

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
---	--

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 29, 30, 31, 2014 and August 1, 4, 5, 6, and 7, 2014</p> <p>Facility number: 000255 Provider number: 155364 AIM number: 100273280</p> <p>Survey team: Rick Blain, RN – TC Tim Long, RN (7/29, 7/30, 7/31, 2014) Carol Miller, RN (7/29, 7/30, 7/31, 8/4, 8/5, 8/6, 8/7, 2014) Diane Nilson, RN (7/29, 7/30, 7/31, 2014)</p> <p>Census bed type: SNF/NF: 100 Residential: 47 Total: 147</p> <p>Census payor type: Medicaid: 137 Other: 10 Total: 147</p> <p>Residential sample: 7</p>	F000000	<p>This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
---	--

(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
F000282 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on August 8, 2014 by Randy Fry RN.</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure fall prevention interventions were in place as indicated on the care plan and as ordered by the physician for 1 of 3 residents reviewed for accidents (Resident #44).</p> <p>Findings include:</p> <p>The record for Resident #44 was reviewed on 8/4/14 at 9:00 A.M. Diagnoses included, but were not limited to, vascular dementia, subarachnoid hemorrhage (bleeding in the brain), and</p>	F000282	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> On 8/5/2014 the anti-roll device was located and applied to resident #44's wheelchair. On 8/5/2014 the resident complained the wheelchair did not roll as smoothly and the device was adjusted. The anti-roll device was adjusted twice more by the COTA on 8/6/2014. At that time, the COTA spoke with the resident about the benefits of using the anti-roll device as well as the risks of not using the device. The resident used the device for one</p>	09/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014	
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818			
(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			
	<p>left hemiparesis (left sided weakness).</p> <p>A copy of Resident #44's current physician orders were printed from the electronic medical record and provided by the facility's Director of Nursing (DON) on 8/5/14 at 9:15 A.M. The orders indicated the resident was to utilize an anti-roll back wheel chair for safety.</p> <p>A care plan, with a start date of 2/14/14, indicated "Risk for Falls" as a problem for Resident #44. Approaches on the care plan included, but were not limited to, "anti-roll back wheelchair" and "uses w/c (wheelchair) for mobility, anti-roll back w/c."</p> <p>A care plan, with a start date of 2/14/14, indicated "Actual Falls" as a problem for Resident #44. Approaches on the care plan included, but were not limited to, "anti-roll back w/c."</p> <p>A "Fall Risk Assessment", dated 7/28/14, indicated Resident #44 scored a 14 on the risk assessment. The assessment form indicated any resident scoring over 9 as being at risk for falls.</p> <p>On 8/4/14 at 9:30 A.M., Resident #44 was observed in the first floor hallway near the nursing desk propelling himself</p>		<p>more day. On 8/7/2014, the resident returned from dialysis and was complaining still about the anti-roll device. Once again, the benefits and risks were explained to the resident. Despite the education, the resident demanded the device be removed from his wheelchair. The resident's physician was informed and an order was received to discontinue the anti-roll device. <b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.</b> All residents using wheelchairs who have orders for adaptive equipment are at risk. An audit of all residents using wheelchairs will be conducted to ensure all adaptive equipment is installed and working properly. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b> Resident's orders will be reviewed during the care plan meetings to ensure adaptive equipment is still installed and in working order. All new orders will be reviewed weekly during the therapy meeting to ensure new equipment has been ordered, installed, and is working properly. Attachment #1 <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014	
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818			
(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			
	<p>in a wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>On 8/4/14 at 10:30 A.M., Resident #44 was observed in the first floor hallway near his room, propelling himself in a wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>On 8/4/14 at 11:25 A.M., Resident #44 was observed in the first floor hallway near his room, propelling himself in a wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>On 8/4/14 at 1:30 P.M., Resident #44 was observed in the ground floor hallway near the elevator sitting in his wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>Physical Therapy Assistant (PTA) #2 was interviewed on 8/4/14 at 2:20 P.M. During the interview, PTA #2 observed Resident #44 in his wheelchair. PTA #2 indicated the chair did not have an anti-roll back device attached. PTA #2 further indicated the anti-roll back device is designed to automatically lock the wheels on the wheelchair when the resident stands up and prevents the</p>		<p><b>i.e., what quality assurance program will be put into place.</b> The ADON, or her designee, will randomly select 10% of the wheelchairs with adaptive equipment per week and ensure they have all ordered equipment on the resident's wheelchair and in good working order. The results of the audit will be reviewed in the QAPI meeting.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014	
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818			
(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			
	<p>wheelchair from rolling backwards, reducing the risk of falls.</p> <p>The facility Assistant Director of Nursing (ADON) was interviewed on 8/5/14 at 9:25 A.M. During the interview, the ADON indicated the anti-roll back device had originally been purchased for Resident #44's wheelchair on 2/22/12, based on a therapy recommendation at that time. The ADON also indicated, based on the current physician orders and the resident's current care plan, Resident #44 should still have the anti-roll back device on his wheelchair. The ADON indicated she did not know why the device was not on the resident's wheelchair or how long it had not been on the wheelchair. The ADON also indicated CNA's were informed about safety adaptive devices a resident was to have. The ADON indicated this information could be referenced in the resident's electronic medical record by the CNA's assigned to the resident.</p> <p>CNA #3 was interviewed on 8/5/14 at 11:15 A.M. During the interview, CNA #3 indicated CNA's can find out what adaptive safety equipment a resident is supposed to have by reviewing the electronic medical record. During the interview, CNA #3 accessed Resident #44's electronic medical record in the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818		
(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	
F000323 SS=D	<p>CNA section for adaptive equipment. CNA #3 indicated there was no documentation in the electronic record to indicate Resident #44 was to have an anti-roll back wheelchair. CNA #3 further indicated she was regularly assigned to work with Resident #44 and was not aware he was to have an anti-roll back wheelchair.</p> <p>A facility policy entitled "Falls and Fall Risk Managing", dated 2001, indicated "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
---	--

