STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155539	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERTHA D GARTEN KETCHAM MEMORIAL CENTER	601 E RACE ST ODON, IN 47562

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F000000	This visit was for a Recertification and State Licensure Survey Survey dates: February 4, 6, 7, 10, 11, 2013 Facility number: 000300 Provider number: 155539 AIM number: 100287340 Survey team: Amy Wininger, RN, TC Dorothy Watts, RN February 4, 6, 7, 10, 2013 Terri Walters, RN Sylvia Martin, RN Census bed type: SNF: 12 SNF/NF: 41 Total: 53 Census payor type: Medicare: 7 Medicaid: 29 Other: 17 Total: 53 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2	F000000	February 24, 2014 Ms. Jodi Meyer Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204-3003 RE: Ketcham Memorial Annual Survey February 4, 6, 7, 10 and 11, 2014 Dear Ms. Meyer; The Indiana State Department of Health visited our facility on February 4, 6, 7, 10 and 11, 2014 for the purpose of conducting our annual recertification survey. By submitting the enclosed material we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We have included copies of our revised policies and procedures along with copies of our monitoring tools for your review. We respectfully request a desk review and request that our plan of correction be considered our allegation of compliance effective February 28, 2014. Please feel free to contact me if any additional information is needed. Respectfully submitted, Kathy Wittmer, HFA AdministratorBy submitting the enclosedmaterial we are not admitting the truth or accuracy of any specific findings orallegations. We reserve the right tocontest the findings or allegations as part of any	

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.

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	Quality review completed on February 17, 2014, by Jodi Meyer, RN		proceedings and submit theseresponses pursuant to our regulatory obligations. The facility request the plan of correctionbe considered our allegation of compliance effective February 28, 2014 to thestate findings of the annual survey conducted on February 4, 6, 7, 10 and 11,2014	
F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F000164	F – 164 The corrective action	02/28/2014

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	Based on observation, interview, and record review, the facility failed to ensure privacy for 1 of 2 residents during the administration of medication through a g (gastrostomy)-tube. (Resident #49) Findings include: During an observation of the medication pass for East Hall on 2/7/14 at 11:05 A.M., LPN #4 entered Resident #49's room in preparation of administering medication through Resident #49's g-tube. Resident #49 was lying on her back, in her bed. Resident #14, who was Resident #49's roommate, was sitting in her chair located between the 2 beds. The privacy curtain was not pulled between the 2 residents upon entering the room. The window treatments, which were levered blinds, were open and the outside parking area was visible. LPN #4 pulled back the bed sheet, raised Resident #49's gown and checked the patency of the g-tube by administering 30 cc (cubic centimeter) of air into the tube and listening with her stethoscope. LPN #4 then administered the medication and flushed the g-tube. The privacy curtain was never pulled between the 2 residents during the		taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #49 is now and will continue to be provided privacy during the administration of her g-tube medication along with continuing to provide privacy during all other personal care services. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the nurse identified as LPN #4 has received one on one additional education on the facility's practices as it relates to providing privacy during the administration of g-tube medications along with providing privacy during all other personal care services. The facility policy on Gastrostomy Tube Feeding was reviewed with LPN #4 with a focus on providing privacy during the procedure. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all nursing staff on the facility's practice as it relates to privacy during care, including the administration of g-tube medication. The corrective action taken to monitor to assure compliance is that a Quality Assurance Tool has been developed and implemented to monitor the facility's practices as it relates to providing privacy during personal care including the	

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	medication administration. The clinical record of Resident #49 was reviewed on 2/10/14 at 2:35 P.M. The record indicated Resident #49 was admitted on 1/11/12. The diagnoses of Resident #49 included, but were not limited to: dysphasia, cerebral vascular accident, depression. Physician's orders for February 2014 included, but were not limited to: "Flush G-tube with 160 cc of water every shift " The facility's policy and procedure for Gastrostomy Tube Feeding was provided by the Director of Nursing and reviewed on 2/10/14 at 11:32 A.M. The policy and procedure read as follows: "...Key points: Provide Privacy during procedure." During an interview with LPN #2 on 2/10/14 at 9:32 A.M., LPN #2 indicated when flushing a g-tube or administering medication through a g-tube you should pull the curtain between the residents' beds to maintain privacy. On 2/10/14 at 11:20 A.M., the Health Care Administrator (HCA) was made aware of the lack of privacy during		administration of medication via a g-tube. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed during the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	the g-tube medication administration of Resident #49 on 2/7/14 at 11:05 A.M. The HCA indicated the privacy curtain needed to be pulled between the residents. 3.1-3(p)(2)			

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F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview and	F000225	F - 225 The corrective action	02/28/2014

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	record review the facility failed to ensure allegations were promptly reported to the administrator and/or the state agency for 1 of 3 allegations of abuse reviewed. The facility also failed to ensure a thorough investigation was completed for an allegation of abuse by 1 of 19 residents interviewed. (Resident #28, Resident #13, Resident #60) Findings Include: 1.) Resident #28 was observed to be lying in bed on 2/6/14 at 9:43 A.M., during an interview at that time Resident #28 indicated at times he felt verbally abused. Resident #28 indicated that some staff was not as courteous as they should be and he felt it was verbal abuse. Resident requested not to be named. The Health Facility Administrator (HFA) was notified on 2/6/14 at 10:35 A.M., that a resident had made an allegation of abuse. HFA indicated an investigation would be started and they would talk with all residents in the facility. On 2/10/14 at 1:00 P.M., Resident #28 was interviewed about		taken for those residents found to have been affected by the deficient practice is that the residents identified as resident #28, #13 and #60 upon interview by facility administration indicate that they feel safe and secure in their environment. The identified residents as well as all facility residents are free of any type of abuse. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all interviewable residents have been questioned on abuse. No residents have reported any allegations of abuse. In addition each facility staff member has been interviewed and no staff members have indicated that they have witnessed or heard of any staff member being abusive in any way to any of the residents of the facility. The facility also conducted a “customer service” in-service with facility staff on 02-10-14 as a result of the investigation. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised its policy and procedure on abuse and abuse reporting. The revised policy now includes the instructions that any allegation of abuse must be immediately reported to the administrator and/or her designee, who then will immediately report the allegation	

