

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 10/29/2014
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: October 27, 28 and 29, 2014</p> <p>Facility number: 011389 Provider number: 011389 AIM number: N/A</p> <p>Survey team: Debora Kammeyer, RN, TC Lora Swanson, RN Julie Wagoner, RN</p> <p>Census bed type: Residential: 19</p> <p>Sample: 10</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on November 5, 2014, by Brenda Meredith, R.N.</p>	R000000		
R000029	<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 observations and interviews,</p>	R000029	<p>R-029 –Care Service Manager provided one-one education to</p>	12/15/2014

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>the facility failed to feed 2 of 3 residents needing assistance in a dignified manner. (Resident #2 and Resident #5)</p> <p>Finding includes:</p> <p>On 10-27-14 at 12:35 P.M., CNA #21 was observed to have approached Resident #2 and picked up the resident's fork. CNA #21 was then observed feeding the resident while standing next to the resident. CNA #21 continued to stand and provided the resident several bites before she put the resident's fork down and walked away.</p> <p>On 10-28-14 at 8:27 A.M., CNA #21 was observed standing while feeding Resident #2. After several minutes, CNA #21 was then observed to move to another table and stand next to Resident #5 while feeding her. After giving Resident #5 several bites, the CNA was observed to walk away from Resident #5 after placing her fork in her hand. CNA #21 then walked over to Resident #2's table again and without speaking or sitting next to the resident, fed the resident several bites of food while standing next to her.</p> <p>On 10-28-14 at 12:15 P.M., CNA #21 was observed standing next to Resident #2 to feed her. A conversation between the resident and the CNA was not heard.</p>		<p>CNA #21 concerning dignity and infection control. Executive Director and Care Service Manager to conduct a mandatory orientation for staff. The orientation for staff will cover Resident Rights, Neglect &amp; Abuse, Universal Precautions, Proper hand washing procedure as well as covering polices &amp; procedures for resident care. Orientation held on 11/10/14, 11/12/14 &amp; 11/18/14. Executive Director &amp; Care Service Manager will be monitoring these policies &amp; procedures as task sheets &amp; facilities job performances are monitored and will correct accordingly to adhere to state regulations pertaining tag R-029. Monitoring With Monthly in-services as scheduled. Findings will be reported to the Quality/Safety Committee and recommendations will be made accordingly from the committee. Care Service Manager or Designee will be responsible for compliance and monitoring.</p>	

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R000090	<p>During an interview on 10-29-14 at 1:50 P.M., the Administrator indicated an employee should not stand to feed a resident as it was not a dignified approach to feeding residents at the facility. She further indicated she had seen CNA #21 feeding several residents while standing next to them. A feeding policy was requested but was not provided.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone</p>			

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	<p>number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review the facility failed to timely report an unusual occurrence involving a fall with a fracture to the Indiana State Health Department (ISDH) for one of one occurrences reviewed. Resident #8.</p> <p>Finding includes:</p> <p>On 10-28-14 at 10:10 A.M., the Regional Director of Care Services indicated a</p>	R000090	<p>R-90- Administrator will adhere by state and corporate policies &amp; procedures. Immediate disciplinary action was taken with LPN #24 concerning lack of documentation of assessment following incident. Employees will be in-serviced on the protocol used for Incident reporting and timely assessment of residents. This was addressed during the mandated orientation held for employees on 11/10/14, 11/12/14 &amp; 11/18/14. Executive Director</p>	12/15/2014

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	<p>corporate nurse had contacted her, on 10-24-14, regarding an incident which had occurred on 10-23-14, involving Resident #8. The Regional Director of Care Services further indicated she would be doing a reportable to ISDH due to the resident being admitted to a local hospital for a fractured hip and she indicated she had failed to complete the report on 10-24-14.</p> <p>On 10-28-14 at 1:10 P.M., an "Incident Report Form," dated 10-28-14, indicated Resident #8 had reported to a staff member on 10-23-14 at 4:00 P.M., he had "fallen into his chair" while transferring himself earlier in the day. The incident report further indicated the resident was offered to be sent to the ER (Emergency Room) for X-rays, however the resident declined. During the day shift, on 10-24-14, the resident's pain level was documented to have increased. The family and physician was notified of the incident and resident was transferred to a local hospital. The type of injury the resident sustained was reported as a right fractured hip.</p> <p>On 10-28-14 at 1:45 P.M., a form titled "Universal Incident Report," dated 10-24-14, indicated Resident #8 had an unwitnessed fall on 10-23-14 while resident was trying to self transfer. The</p>		<p>and Care Service Manager shall visualize incident report logs and receive a telephone call per state regulations and report such incidents according to policies &amp; procedures accordingly. Incident Report Logs will be reviewed at Quality/Safety Committee and recommendations will be made accordingly from committee. Executive Director or Designee is responsible for compliance</p>	

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	<p>form indicated the family was notified at 6:15 AM on 10-24-14 and at 6:30 A.M. the resident was transferred for treatment by EMS (Emergency Medical Service) and was hospitalized. The form did not indicate if the Administrator was notified of the occurrence.</p> <p>On 10-28-14 at 2:00 P.M., a policy titled "Resident Fall Response," dated 7-1-14, indicated, "I. Assess Situation - take vital signs (BP, pulse, respirations), assess resident's discomfort, perform a brief check of resident to include feeling elbows, shoulders, back, hips, and knees...." The policy further indicated documentation should include the following: time of day, where incident occurred, accurate description of the incident, physical status, physician notification, family notification, remedial measures taken to ensure continued resident safety and follow the Incident Reporting Guidelines. The policy indicated the Executive Director and or Care Services Manager was responsible for following state-specific reporting guidelines.</p> <p>On 10-28-14 at 2:30 P.M., a review of form titled "Community Incident Reporting Guidelines" indicated the employee who observed and first became aware of an incident should begin the</p>			

