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
	155720		06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHEDRAL HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00175171. Complaint IN00175171 - Substantiated, Federal/State deficiencies related to the allegations are cited at F441. Survey dates: June 29 and 30, 2015 Facility number: 000315 Provider number: 155720 AIM number: 100289030 Census bed type SNF/NF: 35 Total: 35 Census payor type Medicare: 1 Medicaid: 29 Other: 5 Total: 35 Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHEDRAL HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(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 0441 SS=E 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			

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
	155720		06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHEDRAL HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(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
	transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure staff consistently wore gloves during resident care, and failed to wash their hands between caring for residents and handling dirty linen, for 6 of 8 residents reviewed for infection control practices, in a sample of 10. Residents E, F, G, H, J, and K Findings include: On 6/29/15 at 11:40 A.M., CNA # 1 and CNA # 2 indicated they were going to transfer Resident K from his bed to his wheelchair. CNA # 1 was not wearing gloves. CNA # 1 and CNA # 2 were observe to roll the resident back and forth to position a hoyer (mechanical lift) pad under him, and then transferred him to his wheelchair. CNA # 1 straightened up the resident's bed, and then propelled the resident to the lounge. On the way back from the lounge, CNA # 1 stopped to talk to a resident, and held the resident's hand briefly, then went into Resident E's room. Without washing her hands, CNA # 1 put on gloves. CNA # 2 was also wearing gloves. The staff changed the resident's shirt, removed their gloves, and transferred Resident E	F 0441	Cathedral Complaint June 2015 By submitting the enclosed materialwe are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right to contest the findings or allegations aspart of any proceedings and submit these responses pursuant to our regulatoryobligations. The facility requests thatthe plan of correction be considered our allegation of compliance effective July20th, 2015 to the complaint survey conducted on June 29th and 30th,2015. We also respectfully request thatthis survey be considered for a desk review. **F441 It is the practice of thisfacility to assure that all procedures and services are conducted in a mannerthat is in accordance with infection control guidelines.** ***The correction action taken for those residents found to beaffected by the deficient practice include:*** Residents #K, #F, #E, #G, and #H are receiving services relatedto provision of care in accordance with the facility's infection controlpolicy. CNAs #1, #2, #3, #4, and #5 have been re-educated related to properhand washing, glove use, and handling of linens. ***Other residents that have the potential to be affected havebeen identified by:*** All residents are receiving services	07/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/30/2015
NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546	

(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 his bed to his chair. CNA # 2 then took the resident's dirty linen, bagged it, and took it to the dirty utility room. She did not wash her hands. CNA # 2 then went to Resident F's room. She did not put gloves on. She assisted CNA # 3 in turning Resident F, and placed the hoyer pad underneath her. CNA # 2 then transferred Resident F from the bed to her chair. CNA # 2 put the dirty linen in a bag, went to the dirty utility room, and then immediately obtained the hoyer lift and placed it in a storage room. CNA # 2 then fixed a towel under Resident E's chin, and took Resident E to the dining room. She was not observed to wash her hands. On 6/29/15 at 3:05 P.M., CNA # 4 and CNA # 5 indicated they were going to transfer Resident G from his bed to a wheelchair. Neither CNA was wearing gloves. After the transfer, CNA # 5 indicated she was going to give the resident a shower, and took him to the shower room. CNA # 4 left Resident G's room, and immediately propelled Resident H to the dining room. She did not wash her hands. CNA # 4 then went to Resident J's room, and put on gloves, and assisted him in changing his brief and taking him to the		within acceptableparameters of infection control including proper hand washing, glove changes,and handling of linens. ***The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur include:*** An in-service has been conducted for nurses and CNAs relatedto proper infection control practices. The in-service addresses proper hand washing and proper changing ofgloves. The in-service also addresseshandling of linens in an acceptable manner based on proper infection control standards.The facility will be randomly observing staff that is providing services toassure that proper infection control protocol is followed in accordance withthe facility policy ***The corrective action taken to monitor performance to assurecompliance through quality assurance is:*** A Performance Improvement Tool has been initiated thatrandomly observes 5 residents during provision of services including transfers,toileting, and general provisions of care related to following of properinfection control procedures including glove changes and hand-washing by both staff. This observation will also include handlingof linen in accordance with facility policy. The Director of Nursing, or designee,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/30/2015
NAME OF PROVIDER OR SUPPLIER CATHEDRAL HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546	

(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. On 6/30/15 at 11:40 A.M., during an interview with the Administrator, he indicated it was not good practice for the staff not to wash their hands between resident contact. On 6/30/15 at 1:30 P.M., the Administrator provided the current facility policy on "Handwashing," undated. The policy included: "Handwashing should be performed: As promptly as possible after contact with blood, body fluids, secretions, and equipment or articles contaminated by them, whether or not gloves are worn. After gloves are removed...As promptly and thoroughly as possible between resident contacts. When otherwise indicated to avoid transfer of microorganisms to other residents and environments...." At that time, the Administrator provided an additional current facility policy on "Use of Gloves," undated. The policy included: "...Wash hands after removing gloves. GLOVES DO NOT REPLACE HANDWASHING...." At that time, the Administrator provided an additional current facility policy on "Soiled Linen Handling," dated 11/2011.		willcomplete these tools weekly x3, monthly x3, then quarterly x3. The tool will becompleted randomly for all shifts in a 7 day period. Anyissues identified will be immediately corrected and additional training willimmediately occur. The Quality AssuranceCommittee will review the tools at the scheduled meetings with recommendations fornew interventions as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** July 20, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHEDRAL HEALTH CARE CENTER	520 W 9TH ST JASPER, IN 47546

(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 policy included: "...Hand washing should occur after handling any soiled linen...." This Federal tag relates to Complaint IN00175171. 3.1-18(b) 3.1-18(l)			