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	allegation of abuse. Resident #28 gave permission for his name to be released to HFA. On 2/10/14 at 1:26 P.M., the HFA was informed that Resident #28 had been the resident who initially voiced the allegation. At that same time during an interview, she indicated that all residents should have been interviewed during the investigation and was unaware of why some resident were not interviewed during the investigation. The HFA indicated they would talk with Resident #28. The DoN was interviewed 1:29 P.M., she indicated at that time that she had interviewed several residents and that resident #28 was one of them. She indicated that she had not documented the names of residents she had interviewed. On 2/10/14 at 9:30 A.M., HFA provided copy of document dated 2/1/14 at 12:45 A.M., indicating it was the follow up for the completed investigation. The document lacked documentation that Resident #28 had been interviewed. On 2/10/14 at 4:00 P.M., during an interview the HFA agreed that		of abuse to all appropriate agencies, including the Indiana State Department of Health. In addition a Quality Assurance tool has been added to the policy to ensure that each step of the reporting process has been completed in a timely manner. The tool also identifies that a thorough investigation has been conducted and statements have been obtained from every potential witness. A mandatory in-service was conducted for all facility staff members on the new revised policy and procedure on abuse. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented which will be utilized to audit each allegation of abuse. This tool will be completed by the Administrator and/or her designee. The outcome of this audit tool will be reviewed at the morning meeting by the facility management team upon completion of each investigation involving allegations of abuse. If there are any additional concerns identified upon this review they will be immediately addressed by the facility management team. This tool will be an on-going pat of the facilities Quality Assurance program. If during the review any areas are found to fail to follow the facilities abuse policy that issue will be immediately corrected to ensure on-going	

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	documentation for interviews was lacking in the initial investigation. The abuse investigation statements were provided by HFA on 2/6/14 at 3:00 P.M., the documentation provided the names of 19 (nineteen) residents had been interviewed during investigation. The resident that had alleged abuse was not named. 2. A untimed facility "Concern/Suggestion Report" dated 2/6/14 was reviewed on 2/7/14 at 1:25 P.M. The report indicated Resident #13 and Resident #60 had made an allegation of verbal abuse on 02/06/14 at 8:00 A.M. A facility "Potential Resident Abuse Report Form" dated 2/6/14 was reviewed on 2/7/14 at 1:25 P.M. The report form was completed by the Social Service Director. The report indicated the incident had occurred on 2/6/14 around 8:00 A.M., in a restroom. The report		compliance.	

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	indicated residents #13 , and # 60 had made the allegation. The alleged perpetrator documented was CNA #5. A Resident Abuse Investigation Report Form completed by the Director of Nursing (DON) but not signed or dated indicated, "2/6/14 8A (8:00 A.M.) CNA- (CNA #5's name) -came to me saying that (Resident #13's name) was upset about the belt on the lift being kept fastened while she was on toilet..." "... Went immediately to resident's rm (room) and talked to her & her husband (who is her roommate)..." "... Res (resident) didn't appear upset but husband was upset saying 'There's no sense in that.' I asked them if any staff had talked 'mean' to them and they said 'no' ..." On 2/10/14 at 9:30 A.M., HFA provided copy of document dated 2/1/14 at 12:45 A.M., indicating it was the follow up for the completed investigation. The document lacked documentation that Resident #28 had been interviewed. On 2/6/14 at 11:45 A.M., the administrator during the investigation, indicated Resident #13 had voiced concerns about an			

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	incident that had happened that morning. The administrator indicated the Director of Nursing (DON) was aware of the incident but she had not been informed until the investigation into the allegation reported by the survey team. A facility incident report had been sent to the Indiana State Department of Health on 2/6/14 at 11:35 A.M. The report indicated, "2/6/14 at 11:35 a.m. ISDH (Indiana State Department of Health) surveyors reported to the administrator that during their interviews an allegation of verbal abuse was reported." " Immediate Action Taken: 2/6/14 Department managers interviewed all facility residents to determine who may have been verbally abused by a staff person. It was determined resident (Resident # 13's name here) may have reported an incident of verbal abuse by staff member CNA #5 (CNA #5's name here) who was immediately suspended..." An interview by the Food Service Manager/department head staff was completed on 2/6/14 at 11:40 A.M., with Resident #13. "... When I asked Resident #13 (Resident's name) if staff was rude or verbally			

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	abusive to her she said not really. When I asked what that meant she would not answer, that she did not want to get anyone in trouble. I continued to carry on conversation with her and reasked [sic] her about if staff had been rude and she stated again that she did not want to get anyone in trouble and refused to say who the CNA was. Reported conversation to ADM (administrator)." A Resident Abuse Investigation Report Form dated 2/6/14 and signed by the Social Service Director (SSD) and LPN unit manager was reviewed on 2/7/14 at 1:25 P.M. The report indicated Resident #13 and # 60 were interviewed regarding the incident that had occurred around 8:00 A.M. Resident # 60 "stated the CNA's were 'nasty' to Resident #13. 3.1-28(c)			