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	<p>Incident Report. The report further indicated the Executive Director/Administrator should be notified immediately of a fall resulting in death, serious injury and/or hospitalization.</p> <p>During an interview, on 10-29-14 at 9:45 A.M., the Regional Director of Care Services (RDCS) indicated LPN #24 was the nurse on duty during Resident #8's incident. The RDCS further indicated LPN #24 had came in on 10-24-14, to document in the Resident Service Notes and should have indicated "late entry" on his documentation. The RDCS further indicated the Resident Service Notes did not indicate if LPN #24 had contacted the Administrator nor the Care Service Manager after he became aware of the occurrence.</p> <p>During an interview, on 10-29-14 at 10:15 A.M., the RDCS indicated she would expect a nurse on duty during a fall incident would do the following: obtain vitals, do an assessment, determine if there are injuries and treat, report incident to superiors, and complete an Incident Report. She further indicated LPN #24 did not follow policy and procedure regarding Resident #8's occurrence. The RDCS indicated the person filling in as the temporary Administrator was notified of the</p>			

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R000117	<p>incident, on 10-24-14 at 10:00 A.M. She was to complete the report to ISDH, as the Service Care Manager/Director of Nursing was on vacation, but she had failed to complete the report until 10-28-14.</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interviews,</p>	R000117	<p>· R-117- Personnel deficiencies will be corrected by ensuring that staff is sufficient in number based</p>	12/15/2014

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	<p>the facility failed to ensure there was an awake, CPR (Cardio Pulmonary Resuscitation) and first aid certified staff member working during 15 of the last 39 shifts (on the past 10 days). This involved 6 of 9 employees.</p> <p>Finding includes:</p> <p>During the review of personnel files, conducted on 10/28/14 between 11:00 A.M. thru 3:00 P.M., the following was not located in the personnel files: Employee #21, with a hire date of 3/28/14, had no CPR/first aid certification. Employee #25, with a hire date of 5-5-14, had no CPR/first aid certification. Employee #26, with a hire date of 9/30/14, had no CPR/first aid certification. Employee #27, with a hire date of 12/30/13, had no CPR/first aid certification. Employee #20, with a hire date of 10-27-14, had no CPR/first aid certification. Employee #28, with a hire date of 9/30/14, had no CPR/first aid certification.</p> <p>On 10/29/14 at 8:30 A.M., the staffing schedule, dated 10/17/14 thru 10/29/14, and received from the Director of</p>		<p>on census and acuity of the facility. The facility shall staff to corporate policy and state regulations. Scheduled staff will be CPR trained &amp; certified according to state regulations. Facility has scheduled two CPR classes to be conducted at facility by instructors for the AHA, 11/18/14 &amp; 11/23/14, to meet this requirement, and shall continue certification of employees as outlined in state regulations. Monitoring shall continue to be done twice a year for compliance. Monitoring will occur with tickler file for CPR Certification dates monitored monthly in Executive Director/CSM meetings. Further monitoring shall be at annual employee review and end of the year for total regulation compliance. Executive Director or Designee is responsible for compliance.</p>				

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R000121	<p>Nursing (DON), indicated the facility did not have a CPR/first aid certified staff member on duty during the following dates and shifts: Day shift - 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/25, and 10/26, 2014. Evening shift - 10/17, 10/21, 10/22, 10/26, 10/27, and 10/29, 2014. Night shift was covered by an outside agency that provided two CNA's to cover the dates reviewed.</p> <p>During an interview, on 1/29/14 at 1:50 P.M., the Administrator indicated all staff working in the facility should have the proper certifications prior to administrating resident care in the facility. She further indicated she first entered the building as the administrator on 10/27/14, and was unaware of the lack of CPR certification among the employees working at the facility.</p> <p>On 10/29/14 at 2:00 P.M., the DON provided a copy of the agency's CNA's CPR/first aid certification. The DON indicated she was aware of the need to get staff certified in CPR/first aid.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously</p>			

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	<p>positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 5 employee files (Employee #26 and #28) contained documentation of tuberculin skin test (Mantoux) prior to resident contact. The facility further failed to</p>	R000121	· R-121- Staff will have TB skin test as per policy. CSM or designee will ensure that employees receive second step mantoux as per state regulations and company policy. Staff LPNs will be provided with certification	12/15/2014

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	<p>have evidence of the 2 step tuberculin test for 1 of 5 employees (Director of Nursing).</p> <p>Findings include:</p> <p>During the review of personnel files, conducted on 10/28/14 between 11:00 A.M. thru 3:00 P.M., the following was located in the personnel files:</p> <p>Employee #26, with a start date of 9/30/14, did not receive a 1st step Mantoux skin test until 10/21/14. Employee #28, with a start date of 9/30/14, did not receive a 1st step Mantoux skin test until 10-2-14.</p> <p>In addition, The Director of Nursing, with a start date of 9/19/14, had no record of receiving a 2nd step tuberculin skin test.</p> <p>On 10/28/14 at 2:45 P.M., review of a policy titled " TB Testing," dated 7/1/14, indicated, "...TB testing will be completed per state regulations for residents, staff and volunteers...."</p> <p>During an interview, on 10/29/14 at 1:50 P.M., the Administrator indicated all staff members should have their TB testing prior to having contact with the residents. She further indicated the TB testing</p>		<p>class to provide/read TB skin test on 11/20/14. This monitor shall be done by new hire check off list, then again upon employee annual evaluation. Executive Director or Designee is responsible for compliance.</p>				

