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
	155093		04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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 000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. Survey dates: April 20, 21, 22, & 23, 2015 Facility number: 000036 Provider number: 155093 AIM number: 100269640 Census bed type: SNF/NF: 40 Total: 40 Census payor type: Medicare: 2 Medicaid: 28 Other: 10 Total: 40 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 000	The SNF requests that the following plan of correction be considered its credible allegation of compliance. The SNF respectfully requests that a post-certification desk review, rather than a post-certification onsite visit, occur to verify compliance.	
F 279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.			

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.

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
	155093		04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to develop a comprehensive plan of care based on the comprehensive assessment, in that, a care plan was not developed for behaviors associated with the use of psychoactive medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #18) Findings include: On 4/22/15 at 10:19 a.m., Resident 18's clinical record was reviewed. Resident #18's diagnoses included, but were not limited to, anxiety. Resident 18's physician orders included, but were not limited to: Seroquel (an antipsychotic medication)	F 279	The plan of care for resident #18 was updated to include approaches to monitor for and respond to delusions and anxiety. These approaches include the use of psychoactive medications as ordered. It was determined that all residents requiring the use of psychoactive medications have the potential to be affected. The following corrective action will be taken: all plans of care for residents with diagnosis of dementia, dementing illness with behavior, insomnia, organic brain syndrome with behaviors that require use of psychoactive medications will be reviewed to assure the behavior that is related to the diagnosis and medication is appropriately care planned. The Director of Nursing (DON) will be responsible for the audit and for assuring corrections are made to	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	12.5 mg (milligrams) every morning Seroquel (an antipsychotic medication) 25 mg (milligrams) every evening Ativan (an antianxiety medication) 1 mg (milligram) three times a day The Annual MDS (Minimum Data Set) Assessment, dated 3/19/15, indicated Resident #18 had received an antianxiety and antipsychotic medication seven out of seven days during the assessment. The care plans lacked a plan of care regarding the behaviors associated with the antianxiety and antipsychotic medication. On 4/22/15 at 1:49 p.m., the Unit Clerk indicated Resident #18's diagnosis for the use of Seroquel was psychosis with dementing illness and associated behavioral symptoms. On 4/22/15 at 1:57 p.m., the Social Worker indicated Resident #18 had been prescribed an antipsychotic medication for delusions. The Social Worker further indicated the facility no longer maintained a care plan for this behavior because Resident #18 no longer had that behavior symptoms because the medication had been effective. The Social Worker was unable to locate a care plan for anxious behavior regarding		assure compliance. She will do so by assigning to and directing the care plan team in this regard. Following the audit, the DON or her designee will review all new or revised plans of care related to psychoactive medications weekly for at least four weeks. After that, the DON or her designee will continue to review at least 25% of new or revised plans of care related to psychoactive medications on a weekly basis for at least three months. To assure compliance the Social Service Designee will update the resident's psychosocial plan of care when a psychoactive medication order is received. This will be an ongoing process and expectation. The MDS Coordinator will monitor and assure compliance. The SNF Administrator and DON will meet weekly for at least six weeks to monitor the corrective action. The SNF Administrator will coordinate this meeting. To further monitor the correction action, the Skilled Nursing Facility Performance Improvement Committee (SNF PIC) will receive a quarterly report summarizing reviews of care plans related to psychoactive medications and responses. This will continue for one year. SNF PIC will assist by monitoring for compliance and making recommendations as necessary to assure that the facility demonstrates use of the assessment to develop, review,	

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
	155093		04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	the use of an antianxiety medication. On 4/23/15 at 2:25 p.m., the UC/LPN (Unit Clerk/ Licensed Practical Nurse)provided the "Care Plan, Comprehensive-SNF" policy, dated 10/28/12. The policy included, but was not limited to, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 4/22/15 at 3:21 p.m., Resident #18 was observed lying in bed. 3.1-35(b)(1)		and revise the resident's comprehensive plan of care.	