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the facility's abuse policy included immediate notification of the state agency and/or was implemented in regard to a thorough investigation for 1 of 3 allegations reviewed. Findings Include: 1. Resident #28 was observed to be lying in bed on 2/6/14 at 9:43 A.M., during an interview at that time Resident #28 indicated at times he felt verbally abused. Resident #28 indicated that some staff was not as courteous as they should be and he felt it was verbal abuse. Resident requested not to be named. The Health Facility Administrator (HFA) was notified on 2/6/14 at 10:35 A.M., that a resident had made an allegation of abuse. HFA indicated an investigation would be started and they would talk with all residents in the facility.	F000226	F - 226 The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #28 has been interviewed by facility administration and the resident reports that he feels safe and secure in his environment and does not have any concerns with the care provided by any staff members. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all interviewable residents have been questioned on abuse. No residents have reported any allegations of abuse. In addition each facility staff member has been interviewed and no staff members have indicated that they have witnessed or heard of any staff member being abusive in any way to any of the residents of the facility. The facility also conducted a “customer service” in-service with facility staff on 02-10-14 as a result of the investigation. The measures that have been put into place to ensure that the deficient practice does not recur is that the	02/28/2014

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	On 2/10/14 at 1:00 P.M., Resident #28 was interviewed about allegation of abuse. Resident #28 gave permission for his name to be released to HFA. On 2/10/14 at 1:26 P.M., the HFA was informed that Resident #28 had been the resident who initially voiced the allegation. At that same time during an interview, she indicated that all residents should have been interviewed during the investigation and was unaware of why some resident were not interviewed during the investigation. The HFA indicated they would talk with Resident #28. The DoN was interviewed 1:29 P.M., she indicated at that time that she had interviewed several residents and that resident #28 was one of them. She indicated that she had not documented the names of residents she had interviewed. On 2/10/14 at 4:00 P.M., during an interview the HFA agreed that documentation for interviews was lacking in the initial investigation. The abuse investigation statements were provided by HFA on 2/6/14 at 3:00 P.M., the documentation		facility has reviewed and revised its policy and procedure on abuse and abuse reporting. The revised policy now includes the instructions that any allegation of abuse must be immediately reported to the administrator and/or her designee, who then will immediately report the allegation of abuse to all appropriate agencies, including the Indiana State Department of Health. In addition a Quality Assurance tool has been added to the policy to ensure that each step of the reporting process has been completed in a timely manner. The tool also identifies that a thorough investigation has been conducted and statements have been obtained from every potential witness. A mandatory in-service was conducted for all facility staff members on the new revised policy and procedure on abuse. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented which will be utilized to audit each allegation of abuse. This tool will be completed by the Administrator and/or her designee. The outcome of this audit tool will be reviewed at the morning meeting by the facility management team upon completion of each investigation involving allegations of abuse. If there are any additional concerns identified upon this review they	

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	provided the names of 19 (nineteen) residents had been interviewed during investigation. The resident that had alleged abuse was not named. On 2/10/14 at 9:30 A.M., HFA provided copy of document dated 2/1/14 at 12:45 A.M., indicating it was the follow up for the completed investigation. The document lacked documentation that Resident #28 had been interviewed. 2. A Resident Abuse Investigation Report Form completed by the Director of Nursing (DON) but not signed or dated indicated, "2/6/14 8A (8:00 A.M.) CNA- (CNA #5's name) -came to me saying that (Resident #13's name) was upset about the belt on the lift being kept fastened while she was on toilet..." "... Went immediately to resident's rm (room) and talked to her & her husband (who is her roommate)..." "... Res (resident) didn't appear upset but husband was upset saying		will be immediately addressed by the facility management team. This tool will be an on-going part of the facilities Quality Assurance program. If during the review any areas are found to fail to follow the facilities abuse policy that issue will be immediately corrected to ensure on-going compliance.	

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	'There's no sense in that.' I asked them if any staff staff had talked 'mean' to them and they said 'no'..." A facility incident report had been sent to the Indiana State Department of Health on 2/6/14 at 11:35 A.M. The report indicated, "2/6/14 at 11:35 a.m. ISDH (Indiana State Department of Health) surveyors reported to the administrator that during their interviews an allegation of verbal abuse was reported." " Immediate Action Taken: 2/6/14 Department managers interviewed all facility residents to determine who may have been verbally abused by a staff person. It was determined resident (Resident # 13's name here) may have reported an incident of verbal abuse by staff member CNA #5 (CNA #5's name here) who was immediately suspended..." An interview by the Food Service Manager/department head staff was completed on 2/6/14 at 11:40 A.M., with Resident #13. "... When I asked Resident #13 (Resident's name) if staff was rude or verbally abusive to her she said not really. When I asked what that meant she would not answer, that she did not want to get anyone in trouble. I			

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	continued to carry on conversation with her and reasked her about if staff had been rude and she stated again that she did not want to get anyone in trouble and refused to say who the CNA was. Reported conversation to ADM (administrator)." On 2/6/14 at 3:00 P.M., the facility's abuse policy entitled "ABUSE PREVENTION (revision date 09/2011) was reviewed and received. One of the policy statements included but was not limited to: " V. ABUSE INVESTIGATIONS:"...All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by the facility management..." "...10. should the investigation reveal that abuse occurred , the administrator or designee will report such findings to the ombudsman, the state licensing agency and others as may be required by state or local laws within 24 hours of the completion of the investigation. If the abuse involved serious bodily injury it must be reported to the ISDH and local law enforcement with in 2 hours."			