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R000214	<p>should be done during the orientation process.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on observation, record reviews and interviews, the facility failed to ensure open areas on 3 of 3 residents with open areas in a sample of 10 were clinically evaluated, routinely assessed and monitored consistently. (Residents #1, 2, and 4) In addition, the facility failed to assess a resident for injuries after an unwitnessed fall. (Resident #8)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 10/27/14 between 10:30 A.M. - 11:05 A.M., the Director of Nursing (DON) indicated Resident #4 was incontinent of his bowel and bladder, required two staff for toileting and transferring needs, received Hospice services, and had a healed open area to</p>	R000214	<p>· R-214- Resident #4 has appropriate 3rd party services to assist in monitoring and caring for Wounds. CSM visits resident weekly with 3rd party provider to observe Resident open areas and documents findings including measurements. Resident #1 – information was obtained from resident daughter that a previous skin graft is breaking down and that she is not a candidate for new graft at this time. CSM or designee will document weekly after visualizing site for signs of infection or worsening. Resident #2 also receives weekly visits with CSM to monitor skin and documentation will be completed. Resident #8 – Lack of assessment and proper documentation by LPN #24 was addressed with immediate disciplinary action resulting in termination of LPN. Regarding</p>	12/15/2014

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	<p>his upper buttocks area.</p> <p>The clinical record for Resident #4 was reviewed on 10/28/14 at 10:00 A.M. Resident #4 was admitted to the facility, on 02/28/13, with diagnosis, including but not limited to, hypothyroidism, non allergic rhinitis, hyperlipidemia, coronary artery disease, depression, dry eyes, and constipation.</p> <p>Resident #4's buttocks were observed during a toileting observation, conducted on 10/28/14 from 11:15 A.M. - 11:45 A.M. The resident had a dime sized stage 2 open area on his right upper buttocks. The resident also had at least one more open area on the left and right side of his gluteal fold near the bottom of his buttocks. The resident's entire coccyx and buttocks area was noted to be bright red. CNA #1, who was assisting with his care, was noted to spread a generous amount of A &amp; D ointment all over the resident's buttocks and wound areas.</p> <p>A Resident Service note, dated 10/20/14 at 10:00 A.M., indicated the following: "RN (registered nurse) et (and) Hospice nurse completed skin assessment today noting red et excoriated bottom et 2 areas 0.3 cm (centimeters) diameter open....Hospice nurse will get order for cream for bottom...."</p>		<p>assessment of resident, residents will be assessed as per state regulations, corporate policy, and as defined as RN duty by the Indiana Nurse Practice Act. Monitor shall be the monthly review of both Executive Director and Care Service Manager to meet the needs of the residents, according to the Indiana State Regulations compliance. Monitoring of weekly documentation will be frequently observed by RDCS during visits for compliance. Results will be discussed with CSM and ED during visits and forwarded to the Quality/Safety Meeting. Quality/Safety Committee will make further recommendations as appropriate. Care Service Manager or Designee is responsible for compliance.</p>	

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	<p>A Hospice nursing evaluation, completed on 10/21/14, by Hospice nurse, RN #3, indicated the resident had "excoriation to bottom." The Hospice nurse did not measure or note the open areas and indicated the resident did not have an skin breakdown, except for an "excoriated" bottom. The Hospice nurse indicated the staff were putting "Zinc Oxide" cream on the resident.</p> <p>On 10/28/14 at approximately 10:00 A.M., a nurse, identified as the Hospice nurse, was noted in the building. Resident #4 was tracked from 8:10 A.M. - 12:30 P.M. At 12:30 P.M. he was noted in the dining room eating his lunch. At 1:30 P.M. he was still noted to be in the dining room eating his lunch. He remained in the dining room, after eating his lunch, for an activity. He was toileted once during the day, at 11:15 A.M. - 11:45 A.M., but the Hospice nurse was not present during the toileting. Interview with LPN #5 and CNA #1, on 10/29/14 at 1:30 P.M. confirmed neither staff member had removed the resident from the dining room between 12:30 P.M. - 1:30 P.M. for any care needs. The Hospice nurse, RN #3 was noted to have left the building between 2:00 P.M. - 3:00 P.M. She was not observed to asses the resident's</p>			

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	<p>buttocks. However, a Hospice clinical report, completed on 10/28/14 from 1:15 P.M. - 2:15 P.M. indicated the resident's skin was "cool and dry." The assessment also indicated A &amp; D ointment to "excoriated bottom continues." There was no assessment of the resident's open areas on the form.</p> <p>An interview was conducted with the DON, during the initial tour of the facility, on 10/27/14 between 10:30 A.M. - 11:00 A.M., The DON indicated the Hospice services for Resident #4 were responsible to manage the resident's comfort issues and medications, skin issues, and provided showers twice a week.</p> <p>2. During an interview with Resident #1, conducted on 10/29/14 at 9:30 A.M., the top of the resident's head was observed. There was an oblong open area noted on the top of the resident's head. The open area was approximately the size of a tennis ball but was oblong. The open area was shallow, dark pink, and moist in appearance. The resident could not remember what had caused the open area but indicated she had the area a long time and it did not hurt her. The resident was noted to place a hat over top of her head.</p> <p>The clinical record for Resident #1 was</p>			

