

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2016
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NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 31, February 1, 2, 3. and 4, 2016.</p> <p>Facility number: 000036 Provider number: 155093 AIM number: 100269640</p> <p>Census bed type: SNF/NF: 42 Total: 42</p> <p>Census payor type: Medicaid: 28 Other: 14 Total: 42</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on February 11, 2016.</p>	F 0000	Gibson General Hospital Skilled Nursing Facility requests that the following plan of correction be considered its credible allegation of compliance. The SNF respectfully requests that a desk review, rather than an on-site visit, occur to verify compliance.	
F 0278	483.20(g) - (j)			

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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SS=D Bldg. 00	<p>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to complete an accurate comprehensive assessment that accurately reflected a resident's status, as a prognosis of less than six months life expectancy was not coded on the assessment for 1 of 1 residents reviewed for hospice services. (Resident #25)</p>	F 0278	The assessment of Resident #25 was updated to reflect a prognosis of less than six month life expectancy. This was done following receipt of a supporting order from the hospice physician. All residents receiving Hospice services have the potential to be affected. The assessments of all residents receiving Hospice services were reviewed to assure	02/18/2016

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	<p>Findings include:</p> <p>On 2/3/16 at 9:29 a.m., Resident #25's clinical record was reviewed. Resident #25's diagnoses included, but were not limited to Alzheimer's disease.</p> <p>The Electronic Health Physician's orders, dated 1/28/16, were reviewed. The orders included, but were not limited to, [Name of Hospice Provider] care related to diagnosis of Alzheimer's disease.</p> <p>The Physician's Telephone Orders, dated 11/6/15, included, but was not limited to, [Name of Hospice Provider] for end of life care.</p> <p>The Hospice Nursing Comprehensive Admission Assessment, dated 11/6/15, indicated the Resident was admitted to hospice services on 11/6/15.</p> <p>The Physician's Progress Note, dated 11/10/15, included, but was not limited to: The patient was recently placed on hospice at the request of the family.</p> <p>A Care Plan, dated 11/6/15, indicated: Hospice-senile dementia, possible Alzheimer type. The interventions included, but were not limited to, hospice</p>		<p>a prognosis, supported by the attending physician or hospice physician, of less than six month life expectancy was reflected. Assessments not reflecting this prognosis were updated following receipt of a supporting order from the attending physician or the hospice physician. To assure the practice does not recur, the MDS Nurse will be responsible to assure that new Hospice residents have a prognosis of less than six month life expectancy. To ensure continued compliance, the MDS Nurse will present audit results for prognosis among hospice residents quarterly to the Skilled Nursing Facility Performance Improvement Committee (SNF PIC) for at least one year. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>	

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F 0371 SS=E Bldg. 00	<p>of choice per physician orders.</p> <p>The Significant Change MDS (Minimum Data Set) Assessment, dated 11/16/15, did not indicate Resident #25 had a prognosis of less than six months.</p> <p>On 2/3/16 at 2:17 p.m., the DON indicated the hospice diagnosis was not a part of the resident's record therefore the facility had not indicated the resident had a prognosis of less than six months on the MDS Assessment.</p> <p>3.1-31(i)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure dietary staff changed gloves between dietary tasks and washed their hands between glove changes as indicated by facility policy during the preparation of the pureed food for 5 of 5 residents who</p>	F 0371	All dietary staff received additional training from the Food Services Director on appropriate hand washing and use of gloves in the dietary department along with a review of the citation and a review of department policy. It was determined that all residents have the potential to be affected.	03/01/2016