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	"11. allegations of abuse are reported to the state agency within 24 hours. If the abuse involves serious bodily injury it must be reported to the ISDH and local law enforcement within 2 hours. The administrator or designee will provide a written report of the results of all abuse investigations and appropriate action taken to the state agency and certification agency within 5 days of the reported incident..." On 2/10/14 at 4:00 P.M.,the facility's abuse policy was reviewed with the Administrator. The Administrator was made aware that (11.) reporting allegations to the state agency within 24 hours was incorrect. She indicated she was aware of the need for immediate notification. She also indicated the statement was in the policy interpretation section of the policy. She indicated the facility was currently redoing the facility abuse policy. 3.1-28(a) 3.1-28(c)			

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to revise a toileting care plan when there was a decline in urinary continence status for 1 of 1 resident reviewed for incontinence in the stage 2 sample. (Resident #43) Findings include: Resident #43's closed record was reviewed on 2/7/14 at 1:58 P.M.	F000280	F – 280 The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #43 no longer resides at the facility. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit was conducted to identify any resident who is incontinent or has had a decline in continency. Those identified residents have had their medical record reviewed to ensure that an	02/28/2014

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	She had been admitted to the facility on 8/30/13. Her diagnoses included, but were not limited to, fractured right wrist, acute renal failure, and history of leukemia. An admission Minimum Data Set Assessment (MDS) dated 9/6/13, indicated always continent of urine and a cognition score of 11 (8-12 moderate cognitive impairment). A MDS dated 9/13/13, indicated always continent of urine and a cognitive score of 12. The following MDS's (9/27/13, 10/22/13, 10/29/13, 11/12/13, 12/5/13, and 12/11/13) indicated frequently incontinent of urine with 7 or more incontinent episodes but at least one episode of voiding continent. A cognitive score of 11 was documented on the MDS's of 9/27/13, 10/22/13, and 10/29/13. A cognitive score of 9 was documented on the MDS's of 11/12/13 and 12/5/13 and 12/11/13. A care plan with an initiation date of 9/6/13, addressed the problem of ADL's (activities of daily living) included, but not limited to, toileting. The target date for toileting was 3/6/14. No goals addressed the resident's toileting needs.		appropriate toileting plan is in place to meet the resident's current needs. In addition the care plan was reviewed and up-dated to include appropriate interventions to address the residents' current toileting needs. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all nursing staff on the importance of reporting any change in the resident's continency to the nurse so that further evaluation can be completed and an appropriate plan of treatment be established. A Communication for Change tool has been developed and implemented for the purpose of reporting any changes in bowel and bladder patterns. In addition the restorative nurse will be reviewing the monthly bowel and bladder flow sheets documentation to assess for any changes in the resident's voiding patterns. Any noted changes will be further reviewed and care plans up-dated as warranted. The corrective action taken to monitor to assure compliance is that the facility has implemented the process whereby the MDS coordinator will review each resident quarterly to ensure that if the resident has had a decline in continency within the last quarter as identified on the MDS that	

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	Interventions included, but were not limited to: "...Extensive assist of 1 or 2 staff for toileting..." Documentation was lacking of the care plan being revised after the initiation date of 9/6/13. On 2/10/14 at 11:00 A.M., the MDS nurse was interviewed regarding a decline in urinary status from admission (MDS 9/6/13) to discharge (MDS 12/11/13). She indicated documentation was lacking of a "specific" toileting plan to address incontinence when the resident had changed from the status of always continent to frequently incontinent. She also indicated she had not changed the care plan but should have. 3.1-35(a) 3.1-35(d)(2)(B)		there is an appropriate toileting plan in place to address the needs of the resident and that the care plan has been up-dated accordingly. If any discrepancies are identified during this review, the interdisciplinary team will be notified and the care plan up-dated at the time of the review. This tool will be completed weekly for three months by the MDS coordinator and/or designee. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if further action is warranted. If a concern is identified at the Quality Assurance meeting the monitoring will revert back to the weekly times four, then monthly times three months and then quarterly for three quarters monitoring cycle.	

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to ensure a toileting program was initiated for a resident who had a decline in continence status for 1 of 1 resident reviewed for urinary incontinence in the stage 2 sample. (Resident #43) Findings include: Resident #43's closed record was reviewed on 2/7/14 at 1:58 P.M. She had been admitted to the facility on 8/30/13. Her diagnoses included but were not limited to, fractured right wrist, acute renal failure, and history of leukemia. An admission Minimum Data Set Assessment (MDS) dated 9/6/13, indicated always continent of urine and a cognition score of 11 (8-12	F000315	F – 315 The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #43 no longer resides at the facility. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit was conducted to identify any resident who is incontinent or has had a decline in continency. Those identified residents have had their medical record reviewed to ensure that an appropriate toileting plan is in place to meet the resident's current needs. In addition the care plan was reviewed and up-dated to include appropriate interventions to address the residents' current toileting needs. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was	02/28/2014