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	<p>reviewed on 10/28/14 at 9:26 A.M. Resident # 1 was admitted to the facility on 06/11/13 with diagnoses, including but not limited to: chronic kidney disease, coronary artery disease, diabetes, esophageal reflux, history of an intestinal obstruction, hypertension, dementia, weakness, and hypothyroidism. The most recent service plan, completed on 08/21/14, indicated the resident required no services and had no skin issues. A physician's office note, dated 06/21/14, indicated the resident had a history of skin cancer on her nose but did not indicate any abnormal issues with the resident's skin or head.</p> <p>A vital signs flow sheet, located in a red binder at the nurses station indicated "open area on scalp" was documented on the form every month since 03/2014. A Resident Service note, dated 10/25/14 at 2:15 P.M., completed when the resident returned from a stay at a skilled nursing facility, indicated the resident had a 2 centimeter by 5.5 centimeter open area on her scalp with a dark pink, moist wound bed.</p> <p>Review of the current physician's orders for Resident #1, current as of 10/25/14, indicated there was no treatment ordered for the open area on the resident's scalp.</p>			

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	<p>Interview with the Regional Nurse Consultant, on 10/29/14 at 1:50 P.M., indicated she had reviewed thinned records for Resident #1 and could not find a thorough assessment or any documentation regarding the origin of the open area, any diagnosis for the cause of the open area, nor could she locate any past treatments for the open areas. There was also no documentation the physician was aware of the open area as the resident daily wore a cap on her head, which covered the open area.</p> <p>3. On 10/28/14 at 9:45 A.M., record review indicated Resident #2's diagnoses included but were not limited to "...dementia, affective disorder, glaucoma and anxiety...." Further review of the medical record indicated Resident #2 was admitted to the facility on 8/10/12.</p> <p>A physician order, dated 12/4/13, indicated Remedy Nutrashield protectant cream apply to peri area/buttocks once a day as needed for skin integrity.</p> <p>A resident service note, dated 9/21/14 at 1400 (2:00 P.M.), indicated "Small open area on L (left) buttock. Cream applied, Remedy nutra-shield. Reported to [hospice] for follow-up." There was no other documentation found in the resident service notes indicating any further assessment was completed regarding the</p>						

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	<p>open area on the left buttock.</p> <p>A hospice nursing comprehensive update/visit note, dated 9/24/14, 10/1/14 and 10/15/14, indicated skin intact, skin/pressure ulcer care plan marked as inactive.</p> <p>A hospice aide visit note, dated 10/27/14, indicated skin care: the box labeled lotion- was marked. The box labeled - notified RN of new wound/skin breakdown was unmarked.</p> <p>On 10/28/14 at 10:25 A.M., an interview with LPN #11 indicated today was her second day working in the facility, and was unaware of any open areas on the resident's buttock. She further indicated when the CNA (Certified Nursing Assistant) assists the resident to the restroom she will check her skin then.</p> <p>On 10/28/14 at 10:30 A.M., Resident #2 was observed in the restroom of her apartment. Two CNA's assisted the resident to stand, CNA #12 removed the resident's brief, at that time LPN #11 indicated it looked like the resident has a small open area in the gluteal fold. LPN #11 further indicated she would contact the hospice nurse and have her follow up regarding the open area.</p>			

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	<p>On 10/28/14 at 10:40 A.M., an interview with CNA #12 indicated she checks the resident's skin when she toilets her and she had not observed any open areas.</p> <p>A hospice nursing comprehensive update/visit note, dated 10/28/14, indicated the resident had a Stage II open area and measured 1.0 cm (centimeters) by 1.0 cm. The visit summary indicated, "...it was reported she had open area . One cm x One cm superficial opening that is red base, area is just above rectum, will use Calazine paste to area...Instructed to have patient lay down after lunch, place patient on her side...."</p> <p>On 10/29/14 at 10:00 A.M., an interview with the Director of Nursing indicated she was aware of a problem with the nursing documentation and skin assessments. She further indicated the hospice nurse visited the resident last evening and changed the type of cream to be used on the open area. The DON further indicated the hospice nurse plans on bringing in a cushion for the residents wheelchair.</p> <p>On 10/29/14 at 1:30 P.M., review of the current policy titled "Skin and Wound Care" received from the Director of Nursing indicated "...I. Residents who are at risk of skin breakdown should be</p>			

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	<p>monitored for redness, irritation, or open areas. II. Staff should report any reported pain, paleness of skin, reddened areas, broken skin areas, dry/cracked skin, or drainage from any wounds to the Care Services Manager. III. Physician orders for wound care should be obtained by the Care Services Manager or designee responsible for implementing the care...."</p> <p>4. On 10-28-14 at 10:10 A.M., the Regional Director of Care Services indicated a corporate nurse had contacted her, on 10-24-14, regarding an incident which had occurred on 10-23-14, involving Resident #8. The Regional Director of Care Services further indicated she would be doing a reportable to ISDH due to the resident being admitted to a local hospital for a fractured hip and she indicated she had failed to complete the report on 10-24-14.</p> <p>On 10-28-14 at 1:10 P.M., an "Incident Report Form", dated 10-28-14, indicated Resident #8 had reported to a staff member on 10-23-14 at 4:00 P.M., he had "fallen into his chair" while transferring himself earlier in the day. The incident report further indicated the resident was offered to be sent to the Emergency Room (ER) for X-rays, however the resident declined. During the day shift on 10-24-14, the resident's pain level was documented to have</p>						

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	<p>increased. The family and physician were notified of the incident. The family encouraged the resident to go to the ER and resident was transferred to a local hospital. The type of injury the resident sustained was reported as a right fractured hip.</p> <p>The clinical record of Resident #8 was reviewed on 10-28-14 at 1:30 P.M. The resident's diagnoses included, but were not limited to: Parkinson's disease, anemia, chronic pain, dementia, fatigue, hallucinations, knee joint pain and osteoarthritis of knee.</p> <p>On 10-28-14 at 1:45 P.M., a form titled " Universal Incident Report," dated 10-24-14, indicated Resident #8 had an unwitnessed fall, on 10-23-14, while the resident was trying to self transfer. The form indicated the family was notified at 6:15 AM on 10-24-14 and at 6:30 A.M. the resident was transferred for treatment by EMS (Emergency Medical Service) and was hospitalized. The form did not indicate if the Administrator was notified of the occurrence.</p> <p>On 10-28-14 at 1:50 P.M., a review of the Resident Service Notes indicated CNA#22 had answered Resident #8's call light at 6:00 A.M., the resident had wet his bed and was complaining of pain.</p>			



