

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 06/05/2014
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6521 GREENDALE DR EVANSVILLE, IN 47711
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 4-5, 2014</p> <p>Facility number: 010681 Provider number: 010681 AIM number: N/A</p> <p>Survey team: Barbara Fowler, RN TC Anna Villain, RN Diane Hancock, RN 6/4/14</p> <p>Census bed type: Residential: 39 Total: 39</p> <p>Census payor type: Other: 39 Total: 39</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on June 9, 2014 by Jodi Meyer, RN</p>	R000000		
R000414	<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</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>for which hand washing is indicated by accepted professional practice.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the infection control program was maintained to prevent potential infections of residents who ate in the dining room, in that, handwashing or hand sanitizing procedures were not completed as necessary. This had the potential to affect all 34 residents who dined in the dining room.</p> <p>Findings include:</p> <p>During an observation on 6/5/14 at 11:50 a.m., the Adm Asst (Administrative Assistant) was observed to be in the dining room. The Adm Asst was observed to be serving drinks to the residents. The Adm Asst was observed to move Resident #34's walker and place it outside the dining room. The Adm Asst was further observed to touch the various residents sitting in the dining room, touch her glasses, and would proceed to serve drinks and food. No handwashing or sanitizing was observed between resident contacts.</p> <p>During an observation on 6/5/14 at 11:57 a.m., LPN #1 was observed to enter the dining room and serve drinks to the residents. No handwashing or sanitizing</p>	R000414	<p>What action was taken for those residents affected by deficient practice? No harm was identified to residents who were identified affected by the deficient practice. How were other residents identify that may have been affected by the deficient practice? Residents were monitored for side effects from alleged deficient practice and no other residents were identified. What systems change will be in place to ensure this deficient practice will not occur and who will monitor it? Associates to be educated on hand washing with a return demonstration, in the monthly in-service on 6/20/14. The Dietary Service Manager will complete random hand washing checks 3 times a week for 8 weeks. The documented results to be reviewed during monthly collaborative care meeting and at the end of eight weeks, an evaluation of correct hand washing techniques will be completed to determine further need for monitoring. (Starting 6/16/14). The Executive director or designee will monitor the process. what date will these practice be completed? 6/30/2014</p>	06/30/2014

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	<p>was observed.</p> <p>On 6/5/14 at 12:01 p.m., LPN #1 pulled Resident #33's chair out and removed the resident's walker, placing it outside of the dining room. LPN #1 returned to the dining room and served drinks and food to the residents. No handwashing or hand sanitization was observed.</p> <p>During an interview on 6/5/14 at 2:10 p.m., LPN #1 indicated hands should be washed prior to and after serving food or if the staff has touched anything dirty. LPN #1 indicated hands should also be washed after touching their face or hair. LPN #1 further indicated the staff had hand sanitizer to use if they are unable to wash their hands immediately.</p> <p>A policy titled, "Hand Washing - Associates, revised 12/2007, and obtained from the Health and Wellness Director on 6/5/14 at 2:05 p.m., indicated handwashing should be performed before touching, preparing, or serving food.</p>						