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	moderate cognitive impairment). A MDS dated 9/13/13, indicated always continent of urine and a cognitive score of 12. The following MDS's (9/27/13, 10/22/13, 10/29/13, 11/12/13, 12/5/13, and 12/11/13) indicated frequently incontinent of urine with 7 or more incontinent episodes, but at least one episode of voiding continent. A cognitive score of 11 was documented on the MDS's of 9/27/13, 10/22/13, and 10/29/13. A cognitive score of 9 was documented on the MDS's of 11/12/13 and 12/5/13 and 12/11/13. A care plan with an initiation date of 9/6/13, addressed the problem of ADL's (activities of daily living) included, but not limited to toileting. The target date for toileting was 3/6/14. No goals addressed the resident's toileting needs. Interventions included but were not limited to: "...Extensive assist of 1 or 2 staff for toileting..." Documentation was lacking of the care plan being revised after the initiation date of 9/6/13. On 2/10/14 at 10:35 A.M., the MDS nurse was interviewed regarding Resident #43's incontinent status. She indicated the resident had an		provided for all nursing staff on the importance of reporting any change in the resident's continency to the nurse so that further evaluation can be completed and an appropriate plan of treatment be established. A Communication for Change tool has been developed and implemented for the purpose of reporting any changes in bowel and bladder patterns. In addition the restorative nurse will be reviewing the monthly bowel and bladder flow sheets documentation to assess for any changes in the resident's voiding patterns. Any noted changes will be further reviewed and care plans up-dated as warranted. The corrective action taken to monitor to assure compliance is that has implemented the process whereby the MDS coordinator will review each resident quarterly to ensure that if the resident has had a decline in continency within the last quarter as identified on the MDS that there is an appropriate toileting plan in place to address the needs of the resident and that the care plan has been up-dated accordingly. If any discrepancies are identified during this review, the interdisciplinary team will be notified and the care plan up-dated at the time of the review. . This tool will be completed weekly for three months by the MDS coordinator	

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	urinalysis on 10/1/13. She indicated antibiotics had been initiated for an urinary tract infection on 10/3/13. She also indicated Resident #43 had been hospitalized from 10/12/13 to 10/15/13. The hospital transfer sheet dated 10/15/13, indicated a diagnosis of bronchitis with clinical pneumonia. On 2/10/14 at 11:00 A.M., the MDS nurse was interviewed regarding a decline in urinary status from admission (MDS 9/6/13) to discharge (MDS 12/11/13). She indicated documentation was lacking of a "specific" toileting plan to address incontinence when the resident had changed from the status of always continent to frequently incontinent. She indicated she had not changed the care plan but should have. She also indicated there had been no restorative toileting program for the resident. 3.1-41(a)(2)		and/or designee. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if further action is warranted. If a concern is identified at the Quality Assurance meeting the monitoring will revert back to the weekly times four, then monthly times three months and then quarterly for three quarters monitoring cycle.	

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F000323 SS=D	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 assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure interventions to prevent falls were implemented and/or adequate supervision was provided to prevent falls for 1 of 1 resident who met the criteria for review of accidents. (Resident #8) Findings include: Resident #8 was observed on 02/04/14 at 10:00 A.M. to be seated in a recliner. A mat was observed on the floor in front of the recliner. During an interview on 02/06/14 at 9:30 A.M. LPN #2 indicated Resident #8 had a history of falls and had experienced a fall on 01/14/14 with no injury. The clinical record of Resident #8 was reviewed on 02/10/14 at 10:30 A.M. The record indicated the diagnoses of Resident #8 included, but were not limited to, dementia	F000323	F – 323 The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #8 has been reviewed by the interdisciplinary team. All fall interventions are in place and effective. The resident has not had any further falls. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit of all high fall risk residents was completed. All interventions were validated to be in place and functioning properly. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised the fall prevention program to include specific instructions that if an alarm must be turned off while providing care, toileting, bathing etc. that the staff MUST remain with the resident until such time that the safety alarm is put back in place. A mandatory in-service has been provided for all nursing staff on the revised policy. The staff was instructed that any resident who	02/28/2014

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	and gait instability. The most recent quarterly MDS [Minimum Data Set Assessment] dated 12/29/13 indicated Resident #8 experienced severe cognitive impairment, unsteady balance when moving from seated to standing position, and was only able to "...stabilize balance with human assistance..." The MDS further indicated Resident #8 had not experienced a fall since the previous assessment period, A Care Plan dated 01/08/14 for High Risk Fall indicated included, but was not limited to, an undated interventions of "...pull tab to recliner...and bed to alert staff of rising unassisted...floor sensor in front of recliner to alert staff of rising unassisted..." A Nurse's Note dated 01/04/14 at 3:45 P.M. indicated, "...Resident fell after getting self up from recliner. Alarming floor mat was off because resident's feet were down pull tab alarm on but did not release with fall . came off of resident's shirt..." A Resident /Visitor Incident Report dated 01/04/14 at 3:45 P.M. indicated Resident #8 experienced a		has been deemed to require safety alarms must be provided with direct supervision during any time that the safety alarms are removed to provide care. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor safety interventions for proper placement and functioning. This tool will be completed by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.	

