STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00180447. Complaint IN00180447- Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 9, 10, 11, 14, and 15, 2015 Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census bed type: SNF/NF: 96 Total: 96 Census payor type: Medicare: 12 Medicaid: 77 Other: 7 Total: 96 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview,	F 0157		10/02/2015

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	the facility failed to notify the resident's physician in a timely manner, with a significant change of condition, related to the presence of elevated blood pressures for 1 of 3 residents reviewed for significant changes. (Resident #61) Findings include: The clinical record for Resident #61 was reviewed on 09/14/2015 at 9:50 A.M. and indicated the resident had a history of hypertension (high blood pressure). The care plan for ineffective tissue perfusion related to hypertension, dated 12/13/2013, indicated staff were to observe for and document variations in blood pressure and to notify the MD (medical doctor) of the variations. Review of Resident #61's Vitals Record indicated the acceptable range of blood pressure was 90-180 systolic / 50-90 diastolic. Resident #61 had documented blood pressure (BP) readings out of the acceptable range on the following dates: On 08/27/2015, BP was 180/111 mmHg (millimeters of mercury) On 08/04/2015, BP was 190/80 mmHg On 07/21/2015, BP was 185/80 mmHg On 07/14/2015, BP was 181/85 mmHg On 06/15/2015, BP was 182/77 mmHg		**F 157 Notify of Changes (Injury/Decline/Room, ETC)** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #61's physician notified of residents blood pressures that read out of range. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All residents have the potential to be affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · The DNS/designee will run a vital signs report each day to ensure any out of range vital signs have been reported to the physician. · The CEC/designee will in-service nursing staff by October 2, 2015 over condition	

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	Resident #61's Nursing Progress Notes lacked documentation of the physician being notified regarding the variations in blood pressure noted on the dates indicated above. During an interview on 09/15/2015 at 10:31 A.M., the Director of Nursing (DON) indicated nursing staff were required to notify the physician when any vital signs were out of the acceptable range. When a physician had been contacted, the nurse was to document it in the Nursing Progress Notes. 3.1-5(a)(2) 3.1-5(a)(3)		change/physician notification when any vital sign is out of range. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · The DNS/designee will monitor weekly using Condition Change CQI tool times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **5. Date completion:** October 2, 2015	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure the plan of care was followed, as written, related to the failure to perform a post fall follow	F 0282	**F 282 Services by Qualified Person/Per Care Plan** It is the practice of this provider to provide care/services for highest well being in accordance with State	10/02/2015

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	up and therapy screening for 1 of 15 residents reviewed for Care Plans. (Resident #61) Findings include: Clinical Record review on 09/14/2015 at 9:50 A.M., indicated Resident #61 had a history of falls. The care plan for falls, initiated on 11/22/2013, indicated the resident was at risk for falls due to decreased mobility and a history of falls. The goal was for the resident to be free from fall related injuries with an approach for the resident to have a therapy screen. Review of Resident #61's "Event Report" dated 05/11/2015, indicated the resident had fallen on 05/11/2015. Review of Resident #61's "IDT (Interdisciplinary Team) Progress Notes" indicated no IDT meeting was held related to the fall that occurred on 05/11/2015. During an interview on 09/14/2015 at 1:55 P.M., the DPT (Director of Physical Therapy) indicated Resident #61 did not have a therapy screening for the fall on 05/11/2015. The DPT indicated she was not aware of Resident #61's fall on 05/11/2015. The DPT further indicated		and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #61 with therapy screen completed by therapy services. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident have the potential to be affected by the alleged deficient practice · All residents with falls with IDT intervention of therapy screen have been audited and therapy screen completed. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · Executive Director/designee will in-service IDT on fall intervention/fall program by October 2, 2015. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · DNS/designee will be responsible for the completion of Fall Program CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive	

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	falls were discussed during the IDT meetings. During an interview on 09/14/2015 at 2:07 P.M., the DON (Director of Nursing) indicated when there was a fall, during the week or on the weekend, the IDT will have a meeting on the next business day. The DON indicated there were no notes of the IDT team meeting related to the fall for Resident #61 on 05/11/2015. The current "Fall Management Program", dated 02/2015 and provided by the DON on 09/14/2015 indicated "...5. All falls will be discussed by the IDT at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall event will be reviewed by the team. IDT note will be written. The care plan will be reviewed and updated, as necessary..." 3.1-35(g)(2)		quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **5. Date completion:** October 2, 2015	