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	<p>measures taken to ensure continued resident safety and follow the Incident Reporting Guidelines.</p> <p>On 10-28-14 at 2:30 P.M., a review of form titled "Community Incident Reporting Guidelines," updated 9-2014, indicated the employee who observed and first became aware of an incident should begin the Incident Report. The report further indicated the Executive Director/Administrator should be notified immediately of a fall resulting in death, serious injury and/or hospitalization.</p> <p>During an interview, on 10-29-14 at 9:45 A.M., the Regional Director of Care Services (RDCS) indicated LPN #24 was the nurse on duty during Resident #8's incident. The RDCS further indicated LPN #24 had come in on 10-24-14 to document in the Resident Service Notes and should have documented "late entry" on his documentation. The RDCS then provided Resident Service Notes with LPN #24's documentation of the incident. The Resident Service Note dated 10-23-14, indicated at 4:00 P.M., Resident #8 stated "...he had fallen into his chair...earlier in the day. Stated that he had twisted his knee...." The 5:00 P.M. Service Note, written by LPN #24, indicated Resident #8 had been taken to the dining room in a wheelchair per</p>			

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	<p>resident's request. At 7:00 P.M., LPN #24 documented Resident #8 requested assistance to get into bed. The resident had been standing but had his right leg wrapped around his left leg and was having trouble balancing himself. LPN #8 documented he picked the resident up to position him better in bed. A 7:30 P.M. a Service Note, written by LPN #24, indicated the resident was given Tylenol for complaints of right leg pain. LPN #24 further indicated the resident had no shortening or outward rotation of right leg. LPN #24 documented at 9:30 P.M. the resident was asked if he would like to go to the hospital to have a right leg x-ray. The resident indicated he just strained his right hip and didn't want to go to the hospital. At 11:30 P.M. LPN #24 was called in by CNA on duty to medicate Resident #8 for pain. LPN #24 documented Tylenol was given for "body aches" at 11:45 P.M.</p> <p>During an interview, on 10-29-14 at 10:15 A.M., the RDCS indicated she would expect a nurse on duty during a fall incident to complete the following: obtain vitals, do an assessment, determine if there are injuries and treat, report incident to superiors, and complete an Incident Report. She further indicated LPN #24 did not follow policy and procedure regarding Resident #8's</p>			

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R000240	<p>occurrence.</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review and interviews, the facility failed to ensure 1 of 3 residents dependent on staff for toileting needs was toileted timely. (Resident #4).</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 10/27/14 between 10:30 A.M. - 11:05 A.M., the Director of Nursing (DON) indicated Resident #4 was incontinent of his bowels and bladder, required two staff for toileting and transferring needs, received Hospice services, and had a healed open area to his upper buttocks area.</p> <p>The clinical record for Resident #4 was reviewed on 10/28/14 at 10:00 A.M. Resident #4 was admitted to the facility, on 02/28/13, with diagnosis, including but not limited to, hypothyroidism, non allergic rhinitis, hyperlipidemia, coronary artery disease, depression, dry eyes, and constipation.</p>	R000240	<p>R-240- Resident #4 will continue to be encouraged to allow staff to assist with toileting on a frequent basis. Regarding health services: Assistance with ADL's/ Toileting, the facilities staff has been increased to include eight additional hours of coverage that overlap the day and evening shift to increase care of the residents. Task sheets have been updated to reflect care needs of each resident. Care Service Manager or designee will monitor task sheets daily (Monday – Friday) and take corrective and disciplinary action as necessary. Care Service Manager or Designee is responsible for compliance.</p>	12/15/2014

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	<p>The current service plan for Resident #4, completed on 08/22/14, indicated needed staff assistance to the bathroom, wore incontinence briefs, and had frequent episodes of soiling his clothes r/t bowel and bladder incontinence. The service plan did not indicate the frequency for the resident's toileting needs.</p> <p>Resident #4 was observed, on 10/28/14 at 8:10 A.M., seated in a high back wheelchair in the dining room, eating breakfast. He remained in the dining room, slowly feeding himself from 8:10 A.M. - 10:33 A.M. when he was pushed from the dining room to the facility lounge so he could participate in activities. At 11:15 A.M. he was pushed in his wheelchair from the lounge to his room by CNA #2. The bathroom floor was noted to be wet so CNA #2 sat and talked with Resident #4 from 11:15 A.M. - 11:30 A.M. At 11:30 A.M. - 11:45 A.M., Resident #4 was toileted in his room by CNA #1 and #2. At 11:50 A.M., the resident was pushed into the dining room. He remained in the dining room at the dining table from 11:50 A.M. - 12:30 P.M. The resident was again observed, still in the dining room at 1:30 P.M., and he remained in the dining room from 1:30 P.M. - 3:15 P.M. After he finished feeding himself lunch, an</p>			