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	<p>received pureed food from the kitchen. (Dietary Staff #1)</p> <p>Findings include:</p> <p>On 2/2/16 at 9:58 a.m., DS (Dietary Staff) #1 was observed to prepare pureed meal items. DS #1 applied gloves and retrieved the chicken and food processor basin. DS #1 cracked two eggs into the food processor basin. DS #1 removed the gloves and retrieved the bread and applied new gloves. DS #1 tore the bread and placed it in the food processor basin. DS #1 retrieved a broth packet and then retrieved milk from the cooler. DS #1 placed the milk and butter into the food processor basin. DS #1 returned the milk to the cooler. DS #1 removed the gloves and retrieved a spoon to stir the broth into the water. DS #1 poured the broth into the food processor basin. DS #1 carried the food processor basin across the kitchen to the food processing machine. DS #1 applied new gloves, adjusted the food processor basin, and turned the machine on. DS #1 poured the contents of the food processor basin into a pan. DS #1 removed the gloves, wrapped the pan, and placed the pan in the oven. DS #1 then washed her hands.</p> <p>On 2/4/16 at 9:00 a.m., the Dietary Manager indicated kitchen staff should</p>		<p>To prevent the practice from recurring, there will be ongoing observation by the Food Service Director and Dietary Supervisors and designees. Supervisors will document monitoring of 10 observations of hand washing and glove use weekly by dietary employees. This will continue for at least 12 weeks. The Food Service Director may decrease the frequency of observations after that. Observations of non-compliance will result in immediate redirection or additional training or performance counseling. Glove use and hand washing reminder posters will be developed and placed in the Food Service work area. To assure continued compliance, results from supervisor monitoring in the dietary work area will be reported quarterly to SNF PIC by the Clinical Dietitian. Quarterly reporting will occur for at least one year. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>		

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	<p>remove their gloves and wash their hands when staff members leave their work area and touch other items.</p> <p>On 2/4/16 at 2:46 p.m., the Administrator provided the "Glove Use" policy, revised on 9/13/12. The policy included, but was not limited to, "if used, single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."</p> <p>On 2/4/16 at 2:46 p.m., the Administrator provided the "Guidelines for Hand Hygiene Policy and Procedure", revised on 9/30/15. The policy included, but was not limited to: "Decontaminate hands after removing gloves." "Lather all areas of hands and wrists, rubbing vigorously for at least 20 seconds..."</p> <p>3.1-21(i)(3)</p>			

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were labeled with open dates</p>	F 0431	<p>Resident #23: Visine and Liquears was removed from the cart and replaced with new. Resident #13: Artificial Tears was removed from the cart and</p>	03/04/2016			

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	<p>and over-the-counter medications were labeled to include physician's names for 2 of 2 medication carts and 2 of 2 medication rooms. (East Medication Cart, West Medication Cart, East Medication Room, West Medication Room)</p> <p>Findings include:</p> <p>1. During an observation of the East medication cart on 2/4/15 at 8:50 a.m., the following were observed:</p> <p>a. Resident #23 was observed to have an opened bottle of Visine Ophthalmic Solution with no label on it and a bottle of Liquears 1.4% Ophthalmic Solution with no open date on it.</p> <p>b. Resident #13 was observed to have an open bottle of Artificial Tears, dated 4/11/15.</p> <p>c. Resident #24 had an opened bottle of Brimonide 0.2% Ophthalmic Solution with no open date, Systane 0.6% Ophthalmic Solution, dated 8/31/15, and Refresh PM Ophthalmic Solution with no open date on it.</p> <p>d. Resident #40 had an open bottle of Atropine 1% Ophthalmic Solution and Timolol 0.5% Ophthalmic Solution with</p>		<p>replaced with new. Resident #24: Brimonide, Systane and Refresh were removed from the cart and replaced with new. Resident #40: Atropine and Timolol were removed from the cart and replaced with new. Resident #14: Inhaler was removed from the cart and replaced with new. Resident # 4: Artificial Tears was removed from the cart and replaced with new. Resident #28: Liquears was removed from the cart and replaced with new. Resident #17: Artificial Tears was removed from the cart and replaced with new. Resident #5: Liquears was removed from the cart and replaced with new. Resident #10: Artificial Tears was removed from the cart and replaced with new. Resident #25: OcuPhase was removed from the cart and replaced with new. All Lorazepam in use was verified to be properly labeled, including date opened Resident #24: Refresh ointment was removed from the medication room and replaced with new. The DON was responsible for the replacement process and did so at the facility's expense on 2/25/16 The Hormel Food and Beverage Thickeners from east and west medication rooms were replaced with new. Training was done instructing to not store the scoop in the product after it is opened. Medication carts and medication rooms were checked by DON and</p>	