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to provide adequate monitoring of pain medication for 1 of 5 in a total sample of 30 residents reviewed for unnecessary medications. (Resident #24) Findings include: During an observation on 4/20/15 at 2:08 p.m., Resident #24 was observed to be sitting in a chair by her bedside. Resident #24 indicated she had neck and back pain at times. The clinical record of Resident #24 was reviewed on 4/21/15 at 2:05 p.m. Resident #24 had diagnoses including, but not limited to, dementia with behaviors, psychosis, cellulitus of the leg, venous insufficiency, diabetes mellitus type II, congestive heart failure, hypertension, chronic pain, chronic kidney disease, and reflux esophagitis. A quarterly MDS (Minimum Data Set) assessment, dated 3/9/15, indicated	F 329	The medication administration record (MAR) of resident #18 was changed in regards to ordered pain medication to reflect non-pharmacologic intervention, location of pain, and pre- and post-administration assessment of pain. All residents receiving pain medication have the potential to be affected. The following corrective action will occur: All residents receiving pain medication will have a MAR that reflects non-pharmacologic intervention, location of pain, and pre- and post-administration assessment of pain. Revising the MAR format will be a collaborative effort between the Unit Clerk, DON, and Software Provider. The Nurse assigned to the resident will be responsible to properly document pain medication administration. The DON will be responsible to assure that all Nurses are trained in this regard. The DON or designee(s) will monitor for compliance. At least 50% of MARs of residents receiving pain medication will be checked weekly for compliance for 4 weeks. At least 25% of MARs of residents receiving pain	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	Resident #24 had a BIMS (Brief Interview for Mental Status) assessment score of 5, which indicated severe cognitive impairment. Resident #24 had a physician's order, dated 6/9/14, for Tylenol Extra-Strength 500 mg (milligrams) by mouth 4 (four) times per day as needed. Resident #24 had a physician's order, dated 4/3/14, for Acetaminophen 325 mg 2 (two) tablets by mouth every 4 hours as needed for pain or fever. The pain management flow sheet indicated the following: 1/9/14 at 2000 (8:00 p.m.), Tylenol 500 mg 1 tablet was administered for back pain. No non-pharmacological interventions were provided and no post pain scale assessment was completed. 1/10/15 at 0540 (5:40 a.m.), Tylenol 500 mg 1 tablet was administered for back pain. No non-pharmacological interventions were provided and no post pain scale assessment was completed. 1/11/15 at 3:30 p.m., Tylenol 500 mg 1 tablet was administered for leg pain. No post pain scale assessment was completed. 1/14/15 at 4:15 a.m., Tylenol 500 mg 1 tablet was administered for pain. No post pain scale assessment was completed.		medication will be checked weekly for compliance for at least three months after that. Compliance checks will include verifying non-pharmacologic intervention, location of pain, and pre- and post-administration assessment of pain. To assure compliance, the DON will assure that newly hired Nurses receive training in department orientation regarding the expectation that administration of pain medication includes non-pharmacologic intervention, documenting location of pain, and pre- and post-administration pain assessments. In addition, new pain medication orders will be checked within three business days of receipt to assure that the MAR reflects non-pharmacologic intervention, location of pain, and pre- and post-administration assessment of pain. Checking will be the responsibility of the DON or designee(s). The SNF Administrator and DON will meet weekly for at least six weeks to monitor the corrective action. The SNF Administrator will coordinate this meeting. To further monitor the corrective action, SNF PIC will receive a quarterly report summarizing compliance checks and their response for one year. SNF PIC will assist by monitoring for compliance and making recommendations as necessary to assure that the facility demonstrates drug regimens for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	1/15/15 at 3:00 a.m., Tylenol 500 mg was administered for back pain. No pre or post pain scale assessments were completed. 1/16/15 at 3:30 p.m., Tylenol 500 mg was administered for back pain. No post pain scale assessment was completed. 