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F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided related to increased confusion in a resident with a history of falls and urinary tract infections and failure to obtain a full set of vital signs, including blood pressure, in a resident with a critical lab value (potassium). This deficient practice affected 1 of 3 residents reviewed for accidents of 2 residents who met the criteria for accidents. (Resident #61) Findings include: The clinical record for Resident #61 was reviewed on 09/14/2015 at 9:50 A.M. and indicated the resident had a history of falls and urinary tract infections. The physician telephone orders, dated 08/06/2015, indicated the physician ordered a full set of vital signs, CBC (complete blood count), BMP (basic	F 0309	**F 309 Provide Care/Services for Highest Well Being** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #61's physician notified of residents blood pressures that read out of range. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident have the potential to be affected by the alleged deficient practice. **3: What measures will be put into**	10/02/2015

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	metabolic panel), and UA (urinalysis) "now". Resident #61's MAR (Medication Administration Record), dated 08/06/2015, indicated Resident #61 had the labwork (CBC, BMP, and UA) ordered "now". No documentation of a complete set of vital signs was found on the MAR. Resident #61's vitals report, dated 08/06/2015, indicated no vital signs of blood pressure, respirations, pulse, or temperature were acquired on any of the following days August 6, 7, 8, or 9, 2015. Review of Resident #61's MAR, dated 08/07/2015, indicated the resident had a critical potassium level and the resident was administered "Kayayloxate" [sic] (medication used to reduce high levels of potassium in the blood) on 08/07/2015. Review of Resident #61's nursing progress note, dated 08/05/2015 at 9:10 P.M., indicated the resident voiced no feelings of anxiety that shift. The nursing progress note dated 08/06/2015 at 10:40 A.M., indicated, "...resident toileted frequently per staff assistant..." The nursing progress note dated 08/06/2015 at 6:37 P.M., indicated the resident was nervous about several different things.		**place or what systemic changes will be made to ensure that the deficient practice does not recur.** · The DNS/designee will run a vital signs report each day to ensure any out of range vital signs have been reported to the physician. · The CEC/designee will in-service nursing staff by October 2, 2015 over condition change/physician notification when any vital sign is out of range. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · DNS/designee will be responsible for the completion of Condition Change CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **5. Date completion:** October 2, 2015	

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	No documentation of a complete set of vital signs were noted in the progress notes for 08/06/2015. Review of Resident #61's nursing progress notes, dated 08/07/2015 at 10:10 A.M., indicated the residents hypertension medication was decreased from Lisinopril 20 mg (milligrams) daily to Lisinopril 10 mg to be taken daily. No documentation of a complete set of vital signs were noted in the progress notes for 08/07/2015. During an interview, on 09/15/2015 at 10:31 A.M., the Director of Nursing (DON) indicated a full set of vitals included the resident's blood pressure, pulse, respirations and temperature. The DON indicated vital signs were to be documented in the computer under the resident's Vitals Report. The DON indicated she could not find a complete set of vital signs documented for Resident #61 on 08/06/2015 or 08/07/2015. 3.1-37(a)			
F 0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES			

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Bldg. 00	OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having 5 medication errors out of 26 opportunities for error, resulting in a 19.2% error rate. This affected 1 of 3 residents observed for medication pass (Resident #10), and 1 of 2 nurses observed to pass medications. (LPN #1) Findings include: During an observation of medication administration on 09/14/2015 at 9:42 A.M., LPN (Licensed Practical Nurse) #1 administered the following medications, Gemfibrozil, Mucinex, Lamotrigine, Metoprolol Succinate, and Polyethylene Glycol 3350, one hour and forty-two minutes after the physician's ordered time of 8:00 A.M. During an interview on 09/14/2015 at 10:59 A.M., LPN #1 indicated she had given medications at 9:42 A.M., but the current MAR (Medication	F 0332	**F 332 Free of Medication Error Rates of 5% or More** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #10's physician notified of medication error. · LPN #1 given medication error disciplinary action per policy. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident have the potential to be affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · CEC/designee will in-service	10/02/2015