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	<p>activity had started in the dining room and he attended the activity.</p> <p>During an interview, on 10/29/14 at 1:50 P.M., CNA #1 indicated she was supposed to toilet Resident #4 every two hours. She indicated, on 10/28/14 before breakfast, she had toileted Resident #4, and again before lunch.</p> <p>The facility's policy and procedure, titled, "Toileting Assistance," dated 07/01/14, included the following: "1. The type and amount of assistance needed for toileting will be noted on he resident's Negotiated Service plan. 2. The specific detail of how the staff should provide assistance to the resident is noted on he Community Task Sheets and the care is assigned to a specific Care partner...."</p> <p>Review of the facility task sheet for the licensed nursing staff on the day and evening shift, and the unlicensed nursing staff on the night shift indicated Resident #4 was to be toileted immediately after breakfast from 8:30 A.M. - 9:15 A.M., again between 12:30 P.M. - 1:00 P.M., again between 5:30 P.M. - 6:00 P.M., and again between 9:00 P.M. - 10:00 P.M. The night shift indicated Resident #4 was to be assisted with toileting between 10:15 P.M. - 11:00 P.M., between 2:00 A.M. - 3:00 A.M. and again between</p>			

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R000243	<p>4:30 A.M. - 5:30 A.M.</p> <p>There was no indication the Licensed nurse, during the day shift on 10/28/14 was aware or monitored the toileting for Resident #4, which did not occur after breakfast. In addition, the task sheet did not provide every two hour toileting and incontinence checks for Resident #4 as CNA #1 indicated he required.</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observations, interview and record review, the facility failed to administer medications within the allowed time frame for 2 of 5 residents observed during a medication pass. (Resident #9 and Resident #10)</p>	R000243	<p>R-243- Medication will be passed to residents in accordance with physician order, state law, and assisted living guidelines. The parameters for medication pass times will be utilized. Medication pass times will be adjusted and orders obtained from physician if</p>	12/15/2014

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	<p>Finding includes:</p> <p>1. On 10-28-14 at 8:15 A.M., Resident #10 was observed being administered her medications by the Director of Nursing (DON). The resident's medications were to be given at 8:00 A.M., except for her levothyroxine (thyroid medication), it was to be given at 7:00 A.M. The DON was observed giving the resident her levothyroxine at 8:15 A.M. with her other medications. She did not have an explanation as to why the medication was given at the incorrect time.</p> <p>2. On 10-28-14 at 9:40 A.M., Resident #9 was observed being administered his medications by LPN #20. The resident's medications were to be given at 10:00 A.M., except for his Prednisone which was to be given at 9:00 A.M. and his Ativan which was to be given at 8:00 A.M. The LPN #20 was observed giving these medications at 9:40 A.M.</p> <p>During an interview, on 10-28-14 at 10:20 A.M., the DON indicated a nurse could give medications one hour prior or one hour after the prescribed time. She further indicated Resident #9 nor Resident #10 had an order to give the medications outside of the range.</p> <p>On 10-29-14 at 9:15 A.M., a policy titled</p>		necessary. An in-service will be conducted for staff that administer medications to residents. The in-service to cover the Six Rights of medication and treatment administration. CSM or Designee will Monitor the MAR frequently to ensure full compliance. Findings will be reported to the Quality/Safety committee at meetings. Committee will make further recommendations and determine when monitoring can become less frequent. Care Service Manager or designee is responsible for compliance.				

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R000268	<p>"Medication Administration," dated 7-1-14, indicated, "1. Medications and treatments are administered to residents as determined by review of their medication status, and in accordance with physician order, state laws, and assisted living regulations. All medications, including over-the-counter (OTC) medications must have a physicians order... 3. The six "rights" of medication and treatment administration are observed - right resident, right medications, right dose, right from and route, right time, right documentation...."</p> <p>410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements.</p> <p>Based on observation, record review and interviews, the facility failed to ensure 1 of 2 residents who required a mechanical soft diet in a sample of 10 was served a therapeutic diet. (Resident #4)</p> <p>Finding includes:</p> <p>During the observation of the noon meal, conducted on 10/27/14 from 12:00 P.M. - 1:00 P.M., Resident #4 was noted to be served sliced turkey.</p>	R000268	<p>· R-268 Residents will special diets are identified in Dietary Kitchen in a easily visualized area for kitchen and clinical staff. Staff in service was provided on special diets and compliance. Dietary Personnel will be responsible for compliance at each meal and observing proper diet goes out to each resident. Monitoring will be completed on a daily basis (Monday-Friday) at random meals by Executive director or designee – any non-compliance will be addressed immediately and results of</p>	12/15/2014			

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R000273	<p>During observation of the breakfast meal, conducted on 10/28/14 from 8:10 A.M. - 9:00 A.M., Resident #4 was noted to be served fried bacon slices.</p> <p>The clinical record for Resident #4 was reviewed on 10/28/14 at 10:00 A.M. Resident #4 was admitted to the facility, on 02/28/13, with diagnosis, including but not limited to, hypothyroidism, non allergenic rhinitis, hyperlipidemia, coronary artery disease, depression, dry eyes, and constipation.</p> <p>The current physician's orders for Resident #4 included an order for the resident to receive a Mechanical Soft Diet.</p> <p>The current service plan for Resident #4, completed on 08/22/14, indicated the resident had a physician's order for a mechanical soft diet.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. A. Based on observation, interview, and</p>	R000273	<p>outliers will be forwarded to the Quality/Safety Committee. Committee will make recommendations based on findings. Executive Director or designee is responsible for compliance.</p> <p>R-273- Cook #13 and</p>	12/15/2014			