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	<p>no open dates on them.</p> <p>e. Resident #14 had an Advair Diskus 50/50 Inhaler with an open date of 12/12/15.</p> <p>2. During an observation of the West medication cart on 2/4/15 at 9:15 a.m., the following were observed:</p> <p>a. Resident #4 had an opened bottle of Artificial Tears with an open date of 8/1/15.</p> <p>b. Resident #28 had an open bottle of Liquitears 1.4% with an open date of 4/23/15 on it.</p> <p>c. Resident #17 had an open bottle of Artificial Tears, dated 12/5/15.</p> <p>d. Resident #5 had an open bottle of Liquitears 1.4% Ophthalmic Solution with an open date of 12/25/14 on it.</p> <p>e. Resident #10 had an open bottle of Artificial Tears with no open date on it.</p> <p>f. Resident #25 had an open bottle of OcuPhase Ophthalmic Solution with no label with the physician's name or an open date on it.</p> <p>The manufacturer's recommendation for</p>		<p>designees to verify that any necessary corrective steps were taken to assure that over-the-counter medications are labeled with resident name, physician name, and open date and are not expired; that ophthalmic medications and inhalers are labeled with resident name, physician name and open date and are not expired; and, that prescription medications are labeled with resident name, directions for use, medication name, strength, and prescriber's name and are not expired All residents have the potential to be affected. To prevent the practice from recurring, all nurses received additional training that included: the need and expectation that all over-the-counter medications, all ophthalmic solutions, all other solutions, and all inhalers have appropriate labeling. There was also additional training that monitoring and anticipation of expiration dates must occur and that scoops are not to be stored in containers that have been opened. The DON will work with the consulting pharmacy to perform medication cart and medication room checks to assure, per policy, that all over-the-counter medications, all ophthalmic solutions, all other solutions and all inhalers have appropriate labeling and that expiration dates are being monitored and anticipated. Not</p>	

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	<p>the above ophthalmic medications indicated the solution should be discarded 30 days after opening.</p> <p>The manufacturer's recommendation for Advair Diskus inhaler indicated the medication should be discarded 30 days after opening.</p> <p>During an interview with RN #1 on 2/4/16 at 8:50 a.m., RN #1 indicated ophthalmic solutions were good for a year after they had been opened. RN #1 further indicated medications should be dated with the date in which they were opened. She further indicated over-the-counter medications should be labeled with the resident's name and physician.</p> <p>During an interview with RN #2 on 2/4/16 at 9:20 a.m., RN #2 indicated she was not certain when an ophthalmic solution should be discarded after it had been opened.</p> <p>A policy titled, "Medication Labels," undated, and obtained from the DON (Director of Nursing) on 2/4/16 at 2:10 p.m., indicated each prescription medication should be labeled with the resident's name, directions for use, medication name, strength, and prescriber's name.</p>		<p>being able to verify will result in the immediate and necessary corrective step(s) being taken. These checks will be done every 2 weeks for at least 12 weeks. The DON may decrease the frequency of checks after that. To assure continued compliance, the DON or designee will report on medication room and medication cart check results quarterly to SNF PIC for at least one year. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>				

