a total sample of 7 residents, had an assessment for the self administration of an inhaler ordered to be placed at the resident's bedside and used as needed. (Resident #5)</p> <p>Findings include:</p> <p>On 9/11/12 at 11:15 a.m. an observation was made of Resident #5 in his room. At this time the resident was interviewed and asked if he had an inhaler at his bedside. The resident opened his night stand drawer and pulled out an inhaler of Albuterol (an inhaled medication</p>	R0216	<p>R216 All residents have the potential to be effected. 1.) Resident # 5's self administration of medication form was updated to reflect physicians order to allow resident to have inhaler at bedside. Nursing staff has been in-serviced on notifying DON if any resident receives and order to self administer any medication. The DON or his designee will audit physicians' orders daily during business days times two weeks, weekly times four weeks, monthly times four, then quarterly times four. The results will be forwarded to QA. Completed 10/30/2012</p>	10/30/2012			

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	<p>which is used in moments of difficult breathing).</p> <p>On 9/11/12 at 10:00 a.m. Resident #5's clinical record was reviewed. The resident had a diagnosis of, but not limited to, chronic obstructive pulmonary disease (an airway disease which makes breathing difficult).</p> <p>A service plan record dated 3/5/12 indicated the facility was to administer all medications to Resident #5.</p> <p>A physician's order dated 9/2/12 indicated the resident was to have an Albuterol inhaler at the bedside to use as needed.</p> <p>The clinical record had a document, titled self administration assessment, and dated 3/5/12, which indicated the resident would not self administer medications.</p> <p>In an interview with RN #3 on 9/17/12 at 10:20 a.m., she indicated Resident #5 had a doctor's order for an inhaler at the bedside, and the inhaler should be there. She stated, "the resident lets us know when he needs another inhaler."</p> <p>A document provided by the Director</p>						

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	of Nursing [DoN] on 9/18/12 at 8:15 a.m. and titled "Riverwalk Communities Self Administration of Meds," and dated "revised on 5/2010," indicated, "A resident may keep and take their own medication with a physician's order if cognitively able."			

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R0217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to review and revise the service plan as appropriate as the resident's needs changed in 1 of 3 residents reviewed for falls in a sample of 7 residents. (Resident #90).</p>	R0217	<p>R217 All residents have the potential to be effected. 1.) Resident #90 was discharged prior to survey. The fall documentation form has been revised and will have a carbon copy that will be forwarded to DON's office to insure that new</p>	10/30/2012			

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	<p>Findings include:</p> <p>Resident # 90's record was reviewed on 9/17/12 at 2:45 p.m. Resident #90 was admitted on 4/13/12 with a diagnosis of, but not limited to, Alzheimer's disease, vertigo, paranoia, and depression.</p> <p>A post fall assessment, dated 4/25/12 at 9:50 a.m., indicated Resident #90 had a fall in her room resulting in a laceration to her left forehead in which the resident was sent to the emergency room. On 4/26/12 at 12:15 a.m., the interventions included the resident's call light within reach, close observation of the resident, the resident's room free of clutter, assist the resident with transfers and ADLs [activities of daily living], and monitoring for side effects/complications from falls. On 4/26/12 at 6:15 a.m., the above interventions were in place and a new intervention of frequent toileting was included.</p> <p>On 5/29/12 at 7:00 p.m., the post fall assessment indicated Resident #90 had an unwitnessed fall in her room. The resident indicated she hit her head and her left shoulder resulting in the resident being sent to the emergency room. On 5/29/12 at 9:00</p>		<p>interventions are put in place. Should the resident fall again a different new intervention will initiated.</p> <p>The nurses will be in-serviced on the new fall documentation form.</p> <p>The DON or his designee will audit the fall forms weekly times four weeks, monthly times four months, monthly times four months, then quarterly for four quarters. The results will be forwarded to QA. Completed 10/30/20012</p>				