1/17/15 at 4:40 a.m., Tylenol 325 mg 2 tablets were administered for neck and back pain. No non-pharmacological interventions were provided and no pre or post pain scale assessments were completed. 1/17/15 at 7:30 p.m., Tylenol 500 mg 1 tablet was administered for neck and back pain. No non-pharmacological interventions were provided and no pre or post pain scale assessments were completed. 1/18/15 at 4:30 a.m., Tylenol 325 mg 2 tablets were administered for back pain. No pre or post pain scale assessments were completed. 1/18/15 at 7:30 p.m., Tylenol 325 mg 2 tablets were administered for back pain. No non-pharmacological interventions were provided and no post pain scale assessment was completed. 1/19/15 at 4:20 a.m., Tylenol 325 mg 2 tablets were administered for back pain. No non-pharmacological interventions were provided and no post pain scale assessment was completed. 1/20/15 at 12:48 a.m., Tylenol 500 mg		residents are free from unnecessary drugs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	was administered for back pain. No non -pharmacological interventions were provided and no post pain scale assessment was completed. 1/23/15 at 8:00 p.m., Tylenol 500 mg was administered. No non-pharmacological interventions were provided and no pre or post pain scale assessment was completed. 1/24/15 at 8:00 p.m., Tylenol 325 mg 2 tablets were administered. No non-pharmacological interventions were provided and no pre or post pain scale assessment was completed. 1/25/15 at 2:25 a.m., Tylenol 325 mg 2 tablets were administered. No non-pharmacological interventions were provided and no pre or post pain scale assessment was completed. 1/25/15 at 8:00 p.m., Tylenol 325 mg 2 tablets were administered. No non-pharmacological interventions were provided and no pre or post pain scale assessment was completed. 1/28/15 at 4:30 a.m., Tylenol (no dosage) was administered per the resident's request. No pre or post pain scale assessment was completed. During an interview on 4/22/15 at 10:58 a.m., RN #2 indicated residents were to be assessed using the pain scales prior to and after administration of pain medication and non-pharmacological			

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
	155093		04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	interventions were to be provided prior to providing pain medication. RN #2 further indicated the location and type of pain the resident had should be documented. A "Pain Management Flow Sheet," dated 1/9/15 through 1/28/15, indicated the pain scale was to be used before and after the medication was given and alternative treatments were to be given prior to the administration of the medication. A policy titled, "Pain Assessment- SNF," dated 11/28/14 and obtained from the UC/LPN (Unit Clerk/ Licensed Practical Nurse) on 4/23/15 at 2:10 p.m., indicated the pain rating scale would be used for assessment of pain and comfort measures would be provided for the residents. 3.1-48(a)(3) 3.1-48(a)(4)			
F 371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and	F 371	Residents #2, #28, #51, and #53 were not adversely affected. It	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	record review, the facility failed to provide, distribute, and serve food under sanitary conditions, in that, the CNAs in the dining room were going from 1 (one) resident to another resident to feed them without hand hygiene being performed. (Resident #51, Resident #2, Resident #53, Resident #28) Findings include: 1. During an observation on 4/20/15 at 12:07 p.m., RN #1 was observed to be in the dining room delivering trays to the residents. RN #1 was observed to deliver a tray to Resident #51. RN #1 was observed to open a straw and place it in a cup by handling the entire straw. No hand hygiene was performed. RN #1 was observed to feed Resident #1 by holding the a cup of milk by the rim and also held the straw to the resident's mouth. 2. During an observation on 4/20/15 at 12:12 p.m., the DON (Director of Nursing) was observed to be feeding Resident #2. The DON was observed to pick Resident #2's feet up and position them on the foot of the chair. The DON was observed to pick up of plastic cup of chocolate drink by holding the cup by the rim. No hand hygiene was performed. 