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	<p>The facility lacked documentation of a policy for ophthalmic solutions and Advair Diskus inhalers.</p> <p>3. On 2/4/16 at 10:05 a.m. during an observation of the west unit medication room, the following medication was found:</p> <p>. A container of Hormel Thick and Easy Instant Food and Beverage Thickener had been opened and dated on 1/31/16. The can had a scoop inside the can. There was no patient name on the can.</p> <p>4. On 2/4/16 at 10:15 a.m., during an observation of the east unit medication room the following were found:</p> <p>a. A container of Hormel Thick and Easy Instant Food and Beverage Thickener had no open date. The can had a scoop inside. There was no patient name on the can.</p> <p>b. Resident #24 had an open tube of Refresh Lacri-lube eye ointment which had no open date.</p> <p>c. Resident #7 had an open bottle of lorazepam 2 mg(milligrams)/ ml (milliliter) had which had no open date.</p> <p>The manufacturer's recommendation for</p>			

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F 0441 SS=E Bldg. 00	<p>the above ophthalmic medication and lorazepam Solution indicated the solutions should be discarded 30 days after opening.</p> <p>On 2/4/16 at 10:41 a.m. an interview with RN #1 indicated all medications should be dated with the open date. RN #1 also indicated the Thickener was used for general population of residents when needing thickened liquids or foods and should be dated.</p> <p>On 2/4/16 at 5:40 p.m., the dietary manager indicated scoops should not be left in the thickener containers.</p> <p>The facility lacked a policy on open dates for medications or the scoops being left in the thickener containers.</p> <p>3.1-25(j) 3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>			

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	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a glucometer was cleaned and hand washing was performed as indicated by the facility policy between implementation of resident blood sugar</p>	F 0441	<p>Residents #1, #9, #13, #14, #24 experienced no adverse effects. The lab tech was immediately provided additional training and a competency check regarding the glucometer and its need and expectation to be cleaned, per policy, after each resident use. All residents having blood sugars</p>	02/18/2016

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	<p>assessment for 1 of 5 residents observed and 2 of 7 residents observed during care. (Resident #9, Resident #14)</p> <p>Findings include:</p> <p>1. During an observation on 2/3/16 at 10:58 a.m., Laboratory Technician (Lab Tech) #1 was observed to enter Resident #9's room to obtain a blood sugar. Lab Tech #1 was observed to apply gloves, wipe the resident's finger, obtain the supplies, obtain blood sample from the resident, and place the blood sample on a test strip which was located in the glucometer. No hand hygiene was performed. After the blood sample was obtained, Lab Tech #1 was observed to remove a marker from her jacket pocket, document the result on a slip of paper, and place the glucometer in the carrying case. Lab Tech #1 removed her gloves, sanitized her hands and left the resident's room. Lab Tech #1 went to the nurse's station and indicated she would stick the label with the results on a slip of paper for the nurses to review. Upon query, Lab Tech #1 indicated she would take the glucometer and case to the laboratory and clean the glucometer at that time. Upon further query, Lab Tech #1 indicated she had performed a total of 5 (five) accuchecks on the unit (Resident #9, Resident #14, Resident #13, Resident</p>		<p>obtained had the potential to be affected. Immediate steps were taken to assure the practice did not recur. All SNF blood sugar checks were observed by qualified personnel until completed competencies on the process were verified. All lab personnel assigned to do blood sugar testing completed a competency check on glucometer cleaning (specifically, the Nova Glucose Screen Meter) prior to doing blood sugar checks after 2/4/16. This was done irregardless of their competency status prior to 2/4/16 To assure continued compliance, lab will periodically provide a list of personnel who have passed a skills check to perform blood sugar checks to SNF. The lab will continue its practice of verifying competency prior to allowing blood sugar testing to be done by newly hired personnel. Nursing or lab will report to SNF PIC quarterly for at least one year on audit results verifying completion of competency checks regarding glucometer cleaning by lab personnel performing the task on SNF. SNF PIC will monitor for compliance and make recommendations as necessary. All C.N.A.s were required to perform a return hand washing demonstration following training on the need and expectation that hands be washed for 40 – 60 seconds from start to finish. All C.N.A.s also received additional</p>	