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	Administration Record) indicated the medications should have been given at 8:00 A.M. During an interview on 09/14/2015 at 2:47 P.M., the DNS (Director of Nursing Services) indicated LPN #1 had not consulted with the Nurse Practitioner before administering Resident #10's 8:00 A.M. medications late. The clinical record for Resident #10 was reviewed on 09/14/2015 at 10:45 P.M. The current physician orders for Resident #10 indicated Gemfibrozil 600 milligram tablet, give one tablet by mouth at 8:00 A.M., Mucinex 600 milligram ER (extended release) tablet, give one tablet by mouth twice daily at 8:00 A.M. and 8:00 P.M., Lamotrigine 25 milligram tablet, give three tablets by mouth twice daily at 8:00 A.M. and 8:00 P.M., Metoprolol Succinate 25 mg ER tablet, give one tablet by mouth at 8:00 A.M., and Polyethylene Glycol 3350 powder, mix 17 grams in 8 ounces of fluid and give by mouth at 8:00 A.M. and 8:00 P.M.		nursing staff on medication administration policy by October 2, 2015. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · DNS/designee will be responsible for the completion of random medication observations with charge nurses daily Monday through Friday times 4 weeks, weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **5. Date completion:** October 2, 2015	

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	The current facility policy, titled "Medication Pass Procedure" and dated 03/2012, was provided by the DNS on 09/14/2015 at 2:00 P.M. and reviewed at that time. The policy indicated, "...Medications administered within 60 minutes before and/or after time ordered..." 3.1-25(b)(9) 3.1-48(c)(1)			
F 0386 SS=D Bldg. 00	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on interview and record review, the facility failed to obtain signed and dated physician orders in a timely manner for 1 of 5 residents reviewed for	F 0386	**F 386 Physician Visits – Review Care/Notes/Orders** It is the practice of this provider to	10/02/2015

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	unnecessary medications. (Resident #119) Findings include: The admission MDS (Minimum Data Set) assessment, dated 06/23/205, was reviewed on 09/11/2015 at 2:07 P.M. The assessment indicated Resident #119 had a BIMS (Brief Interview for Mental Status) of 8, signifying moderate cognitive impairment. Diagnoses included, but were not limited to, coronary artery disease, hypertension, thyroid disorder, dementia, and depression. The current "Physician Services" policy, dated 1/06 and provided by the Medical Records Coordinator on 09/14/2015 at 3:40 P.M., indicated "...The physician reviews the resident's program of care including medications and treatments... The physician writes, signs, and dates progress notes at each visit and signs and dates all orders ..." The "Resident Admission Record" for Resident #119, provided by the DON (Director of Nursing) on 09/15/2015 at 3:53 P.M., indicated the resident was admitted on 06/16/2015. The admission "Physician's Orders"		provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #119 physician orders are now signed by the attending physician. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident have the potential to be affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · All residents' charts audited to ensure that physician orders are signed and dated. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · DNS/designee will be responsible for the completion of	

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	provided by the Medical Records Coordinator on 09/14/2015 at 3:40 P.M. for dates 06/16/2015 through 06/30/2015, were not signed or dated by the attending physician or the medical director to indicate the orders had been reviewed. During an interview on 09/15/2015 at 8:56 A.M., the DON indicated the physician had 60 days to sign off on orders. If they did not sign, the medical director was contacted to sign off on the orders. 3.1-22(c)(1) 3.1-22(c)(3)		Physician Services CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **5. Date completion:** October 2, 2015	
F 0387 SS=D Bldg. 00	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.			

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	Based on interview and record review, the facility failed to provide timely physician visits for 1 of 5 residents reviewed for unnecessary medications. (Resident #119) Findings include: The admission MDS (Minimum Data Set) assessment, dated 06/23/205, was reviewed on 09/11/2015 at 2:07 P.M. The assessment indicated Resident #119 had a BIMS (Brief Interview for Mental Status) of 8, signifying moderate cognitive impairment. Diagnoses included, but were not limited to, coronary artery disease, hypertension, thyroid disorder, dementia, and depression. The current "Physician Services" policy, dated 1/06, provided by the Medical Records Coordinator on 09/14/2015 at 3:40 P.M. indicated, "...The attending physician visits at least once every thirty (30) days for the first ninety (90) days after admission ...". The "Resident Admission Record" for Resident #119, provided by the DON (Director of Nursing) on 09/15/2015 at 3:53 P.M., indicated the resident was admitted on 06/16/2015.	F 0387	**F 387 Frequency & Timeliness of Physician Visit** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident #119 visited by physician with progress note written. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident have the potential to be affected by the alleged deficient practice **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · All residents' charts audited to ensure physician visits with progress notes have occurred per policy. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · DNS/designee will be responsible for the completion of Physician Services CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2	10/02/2015