3. During an observation on 4/22/15 at		was determined that all residents have the potential to be affected. The following corrective action will occur: The DON will assure that all nursing personnel receive training in regards to the expectation that food be served under sanitary conditions at all times. This post-survey training will include the correct way to open a wrapped straw; to hold a straw in use; to hold a cup or other utensil in use; to deliver a cup or other utensil; the need for hand hygiene when transitioning from feeding one resident to feeding another resident; the need for hand hygiene after repositioning a resident during mealtime. In addition, the SNF Administrator or designee(s) will monitor mealtime at least twice a day at least four days per week for four weeks, and then at least five meals per week for at least three months after that. Observation will include unwrapping straws, holding straws and utensils in use, delivery of cups and other serving utensils, hand hygiene during feeding, hand hygiene following repositioning during meal time. To assure compliance, the DON will assure that newly hired nursing personnel receive training during department orientation regarding the expectation that food be served under sanitary conditions at all times. In addition, newly hired nursing personnel will be targeted for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	8:08 a.m., CNA #2 was observed to be feeding Resident #2. CNA #2 was observed to move from Resident #53 and began to assist with feeding the resident. No hand hygiene was performed. 4. During an observation on 4/22/15 at 8:10 a.m., CNA #1 was observed to be feeding Resident #53. CNA #1 was observed to move to Resident #28 and began to feed the resident. No hand hygiene was performed between residents. During an interview on 4/22/15 at 11:05 a.m., CNA #2 indicated hand hygiene should be performed when going from one resident to another. A policy titled, "Feeding a Patient," dated 12/5/11 and obtained from the UC LPN (Unit Clerk/Licensed Practical Nurse) on 4/23/15 at 2:10 p.m., indicated hands were to be washed prior to feeding a resident. 3.1-21(i)(3)		mealtime observations and will receive feedback and guidance/direction as needed. The SNF Administrator and DON will meet weekly to monitor the corrective action for at least six weeks. To further monitor the corrective action, SNF PIC will receive a quarterly report summarizing mealtime observations and responses for one year. SNF PIC will assist by monitoring for compliance and making recommendations as necessary to assure that the facility demonstrates that it always serves food under sanitary conditions.	
F 431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure timely disposal of expired medications with shorten expiration dates, for 1 of 2 medication carts. (east unit) Findings include: On 4/23/15 at 9:48 a.m., the east unit medication cart was examined, the	F 431	No residents were adversely affected. The identified Humalog and Lantus vials were removed from the cart on 4-23-15, disposed of and replaced with new dated vials. It was determined that all residents receiving insulin have the potential to be affected. The following corrective action occurred: A check of both medication carts and med rooms	05/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	following was observed: 1. A vial of Humalog (a medication used to treat high blood sugar) was found to have an expiration date of 4/11/15. 2. A vial of Humalog was found to have an expiration date of 4/18/15. 3. A vial of Lantus (a medication used to treat high blood sugar) was found to have an expiration date of 4/17/15. An interview with RN #3, at the same time as review of medication cart, indicated the medications were expired and were taken out of the drawers and would be replaced. 4. A policy for Infection Control/Safety Procedure- Medication Vial/Ampule Guidelines, was received from the DON (Director of Nursing), on 4/23/15 at 1:38 p.m., which indicated the recommended usage of a vial of Novolog or Lantus, would not be used beyond 28 days after opening. 5. Review of the 2014 Nursing Drug Handbook indicated neither Novolog or Lantus should not be used after 28 days of opening the vial. 3.1-25(o)		was completed and no other expired insulin was found. The DON will assure that all Nurses will be trained on the correct storage, dating, and disposal of insulin and of the need to monitor for, identify and dispose of all expired medications. The DON or designee(s) will do documented checks on med carts and med rooms for expired medications at least once per week for four weeks and at least once per month for at least three months after that. To assure compliance, the DON will assure that newly hired Nurses receive training during department orientation on the storage, dating and disposal of insulin and of the need to monitor for, identify and dispose of all expired medications. The SNF Administrator and DON will meet