(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
	<p>assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure fall prevention interventions were in place as indicated on the care plan and as ordered by the physician for 1 of 3 residents reviewed for accidents (Resident #44).</p> <p>Findings include:</p> <p>The record for Resident #44 was reviewed on 8/4/14 at 9:00 A.M. Diagnoses included, but were not limited to, vascular dementia, subarachnoid hemorrhage (bleeding in the brain), and left hemiparesis (left sided weakness).</p> <p>A copy of Resident #44's current physician orders were printed from the electronic medical record and provided by the facility's Director of Nursing (DON) on 8/5/14 at 9:15 A.M. The orders indicated the resident was to utilize an anti-roll back wheel chair for safety.</p> <p>A care plan, with a start date of 2/14/14, indicated "Risk for Falls" as a problem for Resident #44. Approaches on the care plan included, but were not limited to, "anti-roll back wheelchair" and "uses w/c (wheelchair) for mobility, anti-roll back w/c."</p>	F000323	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>On 8/5/2014 the anti-roll device was located and applied to resident #44's wheelchair. On 8/5/2014 the resident complained the wheelchair did not roll as smoothly and the device was adjusted. The anti-roll device was adjusted twice more by the COTA on 8/6/2014. At that time, the COTA spoke with the resident about the benefits of using the anti-roll device as well as the risks of not using the device. The resident used the device for one more day. On 8/7/2014, the resident returned from dialysis and was complaining still about the anti-roll device. Once again, the benefits and risks were explained to the resident. Despite the education, the resident demanded the device be removed from his wheelchair. The resident's physician was informed and an order was received to discontinue the anti-roll device.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>All residents using wheelchairs who have orders for adaptive equipment are at risk. An audit of all residents using wheelchairs will be conducted to ensure all adaptive equipment is installed and working properly.</p>	09/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
---	--