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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713
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	<p>p.m., the interventions for resident #90 included call light within reach, frequent toileting and close observation, room free from clutter, assist with transfers, and monitoring.</p> <p>On 6/8/12 at 6:45 p.m., post fall assessment indicated the resident was found lying in the floor in the hallway, Interventions on 6/9/12 at 2:00 a.m., included call light within reach, frequent toileting and close observation, room free from clutter, and monitoring for side effects/complications from fall.</p> <p>On 7/7/12 at 11:40 a.m., the post fall assessment indicated Resident #90 was standing up from her sofa and lost her balance and sat on the floor in front of an end table which resulted in an injury to the middle of her back. On 7/7/12 at 7:00 p.m., interventions included call light within reach, assist with transfers and ADLs, and monitoring for side effects/complications from falls.</p> <p>On 7/12/12 at 9:00 a.m., the post fall assessment indicated the resident was found lying on her floor next to her sofa. On 7/12/12 at 10:00 p.m., interventions included call light within reach, frequent toileting and close observation, room free from clutter,</p>			

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	<p>staff training and awareness and monitoring for side effects/complications from falls.</p> <p>On 7/13/12 at 3:45 p.m., the post fall assessment indicated Resident # 90 was found lying on the floor in her room. No interventions were documented.</p> <p>Interview of the DoN [Director of Nursing] on 9/18/12 at 8:30 a.m., indicated Resident #90 had no documentation regarding whether the interventions were in place each time the resident fell or whether the intervention were in proper working condition.</p>			

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R0407	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, interview and record review, the facility failed to ensure infection control program measures were implemented to help prevent the potential for transmission of blood borne infections via blood glucose monitoring machines, for 3 of 3 residents randomly observed having blood glucose checks completed. This deficient practice had the potential to affect 37 residents who had their blood glucose checked with a glucometer. (Residents #39, #85, and #77)</p> <p>Findings include: On 9/11/12 at 10:53 a.m., RN #1 was observed checking blood sugars in a treatment room at the facility. Resident #39 came to have her blood sugar checked. RN #1 wore gloves,</p>	R0407	<p>R407All diabetic residents have the potential to be effected.1.) The nursing staff has been in-serviced on cleaning the glucometer between uses, wearing different gloves between residents and sanitizing hands between residents before re-gloving.A sign will be hung for the residents to question the nursing staff asking if the "glucometer has been sanitized."The DON and or his designee will audit blood glucose checks daily during business days times two weeks, weekly times four, monthly times four then quarterly times four quarters. Results will be forwarded to QA.Completed 10/30/2012</p>	10/30/2012			

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	<p>and stuck the resident's finger to obtain a blood specimen. He then used the facility's meter to check the blood sugar. He then laid the meter down on a table. He wore the gloves to document the results, drew up insulin and gave the resident her insulin. He did not do any cleaning or sanitizing of the glucometer. He did not do any hand hygiene following the procedure.</p> <p>At 11:05 a.m., Resident #85 came into the room. He used the facility's glucometer to check his blood sugar. RN #1 wore gloves and assisted with wiping the blood from the resident's finger. The resident's blood sugar was low, so they decided to wait until he ate to give his insulin. The resident placed the glucometer on the table. RN #1 removed his gloves. He did not do any hand hygiene following the procedure, nor did he sanitize the glucometer.</p> <p>At 11:15 a.m., Resident #77 came into the room. At that time, RN #1 was questioned. He indicated he did not routinely do anything to the glucometer between residents. He indicated if the glucometer got contaminated, he had germicidal wipes to disinfect the glucometer. He pointed to the commercial germicidal</p>						

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	<p>wipes container.</p> <p>At 12:00 noon on 9/11/12, the observations were reviewed with the Administrator and the Director of Nurses. Both indicated the germicidal wipes were available, and the staff were supposed to use them.</p> <p>The policy and procedure for "Glucometer Cleaning and Disinfecting," dated 6/1/2010, was provided by the Administrator on 9/17/12 at 9:00 a.m. The policy and procedure indicated the following: "It is the policy of [name of facility] to clean and disinfect glucometers between each use to prevent potential exposure to blood-borne infections from resident to resident." "All glucometers will be cleaned with Sani-Cloth Germicidal Disposable Wipes. Wipe the exterior surfaces of the glucometer with the germicidal wipe after each use. Discard the wipe after each use."</p>						

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R0410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure 1 of 7 sampled residents had tuberculin skin testing completed prior to, or upon, admission to the facility. (Resident #90) Findings include: Resident #90's chart was reviewed on 9/17/12 at 2:45 p.m. Resident #90 was admitted on 4/13/12 with diagnoses of, but not limited to, Alzheimer's disease, vertigo, paranoia, and depression.</p>	R0410	<p>R410 All residents have the potential to be effected. 2.) All resident charts will be audited to ensure that PPD are current. The nursing staff will be in-serviced on admission PPD's The new admissions will be audited, to check to see if PPD was given upon admission or within the three months prior to admission, by the DON or his designee. The results will be forwarded to QA. Completed 10/30/2012</p>	10/30/2012			