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	<p>record review, the facility failed to store food under sanitary conditions. This had the potential to affect 18 of 18 residents who received meals from 1 of 1 kitchen.</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure food preparation, serving, and storage areas were maintained in a sanitary manner. This had the potential to affect 18 of 18 residents who received meals from 1 of 1 kitchen.</p> <p>C. Based on observation, interview, and record review, the facility failed to ensure dietary staff were knowledgeable about the current chemical sanitization (low temp) dishwasher temperatures. This had the potential to affect 18 of 18 residents who received meals from 1 of 1 kitchen.</p> <p>D. Based on observation, interview, and record review, the facility failed to distribute food under sanitary conditions. This had the potential to affect 18 of 18 residents who received meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>A1. On 10/27/14 between 10:20 A.M. and 11:10 A.M. the initial kitchen sanitation tour was conducted, the following was observed:</p>		<p>Maintenance Man have been provided with disciplinary action for failure to follow policies related to infection control and sanitation.</p> <p>The Staff was provided a log with the addition of low temp for dishwasher. The Food Services employees have been in-serviced as to state regulations pertaining to disposal of food, leftovers, out dated, no dated food, cleanliness, handwashing, hair nets, cooking, cleaning of kitchen, temperature logs, dishwashing machine (temps, chemicals, cleaning, traps) to ensure full compliance to state regulations. Staff to be Serve Safe Certified to be completed on or before 11/30/14. Executive Director or designee will inspect kitchen weekly to ensure compliance. Findings will be reported to the Quality/Safety Committee meetings. Committee will make further recommendations and determine when monitoring can become less frequent. Executive Director or designee will be responsible for compliance.</p>				

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	<p>A reach in cooler, used to store premixed juices, teas and milk was observed to have a pitcher of pink lemonade dated 10/19/14, a pitcher of apple juice dated 10/21/14, and a pitcher of cranberry juice dated 10/21/14. Another reach in cooler was observed to have a large metal bowl containing coleslaw dated 10/23/14, and a cherry cheesecake dated 10/23/14. A cottage cheese container was opened and undated.</p> <p>On 10/27/14 at 10:30 A.M., an interview with Cook #13 indicated the nurses serve the juice and tea in the dining room she had nothing to do with it but she thinks it should be discarded after 3 days. She further indicated the cheesecake and coleslaw should be discarded but hasn't had time to do it. She also indicated she thinks left overs should be discarded after 5 days or if it looked bad she threw it away.</p> <p>B1. The door to the dry pantry room was propped open with a door stop. A cabinet that contained the bottled spices had worn laminate on the top of the shelves exposing the bare wood under the laminate. A large chopping knife contained in a knife holder had dried food particles on it and was put way as clean. Three plastic measuring containers</p>			

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	<p>were stacked on top of each other and had moisture between each container. A cabinet located under the coffee maker had a hole drilled in the side of it and the drainage pipe for the ice machine drained into a hole that was drilled into the bottom of the cabinet. The cabinet had a damp, musty smell. Located in this cabinet was coffee filters that were not in a box, a box of tea bags, and a box of straws was observed on top of the drainage pipe. The door hinges had a thick layer of rust on them. The laminate on the bottom shelf was peeling upward. A cabinet that stores the plates, bowls and soup cups had a door missing on the front, the laminate on the shelves was peeling off and all of the dishware was stacked facing upward. All of the kitchen cabinet handles were sticky and the kitchen floor was sticky.</p> <p>On 10/27/14 at 10:40 A.M., review of the daily cleaning schedule and morning walk-thru records from September 1-October 27th 2014 indicated no documentation was available for review from October 4th-October 27th 2014. An interview at that time with the Regional Director of Operations indicated she was unsure why there was no documentation for kitchen cleaning on those dates.</p> <p>C1. On 10/27/14 at 10:50 A.M., Cook</p>			

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	<p>#13 was observed loading dishes into the dishwasher. Cook #13 was unaware of the proper wash temperature for a low temperature dishwasher. Cook #13 indicated "I just fill it and run it, I am really not sure what the temperature should be the maintenance man takes care of that." Cook #13 further indicated she did not know what test strips to use to check the chemical level in the dishwasher.</p> <p>On 10/27/14 at 10:55 A.M., an interview with the Maintenance Director indicated the dishwasher was a low temperature chemical sanitization washer. He further indicated the temperature log that the dietary staff used to document the dishwasher temperatures was incorrect, because the temperature ranges on the log were for a high heat dishwasher.</p> <p>On 10/27/14 at 11:00 A.M., record review of the kitchen appliance temperature log indicated sanitization: high temp dishwasher wash temp: range minimum 150 degrees. High temp dishwasher rinse temp: range minimum 180 degrees. Dish chlorine had no range and the documentation for each day was 200 ppm (parts per million) of chlorine.</p> <p>D1. During the observation of the noon meal service, conducted on 10/27/14</p>			

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	<p>between 12:00 P.M. and 12:30 P.M., the following was observed:</p> <p>* At 12:00 P.M., Cook #13 opened a plastic trash container lid with her bare hands, she was not observed to wash her hands she then picked up a knife and fork and proceeded to slice the roast turkey. At 12:10 P.M., Cook #13 did not wash her hands after throwing trash away and placed 19 salad bowls on top of the counter placing her fingers inside the bowls to rearrange them across the counter top. She then placed gloves over her unwashed hands and proceeded to measure out the chopped salad into each salad bowl. Cook #13 picked up a large bag of croutons and reached inside of the bag with her gloved hand and removed the croutons and placed the individual croutons on each salad. At 12:15 P.M., Cook #13 with gloved hands opened a refrigerator door and a cabinet door, then proceeded to remove biscuits from a baking pan and place them into a bowl with contaminated gloved hands. At 12:22 P.M., Cook #13 with gloved hands buttered slices of bread and then placed cheese slices on top of the bread, she then placed the bread in a skillet and proceeded to flip the toasted sandwiches over in the pan with her hands. During the entire meal service Cook #13 was not observed to wash her hands or change her</p>			

