

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/25/2012
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NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446
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F0000	<p>This visit was for a Recertification and State licensure survey. This visit included the investigation of Complaint IN00106166.</p> <p>Complaint IN00106166- Unsubstantiated due to lack of evidence.</p> <p>Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590</p> <p>Survey dates: 04/22/12, 04/23/12, 04/24/12, and 04/25/12</p> <p>Survey team: Sharon Whiteman, RN- TC, 04/23/12, 04/24/12, 04/25/12 Marla Potts, RN Susan Worsham, RN</p> <p>Census Bed Type: SNF/NF: 85 Total: 85</p> <p>Census Payor Type: Medicare: 13 Medicaid: 61 Other: 11 Total: 85</p>	F0000		

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>Sample: 17</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC.</p> <p>Quality review completed on April 27, 2012 by Bev Faulkner, R.N.</p>				

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F0441	This plan of correction is prepared and executed because	04/26/2012			

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	<p>nursing staff washed their hands appropriately for 3 of 7 residents in a sample of 17 reviewed for wound care and incontinence. (Resident #65, Resident #75, and Resident #70) (LPN #1, CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5)</p> <p>Findings include:</p> <p>1. On initial tour and in interview with LPN#1 on 4/22/12 at 1:25 p.m., LPN #1 indicated Resident #70 was dependent for care.</p> <p>On 4/22/12 at 2:00 p.m., LPN#1 was observed to clean Resident #70 after the resident had a bowel movement. CNA#1 was observed placing a soiled brief at the end of the bed, not in a plastic bag. CNA #1 was observed to not change her gloves. LPN# 1 was then observed to open a sterile solution to clean the resident's wound without changing gloves. LPN#1 then proceeded to apply a new dressing to the wound without changing gloves. The soiled brief was then placed on the floor unbagged. CNA#1 then picked up the soiled brief and placed it in a plastic bag.</p> <p>On 4/23/12, at 10:35 a.m., in Resident #70's room , LPN#1 was observed to remove a dressing from Resident #70's right buttock. CNA#2 was observed to</p>		<p>of the provisions of State and federal law require it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care.</p> <p>Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated.</p> <p>To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction.</p> <p>*Request paper compliance please F 441</p> <p>1. Resident affected by alleged deficient practice: ·Residents #65 and #70 remain free of facility acquired infection. ·Resident #75 at risk for infection due to admitted with long term antibiotic use due to current infection.</p> <p>2. Residents at risk to be affected by alleged deficient practice: ·Residents receiving staff support for care have the potential to be affected by the alleged deficient practice. ·Plan of care for residents #65, #70, and #75 were reviewed by</p>				

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	<p>clean the resident's rectal and buttock area from front to back and over an open wound while cleaning the resident from a bowel movement.</p> <p>2. On initial tour and in interview with LPN#1 on 4/22/12 at 1:25 p.m., LPN #1 indicated Resident #65 was dependent for care.</p> <p>On 4/24/12 at 8:50 a.m., while observing care, CNA #3 did not change gloves after cleaning Resident #65, and prior to applying a new brief. CNA# 3 then picked up Resident #65's jeans and folded them and placed them in Resident #65's wheelchair without changing gloves. CNA#3 then picked up Resident #65's nasal cannula (oxygen tube) and placed it back into Resident #65's nose, wearing the same gloves.</p> <p>3. On 04/23/12 at 9:55 a.m., CNA #2 and CNA #5 were observed to provide incontinence care for Resident #75. Resident #75 was observed to have been incontinent of stool and urine. CNA #2 was observed to wear gloves while cleansing stool from the resident's bottom. CNA #2 was observed to not change her</p>		<p>nursing admin and updated as indicated on 4-24-12.</p> <ul style="list-style-type: none"> <li>·Nursing admin educated all staff April 24, 2012 regarding Handwashing/Infection Control.</li> </ul> <p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>·Ongoing education with all staff will be provided as indicated for non-compliance regarding Handwashing/Infection Control by nursing admin.</li> <li>·Nursing admin will audit 5 residents/wk receiving staff support for care regarding Handwashing/Infection Control M-F X 3 months.</li> </ul> <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>·Plan to be updated as indicated.</li> <li>·Nursing admin will audit 5 residents/wk receiving staff support for care regarding Handwashing/Infection Control M-F X 3 months.</li> <li>·Ensure 100% PI compliance monthly X 3months.</li> </ul> <p>1.Date of compliance: April 26, 2012</p>				

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	<p>gloves or wash her hands before putting a clean brief under the resident's bottom. CNA #2 was observed to not change her gloves or wash her hands before opening a drawer of the resident's bedside table. CNA #2 was observed to not change her gloves or wash her hands before picking up Resident #75's false teeth and handing them to CNA #5. CNA #5 was observed to place the resident's false teeth in a denture cup.</p> <p>On 04/24/12 at 10:00 a.m., CNA #4 and CNA #2 were observed to provide incontinence care for Resident #75. CNA #2 was observed to wear gloves while removing Resident #75's wet brief and providing incontinence care. CNA #2 was observed to not change gloves or wash her hands before opening a jar of Zinc Oxide (medication used to treat reddened skin and prevent skin break down). CNA #2 was observed to not change her gloves or wash her hands before applying the Zinc Oxide to Resident #75's bottom and groin area.</p> <p>Resident #75's clinical record was reviewed on 04/23/12 at 12:55 p.m. A quarterly MDS (Minimum Data Set) assessment, dated 01/29/12, indicated Resident #75 required extensive assistance of staff with hygiene and bathing and was incontinent of bowel and</p>				

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	<p>urine.</p> <p>A policy titled, "Infection Control" was provided by the DON on 04/24/12 at 3:00 p.m. This policy was not dated. The policy indicated, "...Handwashing: Handwashing is the single most important means of preventing the spread of infection. Hands should be washed: ...before and after each procedure...After contact with blood or body fluids, feces, wound secretions or contact with any items contaminated with them...Before and after use of gloves, gown or masks. After handling a resident's belongings.</p> <p>A policy titled "Gloves" was provided by the DON on 04/24/12 at 3:00 p.m. This policy was not dated. This policy indicated, "...Gloves are the most widely used form of personal protective equipment. They act as a primary barrier between your hands and infectious material or bloodborne pathogens. You must wear them when you anticipate hand contact with: -blood - potentially infectious materials - mucous membranes - non-intact skin...Gloves must be removed when soiled, after providing care for a resident...."</p> <p>3.1-18(l)</p>						