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	<p>#24, and Resident #1) and had not cleaned the glucometer between the residents. She indicated the glucometer would be cleaned with a bleach wipe when she had finished. Lab Tech #1 further indicated the laboratory staff had placed the packages of the bleach wipes under the shelf of the kit, in the past, but the staff was no longer allowed to do this.</p> <p>During an interview on 2/3/16 at 1:10 p.m., Lab Tech #2 indicated the accucheck kit contained alcohol wipes. Lab Tech #2 indicated the glucometer machine should be cleaned after each resident's use with a bleach germicidal wipe according to the manufacturer's recommendation. Lab Tech #2 indicated the technician's should carry the bleach wipes with them to the unit, to clean the glucometer.</p> <p>A copy of the "Bleach Germicidal Wipes" label was obtained from Lab Tech #2 on 2/3/16 at 1:30 p.m. The label indicated the surface should be wiped with the wipes to be disinfected and left to air dry.</p> <p>During an interview on 2/3/16 at 1:43 p.m., the DON (Director of Nursing) indicated the glucometer should have been cleaned after each resident use.</p>		<p>training on appropriate glove use and glove changing. It was determined that all residents have the potential to be affected. To prevent future recurrence, the DON or designee will perform hand washing observations to include hand washing checks on every shift at least monthly. There will also be glove change observations on every shift at least monthly. In addition, there will be increased emphasis on hand washing and glove changing during daily rounding by Charges Nurses, the DON, and SNF Administrator. Negative observations will result in immediate redirection or additional training or performance counseling. This will continue for at least 3 months. To assure continued compliance, the DON will present a report on hand washing and glove changing observations/responses on a quarterly basis to SNF PIC for at least one year. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>	

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	<p>A titled, "Chem Nova Stat Strip Glucose Monitoring Meter," created 8/24/10, effective date, 5/12/15 and obtained from the Administrator on 2/3/16 at 11:44 a.m., indicated the glucometer should be cleaned with a cloth that had been dampened with a 10% bleach solution or disinfectant wipe before and after each resident use. This should immediately be followed with a water-dampened cloth to remove all cleaning residue and the machine should be dried thoroughly with a soft cloth or lint-free tissue to prevent patient contamination.</p> <p>2. During an observation on 2/3/16 at 9:43 a.m., CNA #1 and CNA #2 were observed to place Resident #14 into bed, using the mechanical lift. CNA #2 was observed to apply gloves. No hand hygiene was performed prior to applying the gloves. CNA #2 was observed to assist Resident #14 onto her left side and lowered the resident's slacks. The resident was then assisted to turn to her right side and the slacks lowered and the lift sling removed from under the resident. CNA #2 was observed to undo the resident's brief, which was dry. CNA #1 and CNA #2 were observed to place a pillow under Resident #14's lower extremities. CNA #1 was observed to remove the gloves and sanitized her hands for 7 (seven) seconds. CNA #2</p>			

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F 0465 SS=E Bldg. 00	<p>was observed to removed her gloves and wash her hands for 25 seconds from start to finish. CNA #1 was then observed to was her hands for 20 seconds from start to finish.</p> <p>During an interview on 2/3/16 at 9:57 a.m., CNA #1 and CNA #2 indicated hands should be washed and/or sanitized for 15 seconds.</p> <p>A policy for hand washing was requested on 2/4/16 at 12:35 p.m. The facility lacked documentation of a policy for handwashing.</p> <p>The most current World Health Organization information, dated May, 2009, indicated hands should be washed for 40 - 60 seconds from start to finish.</p> <p>3.1-18(a) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p>			