weekly for at least six weeks to monitor the corrective action. To further monitor the corrective action, SNF PIC will receive a quarterly report summarizing med cart and med room checks for expired medications, including insulin. They will receive this report for one year. SNF PIC will assist by monitoring for compliance and making recommendations as necessary to assure expired medications are not available for administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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 441 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. (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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for 2 of 5 residents observed receiving personal care, in that hand hygiene and glove change were not completed. (Resident #28, Resident #54) Findings include: 1. During an observation on 4/22/15 at 9:33 a.m., CNA #1 and CNA #5 were observed to apply soap to their hands and immediately placed their hands under running water for 20 seconds. CNA #1 and CNA #5 were observed to provide pericare to Resident #28. Hand hygiene was performed and gloves applied by both CNAs. CNA #5 was observed to pull the curtain around the foot of the bed, obtained the washbasin and fill it with water. CNA #1 was observed to place 2 wash cloths into the basin of water. CNA #5 was observed to remove the sheet and repositioned Resident #28 onto her left side. CNA #5 was observed to hand CNA #1 a wet washcloth, CNA #1 was observed to lower the resident briefs and washed the resident's buttocks. CNA #1 was observed to change her gloves as the resident had had a bowel movement. No hand hygiene was performed. CNA #5 was observed to	F 441	Residents #28 and #54 were not adversely affected. It was determined that all residents have the potential to be affected. The following corrective action will occur: The DON will assure that all nursing staff receive instruction on hand hygiene and peri care. In addition, the DON or designee(s) will monitor hand hygiene among 50% of staff every week for four weeks. After that, the DON or designee(s) will assure hand hygiene check offs are performed on a monthly basis for at least 25% of staff for at least three months. The DON or designee(s) will also do a skills verification for each C.N.A. regarding peri care practices and this will be completed by 5-15-15. After that, the DON or designee(s) will do periodic documented peri care skills checks for some C.N.A.s for at least three months. To assure compliance, the DON will assure that all newly hired nursing staff are trained during department orientation on hand hygiene expectations and peri care practices. The SNF Administrator and DON will meet weekly for at least six weeks to monitor the corrective action. To further monitor the corrective action, SNF PIC will receive a quarterly report summarizing hand hygiene checks and responses. They will receive this report for one year. SNF PIC will assist by monitoring for	05/18/2015

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
	155093		04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	rinse the resident's buttocks. CNA #5 changed gloves and assisted the resident to turn to the right side. No hand hygiene was performed. During an interview on 4/22/15 at 9:45 a.m., CNA #1 indicated hands should be washed between resident's care, before and after pericare, and when entering and leaving a resident's room. CNA #1 indicated hands should be washed while holding them in a downward position so the water runs down. 2. During an observation on 4/22/15 at 10:46 a.m., CNA #3 and CNA #4 was was observed to provide pericare to Resident #54. Hand hygiene and gloves were applied by both CNAs. CNA #3 was observed to wipe the pelvic area and the perineal area. After washing the perineal area, CNA #3 was observed to re-wipe the pelvic area with the same washcloth. CNA #4 was observed to rinse the resident but Resident #54 was observed to be having a bowel movement. CNA #3 was observed to obtain a bedpan from the bathroom and place it under the resident's buttocks. CNA #3 was observed to remove her gloves and wash her hands. CNA #3 returned with clean washcloths placed under her axilla area and apply clean gloves. CNA #3 removed the bedpan		compliance and making recommendations as necessary to assure that the facility demonstrates professional practice peri care hygiene and handwashing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	from under Resident #54 and washed the resident. Resident #54 was assisted to turn to her left side. CNA #3 took the soiled bedpan into the bathroom. CNA #3 was observed to assist with placing a clean brief onto the resident and assisted with placing a pillow under the resident's legs. CNA #3 removed the soiled linen and trash bags, emptied the bedpan, remove her gloves and wash her hands. During an interview on 4/22/15 at 10:58 a.m., CNA #3 indicated hands should be washed when going from dirty to clean tasks. CNA #3 further indicated hands should be washed by turning on the water, applying soap, and washing them for 30 (thirty) seconds. A policy titled, "Isolation Policy and Procedure," dated 11/10/14 and obtained from the UC LPN (Unit Clerk/Licensed Practical Nurse) on 4/23/15 at 2:10 p.m., indicated hand hygiene should be done before having direct contact with patients. The policy indicated hands should be decontaminated when gloves were removed, between patient contacts and when otherwise indicated to avoid the transfer of microorganisms to other patients. The policy further indicated hands might need to be decontaminated between tasks and procedures on the same patient.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	3.1-18(b)(1) 3.1-18(l)			
F 465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, and sanitary environment, in that, paint was chipped, dirt and debris was built up on the floors, and lime residue was built up in the sink for 5 of 20 rooms reviewed during Stage 1. (Room #5523, Room #5529, Room #5519, Room #5533, Room #5531) Findings include 1. On 4/20/15 at 11:32 a.m., Room #5523 was observed. The doorframe around the bathroom was observed to be chipped. In the bedroom, the drawers were observed with chipped paint and the sink was observed with built up lime residue. On 4/21/15 at 3:11 p.m., the same was observed. 2. On 4/20/15 at 3:44 p.m., Room #5529 was observed. In the bedroom, black marks were observed on the walls. In the	F 465	Resident #43 pressure area was healed prior to their discharge from the facility to the community. It was determined that all residents at risk for pressure ulcers have the potential to be affected. The following corrective action will be taken: The DON will assure that all Nurses are trained regarding the proper documentation of skin integrity and the expectation to note the presence of any skin breakdown/pressure ulcer. This expectation includes attention to pressure areas that overlay a boney prominence or skin fold. In addition the DON or designee will review wound assessments on existing and new wounds weekly for four weeks; After that, the DON or designee will review existing wounds monthly and new wounds weekly for at least three months. Concerns will be addressed with the appropriate staff member when they are found and correction or updating will take place. To assure compliance, the DON will assure	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	bathroom, dirt and debris was observed to be built up in the corners and along the edges. On 4/21/15 at 3:08 p.m., the same was observed. 3. On 4/21/15 at 9:41 a.m., Room #5519 was observed. In the bathroom, dirt and debris was observed to be built up in the corners and along the edges of the floor. On 4/22/15 at 3:11 p.m., the same was observed. 4. On 4/21/15 at 9:45 a.m., Room #5533 was observed. The paint was observed to be chipped by Bed 1. On 4/21/15 at 3:05 p.m., the same was observed. 5. On 4/21/15 at 9:59 a.m., Room #5531 was observed. In the bathroom, dirt and debris was observed to be built up in the corners and along the edges, the toilet was observed with a black ring on the inside of the basin, and the doorframe was observed with chipped paint. On 4/22/15 at 3:14 p.m., the same was observed. On 4/23/15 at 10:18 a.m., Housekeeper #1 indicated the floors, sinks, and toilets were cleaned daily. Housekeeper #1 further indicated if a resident room was in disrepair, maintenance was notified to correct the problem.		that newly hired Nurses are trained regarding the proper documentation of skin integrity during their department orientation. This will include the expectation to note the presence of any skin breakdown/pressure ulcer including pressure areas that overlay a boney prominence of skin fold. The SNF Administrator and DON will meet weekly for at least six weeks to monitor the corrective action. To further monitor the corrective action, SNF PIC will receive a quarterly report summarizing wound assessment reviews and their response for one year. SNF PIC will assist by monitoring for compliance and making recommendations as necessary to assure any pressure areas are accurately identified.	