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	fall at that time, "...Describe EXACTLY what happened:...CNA herd [sic] resident saying "Oh" walked in room found on floor. CNA had turned off alarming floor mat but left pull tab alarm connected to resident neither alarm sounded.... An Interdisciplinary Team Progress Note dated 01/06/13 indicated, "...CNA's reminded to be sure all alarms are on unless staff with res (resident) during this time..." The CNA Assignment Sheet for Resident #8 dated 01/31/14 provided by HFA [Health Facilities Administrator] on 02/04/14 at 12:00 P.M. included, but was not limited to interventions of "...floor alarm infront [sic] of recliner, pull tab alarm to chair & bed, low bed, soft landing mats to both sides of bed,...toilet immediately after meals..." During an interview on 02/10/14 11:10 A.M. RN #1 indicated the staff on duty at the time of Resident #8's fall had turned off the floor alarm, the pull tab did not function properly, and supervision was not provided to Resident #8. 3.1-45(a)(2)			

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F000371 SS=F	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 record review, the facility failed to ensure foods were dated and/or discarded per expiration date, food contact solution was of an adequate strength, and staff coats were not stored in the food storage areas for 2 of 2 survey days. This had the potential to affect 48 of 53 residents. Findings include: 1. On 2/4/14 at 10:55 A.M., the facility kitchen was toured with the Food Service Manager. A refrigerator contained 2 plastic bags of carrots and 2 plastic bags of cucumbers (each bag containing 6-8 food items) that were not dated. The Food Service Manager (FSM) searched the bags for dates and was unable to find any dates on the food bags. The FSM indicated the produce needed to be dated.	F000371	F – 371 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific resident were identified during the survey(1) the two bags of carrots and cucumbers that were identified as not being dated during the survey were discarded. The partial bag of parmesan cheese that was identified as having an expired date of 01-24-14 was discarded. The bag of shredded cheese that was identified as being open to the air was resealed. (2) The food contact solution that was identified as being tested at 50 PPM (parts per million) was discarded and a new solution was prepared which tested at 100 PPM. (3) The two staff member's winter coats were immediately removed from the food storage area along with the plastic bag containing Avon pamphlets. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all	02/28/2014

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	A partial bag of parmesan cheese (approximately 1/3 of a 1.5 lb bag) was also observed with an expiration date of 1/24/14. The FSM indicated the cheese should be discarded and discarded the cheese at that time. Another bag of shredded cheese (approximately 1/3 of a 1 lb bag) was observed open to air. The FSM indicated the cheese bag needed to be kept closed. 2. On 2/4/14 at 10:32 A.M., the FSM checked the red plastic container of the food contact solution with a PHydrion test strip. The strip indicated a 50 PPM (Parts Per Million). The FSM indicated at that time the solution needed to be a 100 PPM. 3. On 2/7/14 at 10:32 A.M., 2 dietary staff winter coats were observed hanging on the plastic racks in the food storage area which contained bread products. A plastic bag containing several paper Avon pamphlets was also stored in one of the plastic food storage racks for bread products. The FSM indicated at that time the coats needed to be stored in the employee break room.		residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the practice. (1) The two bags of carrots and cucumbers that were identified as not being dated were discarded. The partial bag of parmesan cheese that was identified as having an expired date of 01-24-14 was discarded. The bag of shredded cheese that was identified as being open to the air was resealed. (2) The food contact solution that was identified as being tested at 50 PPM (parts per million) was discarded and a new solution was prepared which tested at 100 PPM. (3) The two staff member's winter coats were immediately removed from the food storage area along with the plastic bag containing Avon pamphlets. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised the policies on sanitizing cloths and food storage. The new policies include direction on the storage of food items to ensure that all food items are properly dated when opened, securely sealed and expired items are promptly discarded. The policy also addresses that the food storage area shall be used for no other purpose. The sanitizing cloth policy includes information on the strength of the cleaning	

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	4. On 2/7/14 at 1:35 P.M., the FSM provided the facility policy on food storage (dated 1/97). the policy included, but was not limited to: "...5. All stored food products will be covered, identified, and dated...." "...7. Food storage areas shall be used for no other purposes..." 5. On 2/07/14 at 2:08 P.M., the FSM provided the facility policy for the food contact solution entitled, "Cleaning Cloths and Sponges (dated 1/97). The policy indicated, " Cleaning food contact surfaces of equipment (Cloths) 1. These cloths are to be used for no other purposes. 2. Clean and rinse in disinfecting solution while in use. 3. After use, IMMEDIATELY dispose of by placing in designated container. 6. On 2/10/14 at 8:25 A.M., the FSM provided information from the Indiana Administrative code which indicated at least 50 PPM for the dishwasher and that cleaning with the chemical solution of at least twice the strength required for the sanitizing solution. 7. On 2/11/14 at 10:30 A.M., during interview with the FSM, she indicated the facility had not really		solution along with the frequency that the solution must be changed out. The facility also has a tracking tool to record the checking of the sanitizing solution. The facility has provided a mandatory in-service for all dietary employees on the changes in the dietary policies as identified above along with the notification of the designated storage areas for personal belongings. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the food storage area to ensure all food items are stored in accordance with facility policy and to monitor the strength of the sanitizing solution. This tool will be completed weekly by the Food Service Manager and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.	