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	<p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary environment as indicated by bed rails were cracked, chipped paint, loose call lights, dust and broken equipment, bedroom faucets sprayed, lime and soap scum deposits were present in sinks, and resident equipment was improperly stored or 4 of 21 resident rooms reviewed. (Room #5523, Room #5523-2, Room #5529, Room #5537, Room #5531, Room #5521, Room #5583)</p> <p>Findings include:</p> <p>1) During an observation on 2/1/16 at 10:26 a.m., Room 5523 the over the commode seat in the bathroom was observed to have a brown substance on it. The bathroom was shared with Room 5525. The same was observed on 2/4/16 at 9:11 a.m.</p> <p>2) During an observation 2/1/16 at 10:42 a.m., Room 5523-2 was observed to have a cracked area on the bed side rail. The same was observed on 2/4/16 at 9:11 a.m.</p> <p>3) During an observation on 2/1/16 at 11:17 a.m., Room 5529 was observed to have chipped paint on the closet doors and built-in cabinets. The bathroom call</p>	F 0465	<p>5523: bathroom commode was cleaned on 2/4/16 5523-2: bed rail (door side) was replaced on 2/4/16 5529: call light cover was repaired on 2/4/16 and closet doors and cabinet refurbishing was completed 2/23/16 5531 : the box fan was thrown away on 2/4/16 5537: bedroom faucet was thoroughly cleaned on 2/5/16 5583 : bedpan and wash basin were bagged and stored on 2/4/16 5521: bathroom was thoroughly cleaned on 2/4/16 All residents have the potential to be affected. To prevent future recurrence, all resident rooms and bathrooms will be rounded on and observed for environmental concerns on at least a weekly basis. Concerns will be promptly communicated to Facility Services and a work order will be created. Work order completion times will continue to be logged by Facility Services and monitored by the Facility Services Director or designee for timeliness of completion. All C.N.A.s received additional training that bedpans and wash basins are to be bagged and stored in drawers. Bedpan and wash basin storage will receive increased emphasis and attention during daily rounding by the Charge Nurses, the DON, and SNF Administrator. Negative observations will result in additional training or redirection or performance counseling. To ensure continued compliance,</p>	02/23/2016

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	<p>light cover was loose from the wall. The bathroom was shared by room 5527. The same was observed on 2/4/16 at 9:13 a.m..</p> <p>4) During an observation on 2/1/16 at 11:30 a.m., Room 5531 was observed to have a box fan which had dust and dirt on it and the right upper corner was broken. The same was observed on 2/3/16 at 3:25 p.m.</p> <p>5) During an observation on 2/1/16 at 2:49 p.m., Room 5537 had lime build-up on the bedroom faucet and the faucet sprayed whenever it was turned on. The same was observed on 2/4/16 at 9:15 a.m.</p> <p>During an interview on 2/4/16 at 3:30 p.m., CNA #3 indicated if something was in disrepair or if body fluids were observed on surfaces, the staff should clean and sanitize the areas.</p> <p>A policy titled, "Housekeeping Procedures," dated 4/24/12, indicated occupied rooms were cleaned on a daily bases. 6) On 2/1/16 at 11:10 p.m., Room #5583 was observed. In the bathroom, two washbasins and a bedpan were unlabeled and uncovered on the floor. On 2/2/16 at 8:55 a.m., a washbasin and a bedpan were observed to be unlabeled and uncovered on the bathroom floor.</p>		<p>Facility Services will report on SNF work orders and their completion to SNF PIC quarterly for at least one year. The DON will report on infection control rounding results to SNF PIC quarterly for at least one year. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>	

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F 0494 SS=D Bldg. 00	<p>7) On 2/1/16 at 9:14 a.m., Room #5521 was observed. In the bedroom, a wet wash cloth was stored in the sink. In the bathroom, soap scum was observed to be built up in the sink. On 2/3/16 at 1:09 p.m., the bathroom sink was observed with built up soap scum and a wet washcloth was stored in the bathroom sink.</p> <p>On 2/4/16 at 2:28 p.m., the DON (Director of Nursing) provided the "Bedside Equipment Sanitizing-SNF" policy, dated 8/22/11, it included, but was not limited to, when dry the utensils/equipment shall be returned to the residents room or placed in storage in the clean utility room.</p> <p>On 2/4/16 at 2:45 p.m., the DON indicated bedpans and wash basins should be stored in a bag in the residents drawer in their bedrooms.</p> <p>3.1-19(f)</p> <p>483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4</p>			