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	The "MD Progress Notes" were provided by the Medical Records Coordinator on 09/15/2015 at 10:07 A.M. and reviewed at that time. One progress note was provided. The progress note for Resident #119 was dated and signed by the physician on 06/28/2015. During an interview on 09/15/2015 at 10:07 A.M., the Medical Records Coordinator indicated that progress note was the only document signifying the resident had been seen by the physician up to the current date of 09/15/2015. No other progress notes in the clinical record or computerized charting indicated the doctor had seen the resident since admission. 3.1-22(d)(1)		consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. **5. Date completion:** October 2, 2015	
F 0441 SS=D Bldg. 00	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 development and transmission of disease and infection.			

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	(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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure infection control practices and standards were maintained related to distribution of clothing protectors for two residents seated in the main dining room, dirty linens and personal clothing in the 800 hall shower room and dirty equipment in the 700 hall shower room. (Resident #18	F 0441	**F 441 Infection Control, Prevent Spread, Linens** It is the practice of this provider to provide care/services for highest well being in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · LPN #2 in-serviced	10/02/2015

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	and #84). Findings include: 1. During a dining observation on 09/09/2015 at 11:58 A.M., LPN (Licensed Practical Nurse) #2 was observed holding a stack of clothing protectors under her left arm tight against her uniform top while placing a clothing protector on a resident. CNA (Certified Nursing Assistant) #1 took a clothing protector from LPN #2 and placed it on Resident #18. LPN #2 removed a clothing protector from the stack and placed it on Resident #84. 2. During an observation of the 700 hall shower room on 09/15/2015 at 1:03 P.M., there was a blue and white shower chair with a brown crusty substance smeared on the front opening of the seat and a brown and yellow substance that contained some strands of black hair on the back left corner of the seat. During an interview on 09/15/2015 at 1:05 P.M., CNA #4 indicated the shower chairs were to be washed before and after use by each resident. 3. During an observation on 09/15/2015 at 1:10 P.M. and again at 1:50 P.M., the 800 hall shower room had a sheet and		on infection control practice/linen policy · 700 hall shower chair cleaned · 800 hall shower cleaned **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken** · All resident have the potential to be affected by the alleged deficient practice. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** · CEC/designee will in-service nursing staff on infection control program including preventing spread of infection, shower chair/shower room cleaning guidelines, and linen handling guidelines by October 2, 2015. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place** · DNS/designee will be responsible for the completion of Infection Control CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.	

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	mattress pad on the floor spread out from the shower stall to the sink. There was a bottle of shampoo sitting on the floor and a shirt hanging on the sink. In the second shower stall there were two towels and a wash cloth hanging on the shower chair. There were two plastic bags on the floor with clothing and towels inside. During an interview on 09/15/2015 at 1:50 P.M., LPN #2 indicated the CNAs were to clean the shower chairs before and after each use, bag up all soiled linens, and all of the resident's soiled clothing. Personal hygiene belongings should not be left in the shower room. During an interview on 09/15/2015 at 2:31 P.M., LPN #2 indicated the two CNAs on the 800 hall each thought the other one was going to clean the shower room and the shower room didn't get cleaned. The current Laundry/Linen policy was provided by the Director of Nursing on 09/15/2015 at 3:53 P.M. and reviewed at that time. The policy indicated "...Clean linen should be carried away from body to prevent contamination..." The current CNA Skills Validation shower procedure, dated 04/2012, indicated "...1. Clean shower area and		**5. Date completion:** October 2, 2015	

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	shower chair per facility guidelines.... 19. Place soiled clothing and linens in proper container.... 22. Return resident to room." 3.1-19(f) 3.1-19(g)			