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	<p>gloves.</p> <p>* At 12:05 P.M., the Maintenance Director washed his hands for 10 seconds then turned the faucet off with his clean hands, he then walked over to the plastic trash container, lifted the lid with his bare hands he discarded his paper towels and then walked over to the coffee maker and started to prepare coffee. At 12:16 P.M., the Maintenance Director entered the kitchen and opened a refrigerator door to removed a container of Caesar salad dressing, he then poured the dressing into a smaller container dropping the container lid on the floor, he bent down and picked up the lid off the floor, he did not remove his gloves or wash his hands and continued to serve the salad dressing in the dining room. At 12:20 P.M., the Maintenance Director assisted in cutting up the roasted turkey. He used his right hand to hold the knife and he placed his gloved left hand on top of the turkey on the plate to hold the turkey in place while he sliced it.</p> <p>* At 12:30 P.M., CNA # 12 was observed in the dining room to wash her hands for 6 seconds, the she adjusted a residents oxygen tubing and then started to feed another resident her lunch without washing her hands.</p>			

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	<p>On 10/27/14 at 2:05 P.M., an interview with the Regional Director of Operations indicated she observed several concerns in the kitchen during food service.</p> <p>On 10/27/14 at 2:30 P.M., record review of the current policy titled "Leftovers and prepared Food" received from the Administrator indicated "...IV. Leftover foods that cannot be frozen must be discarded after THREE days from the refrigerator if not used...."</p> <p>On 10/27/14 at 2:35 P.M., record review of the current policy titled " Cleaning and Sanitizing" received from the Administrator indicated "...Food contact surface...wash, rinse, and sanitize surfaces that come in contact with food each time you use them...as often as possible, but at least every four hours if you are using something constantly...Equipment Cleaning and Sanitizing: Wash, rinse, and sanitize equipment after each use to ensure the safety of food served to residents...Plates, bowls and other serving ware:...Allow to air dry...Dishwashing Do's and Don't's:...never put dishes away while wet...monitor dish machine wash and rinse cycle temperatures and record daily on kitchen appliance temperature log. Take corrective action if below recommended temperature. If low</p>			

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R000414	<p>temperature dish machine, check sanitizer concentration minimum of daily, or per state regulation, and record daily...."</p> <p>On 10/27/14 at 2:40 P.M., record review of the current policy titled "Hand Washing" received from the Administrator indicated "...Hand washing...for a minimum of 20 seconds...Immediately before preparing food or handling equipment. as often as necessary, whenever contamination occurs...After touching face, hair, or any body part, and after sneezing or coughing...between each task performed and after removing disposable gloves...any time you do an unsanitary task, such as taking out garbage, handling cleaning chemicals, wiping tables, picking up a dropped item...Glove and Utensil Use: Always wear gloves or use utensil to handle all ready to eat foods that will not be cooked before it is eaten. Change disposable gloves as often as hand washing is required. Wash hands after discarding gloves...."</p> <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.</p>			

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	<p>Based on observation and record review, the facility failed to ensure 1 of 2 nursing staff (CNA #1) observed providing incontinence care washed their hands and changed their contaminated gloves appropriately. This affected 1 of 2 residents observed receiving incontinence care. (Resident #4).</p> <p>Finding includes:</p> <p>1. During an observation of toileting and incontinence care provided to Resident #4, on 10/28/14 at 11:15 A.M., by CNA #1 and #2, the resident was assisted to transfer to the toilet. The resident's incontinence brief was noted to be saturated with urine when he was placed onto the toilet. When Resident #4 was finished on the toilet, CNA #2 then assisted the resident to stand while CNA #1, who had donned disposable gloves, wiped the resident's buttocks with a damp hand towel and then wiped the resident's rectum with toilet paper. The resident had a smear of bowel movement noted and CNA #2 indicated the resident almost always had smears of bowel movement. CNA #1, without changing her gloves or washing her hands, then opened a tube of A &amp; D ointment (protective ointment), which was on a shelf behind the toilet, and proceeded to squeeze a generous portion onto her</p>	R000414	<p>R-414- Executive Director and Care Service Manager to conduct a mandatory orientation for staff. The orientation for staff will cover Resident Rights, Neglect &amp; Abuse, Universal Precautions, Proper hand washing procedure as well as covering polices &amp; procedures for resident care. Orientation held on 11/10/14, 11/12/14 &amp; 11/18/14. Executive Director &amp; Care Service Manager will be monitoring these policies &amp; procedures as task sheets &amp; facilities job performances are monitored and will correct accordingly to adhere to state regulations pertaining tag R-029. With Monthly in-services as scheduled. Monitoring will routinely occur by CSM or designee via walking rounds to identify that staff is using proper hand washing and glove use.</p>	12/15/2014			

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 10/29/2014
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NAME OF PROVIDER OR SUPPLIER  LAKE CITY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580
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	<p>contaminated gloved hand and then wiped the ointment all over the resident's buttocks. The resident's buttocks was reddened and had two dime sized open areas visible. CNA #1 did not provide any incontinence care to the resident's front peri area even though his incontinence brief had been saturated with urine.</p> <p>The facility policy and procedure, titled, "Handwashing", dated 07/01/2014, indicated "Good hand washing and wearing gloves are the best barriers to prevent the spread of germs from one resident to another, and to protect staff from germs." The facility policy and procedure, titled "Contact Precautions," dated 12/01/2013, indicated the following: "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment. Contact Precautions apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission...Wear gloves whenever touching the resident's intact skin or</p>			

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	surfaces and articles in close proximity to he resident (e.g., personal care...) Don gloves upon entry into the apartment..." There were no specific instructions regarding when to change gloves and/or wash your hands in the Contact Isolation policy and procedure.						