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	had a policy addressing the sanitizing contact solution in regard to the preparation and changing of the solution. She indicated she had known the solution needed to be 100 PPM's. She indicated she had worked with the dietician yesterday and was developing a policy which included, but was not limited to: the procedure to change the sanitizing solution every 4 hours. 3.1-21(i)(2) 3.1-21(i)(3)			

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F000431 SS=D	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 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 accurately reconcile narcotic	F000431	F – 431 The corrective action taken for those residents found to have been affected by the deficient practice is that no specific residents were identified	02/28/2014

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	medications and medications that are subject to abuse in a way that would identify loss or diversion in a timely manner for 1 of 2 medication carts located on the West hall. Findings include: During an observation on 2/7/14 at 2:55 P.M., LPN #2 and QMA #3 conducted the end-of-shift narcotic count for the West Hall. LPN #2 had the narcotic count sheets in a binder on the top of the medication cart while QMA #3 opened the locked medication drawer located in the 2nd drawer on the right side of the cart. QMA #3 would look at the medication blister packs or bottles, tell LPN #2 how many pills were remaining on each blister pack or how many milliliters were remaining in the bottle of liquid medication. LPN #2 did not verify the narcotic medication count by actually viewing the narcotic medications in each blister pack when matching the narcotic count totals recorded on the med count sheets. Neither LPN #2 nor QMA #3 actually viewed both the medication blister packs stored in the metal lock box and the narcotic count sheets sitting on top of the medication cart for 9 different narcotics during the reconciliation of		during the survey. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents with physician's orders for narcotics have the potential to be affected. All narcotic medications are currently being reconciled in a manner that would identify loss or diversion in a timely manner. The measures that have been put into place to ensure that the deficient practice does not recur is that the facility reviewed and revised their policy and procedure on controlled medication storage during the survey on 02-10-14. A mandatory in-service has been conducted for all licensed nurses and QMAs on the revised policy for narcotic count. The nurses/QMAs have been instructed that both nurses/QMAs must visually view each narcotic record as well as the front and back of the bubble card containing the medication during the change of shift drug count to ensure accuracy of the count. The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the shift change narcotic count for compliance. The tool includes a visual observation of the nurses/QMAs during the shift change narcotic count to validate that the task is being completed in accordance with facility policy.	

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	the West Hall medication cart. During an interview with LPN #2 on 2/7/14 at 3:10 P.M., LPN #2 was made aware she had not actually viewed both the medication blister packs and the narcotics count sheet to verify that the correct amounts of narcotics were in the drawer. LPN #2 indicated she did not realize she needed to look at both the narcotic blister packs to count the actual number of meds contained therein in order to match the actual number recorded on the med count sheet. During an interview on 2/10/14 at 10:57 A.M., LPN #5 indicated that when she completed the change of shift narcotics count she proceeded as follows: "The nurse coming on shift looks in the drawer and counts the pills. The nurse that is leaving the shift checks the narcotic count book. The nurse who has the count book tells the nurse who is counting the pills how many narcotic pills should be left on the card. The nurse who is counting the pills checks that the number of pills on the medication card is correct." During an interview with the DON on 2/10/14 at 11:45 A.M., the DON indicated both nurses should look at		This tool will be completed by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the tool will be reviewed at the facility Quality Assurance meeting to determine the need for additional action.	

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	the medication and the count book at the same time. The DON further indicated, the facility would develop a specific policy for the counting of narcotics at shift change and have an in-service to cover the new policy. The facility's policy for controlled medication storage was made available by the Director of Nursing (DON) and reviewed on 2/10/14 at 11:45 A.M. The policy read as follows: "D. At each shift change, a physical inventory of all controlled medication, including the emergency supply, is conducted by 2 licensed nurses and is documented on the controlled medication accountability record per facility procedure." 3.1-25(e)(3)			

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F000441 SS=E	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. Based on observation, interview and	F000441	F – 441 The corrective action taken for those residents found to	02/28/2014

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	record review the facility failed to follow its policy and procedure for hand washing between contacts with residents during 1 of 3 medication administrations observed. (Resident #49, Resident #24, Resident #20, Resident #10, Resident #52, Resident #26, Resident #30) Findings include: During an observation of the medication pass on the East Hall on 2/7/14 at 11:00 A.M. the following hand washing by LPN #4 was observed: 1. At 11:00 A.M., LPN #4 administered medication to Resident #49 through a g-tube. Upon returning to the nurses' station on the East Hall, LPN #4 proceeded into the medication storage room and washed her hands in the sink for 6 seconds. The process was timed on the clock which was hanging on the wall that leads into medication storage room. 2. At 11:08 A.M., LPN #4 administered medication to Resident #24. LPN #4 then proceeded to the clean utility room and washed her hands for 8 seconds.		have been affected by the deficient practice is that the nurse identified as LPN # 4 has received one on one education as it relates to proper hand washing technique and glove usage. Resident's identified as residents #49, #24, #20, #10, #52, #26 and #30 are now receiving their medications including insulin, by licensed nurses and QMAs that are utilizing proper hand washing technique as well as proper glove usage in accordance with acceptable standard of infection control practices. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the same deficient practice. The nurse identified as LPN#4 has received one on one education as it relates to proper hand washing technique and glove usage. All residents are now receiving their medications including insulin by licensed nurses and QMAs that are utilizing proper hand washing technique as well as proper glove usage in accordance with acceptable standard of infection control practices. The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses and QMAs on the facility's hand washing and glove usage policy and procedure. The corrective	

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	3. At 11:11 A.M., LPN #4 administered medication to Resident #20. After Resident #20 took the medication with 4 ounces of water, LPN #4 took the cup from Resident #20 by grasping the rim of the cup. Upon returning to the nurses ' station on the East Hall, LPN #4 proceeded into the medication storage room and washed her hands in the sink for 5 seconds. The process was timed on the clock which was hanging on the wall that leads into medication storage room. 4. At 11:14 A.M., LPN #4 handed Resident #10 her medications and a cup of water. After Resident #10 finished taking her medications, she handed the cup back to LPN #4. LPN #4 took the plastic water cup from Resident #10 by grasping the rim of the cup. LPN #4 then walked by the closed trash receptacle in the dining room, pushed open the trash receptacle flap with her hand and disposed of the medication cup and the water cup in the trash receptacle. Upon returning to the nurses ' station on the East Hall, LPN #4 proceeded into the medication storage room and washed her hands in the sink for 5 seconds. The process was timed on the clock		action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor for compliance. The tool includes observation of the licensed nurse/QMA as it relates to handwashing and glove usage during medication administration. This tool will be completed by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the tool will be reviewed at the facility Quality Assurance meeting to determine the need for additional action.	