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	<p>months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.</p> <p>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</p> <p>Based on record review and interview, the facility failed to ensure an individual working as a nurse aid had completed competency evaluation for 1 of 18 nurse aid certifications reviewed. (CNA #3)</p> <p>Findings include:</p> <p>On 2/4/16 at 9:00 a.m., the licenses and certifications of facility staff were reviewed. CNA #3 lacked a certification and had been employed since 9/9/15.</p> <p>On 2/4/16 at 9:15 a.m., the HRE (Human Resources Employee), indicated CNA #3 was a nursing student and had 120 days</p>	F 0494	C.N.A. #3 was assigned a new job description in the Activity Department on 2/4/16 and applied for C.N.A. testing. The test was successfully completed on 2/25/16 It was determined that all residents have the potential to be affected. To prevent future recurrence, the DON or her designee will develop and maintain a spreadsheet to track and monitor C.N.A. certification. The DON or designee will be responsible to keep the spreadsheet current and to audit it at least monthly and to make a timely response to any C.N.A. certification concerns Negative findings will be communicated to the SNF	02/25/2016

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F 0514 SS=D Bldg. 00	<p>to receive a certification.</p> <p>On 2/4/16 at 9:30 a.m., the DON indicated she was unaware that CNA #3's 120 days had expired.</p> <p>On 2/4/16 at 11:33 a.m., the DON indicated the 120 day time period had elapsed, due to a clerical and mathematical error.</p> <p>On 2/4/16 at 2:53 p.m., the Administrator provided the "Certified Nursing Assistant Job Description", revised 10/11/12. The policy included, but was not limited to, maintains current Indiana CNA certificate.</p> <p>3.1-14(b)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p>		<p>administrator immediately To ensure continued compliance, the DON will report to SNF PIC quarterly for at least one year regarding audit results regarding C.N.A.verifications. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>	

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	<p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to ensure that 1 resident was being toileted and 1 resident was being repositioned for 1 of 1 resident reviewed for pressure ulcers and 1 of 3 residents reviewed for urinary incontinence in a total sample of 23 residents whose documentation were reviewed in stage 2. (Resident #14, Resident #9)</p> <p>Findings include:</p> <p>1. During an observation on 2/1/16 at 9:00 a.m., Resident #14 was observed to be sitting in a high-back wheelchair with a pillow tucked down the left side of the arm rest. Resident #14's upper torso and head was observed to be leaning to the left side.</p> <p>During an observation on 2/1/16 at 11:55 a.m., Resident #14 was observed to be sitting in the dining room for lunch in a high back wheelchair. Resident #14's upper torso and head were observed to be leaning to the left side.</p>	F 0514	<p>Resident #14: skin area was healed the week of 2-11-16. Resident #14 care plan was revised to reposition frequently and as needed prior to survey and this manual change did not reflect on the electronic care plan. The correction to the electronic plan was made 2/26/6. Resident #9: the electronic plan of care was revised 2/24/16 to indicate to toilet frequently and as needed rather than every two hours. It was determined that all residents have the potential to be affected. To assure compliance, the MDS Nurse or designee will review all plans of care and revise to communicate "frequently and as needed" versus timed intervals in regards to repositioning and toileting. The MDS Nurse or designee will also review all plans of care to assure that the electronic care plan reflects any changes made on paper copies of care plans. The SNF plan to transition from electronic and paper care plans to electronic care plans is continuing. The DON, MDS Nurse or designee will review the documentation of C.N.A.s in regards to activities of daily living (ADLs). The DON will continue a transition to real time charting of ADLs to replace</p>	03/04/2016			