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	<p>Resident # 90 was found to have a chest x-ray done on 4/7/12 for a cough which indicated no acute pulmonary disease. The resident's physician indicated on the chest x-ray report the resident had no communicable disease. No documentation of a tuberculin skin test was found in the chart.</p> <p>During interview of the DoN [Director of Nursing] on 9/17/12 at 3:50 p.m., the DoN indicated he did not know if the resident had a tuberculin skin test prior or upon admission.</p> <p>During interview of the DoN on 9/18/12 at 11:46 a.m., the DoN indicated he was unable to obtain any documentation of a tuberculin skin test being done on the resident prior to or upon admission to the facility.</p>			

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R0414	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation and interview, the facility failed to ensure proper handwashing was completed during care observations for 5 of 7 randomly observed residents and 1 of 5 sampled current residents in the total sample of 7, in that nursing staff failed to wash their hands between resident activities. (Residents #39, #85, #77, #9, #15, #19)</p> <p>Findings include:</p> <p>1. On 9/11/12 at 10:53 a.m., RN #1 was observed checking blood sugars in a treatment room at the facility. Resident #39 came to have her blood sugar checked. RN #1 wore gloves, stuck the resident's finger to obtain a blood specimen. He wore the gloves to document the results, drew up insulin and gave the resident her insulin. He then removed his gloves but did not do any hand hygiene following the procedure.</p> <p>At 11:05 a.m., Resident #85 came into the room. He used the facility's glucometer to check his blood sugar. RN #1 wore gloves and assisted with</p>	R0414	<p>R414 All residents have the potential to be effected. 1.) The nursing staff has been in-serviced on cleaning the glucometer between uses, wearing different gloves between residents and sanitizing hands between residents before re-gloving. 2.) All nursing staff will be in-serviced on hand washing and/or sanitizing hands before and after resident contact. 3.) All nursing staff will be in-serviced on hand washing and/or sanitizing hands before and after resident contact. An audit form for hand washing between resident care: blood sugar checks, med pass, physical resident contact, will be done by the DON or his designee during business days, daily for two weeks, weekly times four weeks, monthly for four months, then quarterly times four quarters. Results will be forwarded to QA Completed 10/30/2012</p>	10/30/2012			

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	<p>wiping the blood from the resident's finger. RN #1 removed his gloves. He did not do any hand hygiene following the procedure.</p> <p>At 11:15 a.m., Resident #77 came into the room. The RN was stopped and queried about hand hygiene between residents. He indicated he should have been washing his hands.</p> <p>2. On 9/11/12 at 10:30 a.m., RN #1 was observed assisting a resident to the bathroom. He assisted her back to her chair. He provided the resident with a wet wash cloth for her hands. He indicated, "I can't find any soap." He then took the wash cloths and disposed of them in the soiled utility room. He washed his hands at the nursing station for less than 5 seconds.</p> <p>3. An observation was made on 9/11/12 at 9:45 a.m. of RN [Registered Nurse] #2 during medication pass. During a medication pass to Resident #9, the RN did not wash her hands or use hand sanitizer prior to or after giving the resident her medications. RN #2 then moved on to give medications to Resident #15. She was observed to put eyedrops in Resident #15's eyes without washing hands or gloving. RN #2 used her left hand to hold the</p>			

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	<p>eye open and her right hand to administer the drops. She was holding an ink pen in her right hand while administering the drops.</p> <p>4. An observation on 9/11/12 at 9:15 a.m., of Resident #19 indicated the resident was sitting in her recliner in her room with her feet hanging over the end of her recliner. CNA #2 entered the resident's room. CNA #2 indicated the resident needed to be moved up in her recliner and proceeded to request assistance from LPN #1. CNA #2 sanitized her hands and applied gloves. LPN #1 entered the resident's room and assisted the CNA with checking the resident's brief. CNA #2 and LPN #1 proceeded to move the resident in her recliner. CNA #2 then removed her gloves and washed her hands. LPN #1 walked out of the resident's room and proceeded into the nurse's station and began working on charts.</p>						