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	which was hanging on the wall that leads into medication storage room. 5. At 11:19 A.M., LPN #4 prepared Resident #52's Novolog insulin by drawing it up into the syringe. LPN #4 proceeded to Resident #52's room where she administered the insulin injection. While en route back to the nurses ' station, LPN #4 grasped the handles of Resident #30's Geri chair and pushed the chair from the left side of the hall to the right side the hall where she positioned the resident in the chair in front of the restroom door located next to the nurses ' station. Upon returning to the nurses ' station on the East Hall, LPN #4 proceeded into the medication storage room and washed her hands in the sink for 5 seconds. The process was timed on the clock which was hanging on the wall that leads into medication storage room. 6. At 11:26 A.M., LPN #4 prepared Resident #30's insulin injection. LPN #4 pushed Resident #30 in her Geri chair into the restroom room (located next to the nurses ' station) and administered the insulin injection without gloves. Upon returning to the nurses' station on the East Hall, LPN #4 proceeded			

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	into the medication storage room and washed her hands in the sink for 4 seconds. The process was timed on the clock which was hanging on the wall that leads into medication storage room. 7. At 11:29 A.M., LPN #4 proceeded to Resident #26's room and flushed her g-tube and administered eye drops. Upon returning to the nurses ' station on the East Hall, LPN #4 proceeded into the medication storage room and washed her hands in the sink for 4 seconds. The process was timed on the clock which was hanging on the wall that leads into medication storage room. The facility's policy for Handwashing/Handrub was made available by the DON and reviewed on 2/10/14 at 11:45 A.M. The policy read as follows: "NOTE: Direct caregivers must rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers." During an interview with the Health Care Administrator (HCA) on 2/10/14 at 11:20 A.M., the HCA indicated that an in-service on hand washing was provided to staff on 11/20/13. The HCA further indicated			

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(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's policy and procedure was for staff to wash their hands for 20 seconds. 3.1-18(l)			
F009999	Based on interview and record review, the facility failed to ensure 6 hours of dementia training was provided to all employees within the first 6 months of employment, in that, 2.5 hours of dementia training was provided for 4 of 10 employee files reviewed. (RN #5, CNA #6, CNA #7, CNA #8) Findings include: The employee file of RN #5 was reviewed on 02/10/14 at 1:00 P.M. The employee file indicated the hire date of RN #5 was 05/30/13 (8 months and 11 days of employment) and lacked any documentation of dementia training. The employee file of CNA #6 was reviewed on 02/10/14 at 1:15 P.M. The employee file indicated the hire date of CNA #6 was 04/01/13 (10	F009999	F 9999 The corrective action taken for those residents found to have been affected by the deficient practice is that no residents were identified during the survey. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents with dementia have the potential to be affected. The staff identified as RN #5, CNA # 6, CNA #7 and CNA #8 have completed their required 6 hours of dementia training at this time. The measures that have been put into place to ensure that the deficient practice does not recur is that the staff development coordinator has received one on one education of the importance of ensuring that each new hire has completed the State required 6 hours of dementia training within the first six months of employment. The corrective action taken to monitor to assure compliance is that an audit tool has been developed and implemented for all new hires. The business office	02/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155539	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014
NAME OF PROVIDER OR SUPPLIER BERTHA D GARTEN KETCHAM MEMORIAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E RACE ST ODON, IN 47562	

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	months and 9 days of employment) and lacked any documentation of dementia training. The employee file of CNA #7 was reviewed on 02/10/14 at 1:30 P.M. The employee file indicated the hire date of CNA #7 was 06/17/13 (7 months and 24 days of employment) and lacked any documentation of dementia training. The employee file of CNA #8 was reviewed on 02/10/14 at 1:45 P.M. The employee file indicated the hire date of CNA #8 was 06/20/13 (7 months and 21 days of employment) and lacked any documentation of dementia training. A handwritten accounting of dementia training provided by RN #1 on 02/10/14 at 4:00 P.M. indicated the following: 1. RN #5 had received 2.5 hours of dementia training during 8 months and 11 days of employment. 2. CNA #6 had received 2.5 hours of dementia training during 10 months and 9 days of employment. 3. CNA #7 had received 2.5 hours of dementia training during 7 months		manager and/or designee will utilize this tool to monitor the completion of the six hours of dementia training on all new hires. This will be an on-going audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155539	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014
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	and 24 days of employment. 4. CNA #8 had received 2.5 hours of dementia training during 7 months and 21 days of employment. During an interview on 02/10/14 at 4:15 P.M., RN #1 indicated RN #5, CNA #6, CNA #7, CNA #8 were all part-time employees and the six hours of required dementia training had not been provided. The Policy and Procedure for Dementia Training provided by the HFA [Health Facilities Administrator] on 02/11/14 at 11:45 A.M. indicated, "...Policy: This facility will provide 6 [six] hours of dementia training to new employees within 6 months of employment... " 3.1-14(u)			