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	<p>During an observation on 2/1/16 at 3:30 p.m., Resident #14 was observed to be lying in bed on the left side.</p> <p>The clinical record for Resident #14 was reviewed on 2/4/16 at 11:13 a.m. The clinical record indicated Resident #14 had diagnoses including, but not limited to, fibromyalgia, major depressive disorder, Alzheimer's dementia, and polyarthritis. An admission MDS (Minimum Data Set) assessment, dated 12/18/15, indicated Resident #14 had a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive disorder.</p> <p>A care plan, dated 12/10/15, indicated Resident #14 had a potential for skin breakdown related to limited mobility. Interventions included, but were not limited to, reposition every 2 (two) hours and prn (as needed).</p> <p>During an interview on 2/3/16 at 3:30 p.m., the LPN #1 indicated the resident was turned frequently, but the facility did not have a place in the electronic chart to document the times when the resident is repositioned.</p> <p>The clinical record lacked documentation of Resident #14 being repositioned every 2 hours.</p>		<p>charting by shift. This transition will include software review, additional C.N.A. training, and chart monitoring by the DON or designee. To assure continued compliance, the MDS Nurse, DON and SNF Administrator will meet weekly regarding: the transition to real time ADL charting versus the predominance currently of end of shift charting; and, the transition to only electronic care plans vs. the current electronic and paper care plans. The DON will report progress on both of these initiatives quarterly to SNF PIC for at least one year. SNF PIC will review and monitor for compliance and make recommendations for changes as necessary.</p>	

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(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
	<p>2. On 2/2/16 at 8:55 a.m., Resident #9 was observed in a wheelchair. There were not any signs of urinary incontinence observed.</p> <p>On 2/2/16 at 10:43 a.m., Resident #9's clinical record was reviewed. Resident #9's diagnoses included, but was not limited to urinary incontinence.</p> <p>A Care Plan, dated 11/30/15, with a current goal date of 2/2016, indicated, frequently incontinent of bowel and bladder. The interventions included, but were not limited to, toilet every two hours and as needed.</p> <p>On 2/3/16 at 8:37 a.m., CNA #4 indicated Resident #9 was incontinent and the staff checked the resident for incontinence and changed the resident if needed every two hours.</p> <p>On 2/3/16 at 2:17 p.m., the DON indicated the facility had not documented Resident #9's every two hour incontinence care.</p> <p>3.1-50(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2016
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670		
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F 9999 Bldg. 00	<p>3.1-14 PERSONNEL</p> <p>(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:</p> <p>(6) Care of cognitively impaired residents.</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of the cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure dementia training was completed for 2 of 10 employees reviewed. (CNA #4, RN #3)</p>	F 9999	<p>C.N.A. #4 and RN #3 were assigned and completed dementia training to complete their annual requirement. It was determined all residents have the potential to be affected. To prevent recurrence, SNF has increased its inventory of dementia training videos and will assign them to staff. The DON will implement and maintain a spreadsheet to monitor and assure new SNF hires get six hours dementia training within 6 months of hire and that all SNF employees receive 3 hours of dementia training annually. The DON will review and update the spreadsheet at least monthly. Instances of non compliance with completing assigned training will result in redirection or performance counseling. The DON will summarize audit results to SNF Administrator monthly. To assure continued compliance, the DON will report to SNF PIC quarterly for at least one year in regards to dementia training requirements being met for all SNF staff. SNF PIC will review and monitor for compliance and make recommendations as necessary.</p>	03/04/2016	

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	<p>Findings include:</p> <p>On 2/3/16 at 3:45 p.m., the employee files were reviewed. CNA #4 and RN #3 were lacking their annual dementia training. CNA #4's employee file indicated the CNA had last completed four hours of dementia training in 2013. RN #3's employee file indicated the RN had last completed one hour of dementia training in 2014.</p> <p>On 2/4/16 at 10:05 a.m., the DON indicated she was unable to locate annual dementia training for CNA #4 and RN #3.</p> <p>On 2/4/16 at 2:46 p.m., the Administrator provided the "Personnel Orientation and Training" policy, revised on 4/7/15. The policy included, but was not limited to: "It is the policy of [Name of Facility] to select candidates, who best meet the requirements of the position, and to orient newly hired employees to the hospital and their respective department, as well as provide short-term and long-term training through various mediums."</p>			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2016

FORM APPROVED

OMB NO. 0938-0391

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