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
	155093		04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	On 4/23/15 at 3:17 p.m., the Administrator provided the schedule of items to be completed by housekeeping staff. The schedule included, but was not limited to, weekday housekeeping assignment includes dust/wet mop and clean/sanitize the bathroom. 3.1-19(f)			
F 514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to accurately identify a pressure area on admission for 1 of 20 residents admission records reviewed during Stage 1. (Resident #43) Findings include: On 4/22/15 at 8:40 a.m., Resident #43's	F 514	The residents in Room #5519, #3323, #5529, #5531, #5533 were not adversely affected. It was determined that all residents have the potential to be adversely affected. The following corrective action will occur: The Facility Services Director (FSD) or designee will assign that the following tasks related to the environment be completed: paint door frame around #5523 and	05/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	clinical record was reviewed. Resident #43's diagnoses included, but were not limited to, left total hip replacement. The Wound Assessment Report, dated 3/4/15, indicated the wound type was excoriation. The report further indicated, "Wound team assessed resident on 3/3/15 open area on r. [right] gluteal [buttock] measuring 5 x 2.5 [centimeters]. Recommended mepilex dressing 6 x 6 after cleaning with wound cleaner. Doc [doctor] faxed orders." The Wound Assessment Report, dated 3/10/15, indicated the wound type was excoriation. The report further indicated "Wound team assessed resident this day area has healed into two smaller open areas....." The telephone orders for Resident #43 included, but were not limited to: To the area on right gluteal cleanse with wound cleanser and apply mepilex 6 x 6 border dressing every three days and as needed, dated 3/4/15. Discontinue Mepilex border 6 x 6 dressing to right gluteus, start mepliex border 3 x 3 dressing to right buttock after cleaning with wound cleanser, change every three days and as needed, dated 3/11/15		#5531; paint storage drawers #5523; clean sink of lime build up residue #5523; paint walls as need to address chipping and marks #5529, and #5533; clean bathroom corners and edges #5519 and #5529 and #5531; clean bedroom corners and edges #5519; clean the toilet #5531. The FSD or his designee will verify completion occurs by the assigned deadline. To assure compliance: The SNF Administrator or FSD or designee(s) will check each resident room and bathroom at least weekly for six weeks for environmental compliance. More specifically: identify any chipped paint or markings on door frames or storage drawers or walls; verify clean sinks and bathroom fixtures; verify clean bathroom and bedroom corners and edges. Concerns and needs will be recorded on an electronic work order. Assignments will be determined by the FSD or his designee(s). After that, each resident room and bathroom will be checked at least once every two weeks after that by the FSD, SNF Administrator or designee(s) for at least three months. The SNF Administrator and FSD will meet weekly for at least six weeks to monitor the corrective action. To further monitor the corrective action, SNF PIC will receive a quarterly report from Facility Services regarding work orders related to SNF and their	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER GIBSON GENERAL HOSPITAL-SNF		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 SHERMAN DR PRINCETON, IN 47670	

(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
	The Admission MDS (Minimum Data Set) Assessment, dated 3/9/15, indicated Resident #43 had a surgical wound and moisture associated skin damage. On 4/22/15 at 2:42 p.m., the MDS Nurse indicated the area on Resident #43's right buttock was not considered pressure because of its location. The MDS Nurse further indicated the physical therapist had assessed the wound. MDS Nurse further indicated Resident #43 had acquired the open area by moisture. On 4/22/15 at 2:50 p.m., the UC LPN (Unit Clerk/Licensed Practical Nurse) indicated an open area over a bony prominence would be considered a Stage 2 pressure area and not excoriation. On 4/22/15 at 2:59 p.m., the Physical Therapist indicated she did not consider a wound excoriation if it was open. On 4/23/15 at 1:37 p.m., the DON (Director of Nursing) provided the "Management of Skin Integrity and Wound Prevention" policy, dated 11/28/13. The policy included, but was not limited to, " Every patient/resident admitted will have a visual skin assessment performed at the time of admission to note the condition of the skin. Documentation will include skin		status. SNF PIC will receive this report for one year. SNF PIC will assist by monitoring for compliance and making recommendations as necessary to assure a functional and sanitary environment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON GENERAL HOSPITAL-SNF	1808 SHERMAN DR PRINCETON, IN 47670

(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
	integrity at the time of admission and will note the presence of any skin breakdown/pressure ulcer, with particular attention to pressure areas." 3.1-50(a)(2)			