(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
	<p>A care plan, with a start date of 2/14/14, indicated "Actual Falls" as a problem for Resident #44. Approaches on the care plan included, but were not limited to, "anti-roll back w/c."</p> <p>A "Fall Risk Assessment", dated 7/28/14, indicated Resident #44 scored a 14 on the risk assessment. The assessment form indicated any resident scoring over 9 as being at risk for falls.</p> <p>On 8/4/14 at 9:30 A.M., Resident #44 was observed in the first floor hallway near the nursing desk propelling himself in a wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>On 8/4/14 at 10:30 A.M., Resident #44 was observed in the first floor hallway near his room, propelling himself in a wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>On 8/4/14 at 11:25 A.M., Resident #44 was observed in the first floor hallway near his room, propelling himself in a wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p>		<p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>Resident's orders will be reviewed during the care plan meetings to ensure adaptive equipment is still installed and in working order. All new orders will be reviewed weekly during the therapy meeting to ensure new equipment has been ordered, installed, and is working properly. Attachment #1</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</b></p> <p>The ADON, or her designee, will randomly select 10% of the wheelchairs with adaptive equipment per week and ensure they have all ordered equipment on the resident's wheelchair and in good working order. The results of the audit will be reviewed in the QAPI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818		
(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	
	<p>On 8/4/14 at 1:30 P.M., Resident #44 was observed in the ground floor hallway near the elevator sitting in his wheelchair. The wheel chair was not observed to have an anti-roll back device attached.</p> <p>Physical Therapy Assistant (PTA) #2 was interviewed on 8/4/14 at 2:20 P.M. During the interview, PTA #2 observed Resident #44 in his wheelchair. PTA #2 indicated the chair did not have an anti-roll back device attached. PTA #2 further indicated the anti-roll back device is designed to automatically lock the wheels on the wheelchair when the resident stands up and prevents the wheelchair from rolling backwards, reducing the risk of falls.</p> <p>The facility Assistant Director of Nursing (ADON) was interviewed on 8/5/14 at 9:25 A.M. During the interview, the ADON indicated the anti-roll back device had originally been purchased for Resident #44's wheelchair on 2/22/12, based on a therapy recommendation at that time. The ADON also indicated, based on the current physician orders and the resident's current care plan, Resident #44 should still have the anti-roll back device on his wheelchair. The ADON indicated she did not know why the device was not on the resident's wheelchair or how long it had not been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014	
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818			
(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			
	<p>on the wheelchair. The ADON also indicated CNA's were informed about safety adaptive devices a resident was to have. The ADON indicated this information could be referenced in the resident's electronic medical record by the CNA's assigned to the resident.</p> <p>CNA #3 was interviewed on 8/5/14 at 11:15 A.M. During the interview, CNA #3 indicated CNA's can find out what adaptive safety equipment a resident is supposed to have by reviewing the electronic medical record. During the interview, CNA #3 accessed Resident #44's electronic medical record in the CNA section for adaptive equipment. CNA #3 indicated there was no documentation in the electronic record to indicate Resident #44 was to have an anti-roll back wheelchair. CNA #3 further indicated she was regularly assigned to work with Resident #44 and was not aware he was to have an anti-roll back wheelchair.</p> <p>A facility policy entitled "Falls and Fall Risk Managing", dated 2001, indicated "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
---	--

(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
--------------------	--	---------------	---	----------------------

F000441 SS=D	<p>3.1-45(a)(2)</p> <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 -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p>			
-----------------	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818		
(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	
	<p>of infection.</p> <p>Based on observations, interview, and record review, the facility failed to ensure resident's respiratory care equipment was free from potential contamination for 2 of 2 residents reviewed for respiratory equipment (Resident # 67 and #109).</p> <p>Findings include:</p> <p>On 7/29/14 at 12:00 p.m., 7/29/14 at 3 p.m., and 7/30/14 at 10:30 a.m., Resident #67's mask for his BI PAP (bilevel positive airway pressure) machine was observed on top of the resident's bedside stand unprotected and not secured in a bag.</p> <p>On 8/4/14 at 10:45 a.m. during an interview with Resident #109 in the resident's room, a mask and tubing for a nebulizer treatment was observed on top of a plastic bag on the resident's bedside stand.</p> <p>On 8/5/14 at 9:45 a.m. the Director Nursing Service (DNS) was interviewed and indicated the masks for Resident # 67 and #109 should have been placed in a bag when not in use.</p> <p>The policy Departmental (Respiratory Therapy)- Prevention of Infection, revised 8/2012, received from the DNS</p>	F000441	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Both residents had their respiratory equipment bagged immediately.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>All residents utilizing oxygen support, aerosol nebulizer, and Bi-pap have been assessed and 19 residents were found to be at risk of this deficient practice. All residents were assessed on 8/5/2014 and all equipment that was not in use was found to be in plastic bags.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>To serve as a reminder for the nurses and ensure compliance, there will be an entry in the eMAR requiring the nurse to sign off that the equipment is stored in a safe and sanitary manner to ensure proper infection control measures. To serve as a reminder for the C.N.A.'s and ensure compliance, there will be an entry in the task list requiring the aid to sign off that the equipment is stored in a safe and sanitary manner to ensure proper infection control measures. An in-service will be conducted with all nursing staff on</p>	09/05/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/07/2014
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818		
(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 8/5/14 at 11:00 a.m. included "...Keep the oxygen cannula and tubing for all respiratory equipment used PRN (as needed) in a plastic bag when not in use."  3.1-18(b)(5)		best standards for the care of respiratory equipment. Attachment #2 & #3 <b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.i.e., what quality assurance program will be put into place.</b> The infection control nurse, or her designee, will monitorweekly 10% of the residents who require this intervention. Results of the monitoring will be reviewed byQAPI committee. Attachment #4		