STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 7, 8, 9, 10, and 11, 2012 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Survey team: Dorothy Navetta, RN, TC Avona Connell, RN Donna Groan, RN Jennie Bartelt, RN Census bed type: SNF/NF: 88 Total: 88 Census payor type: Medicare: 23 Medicaid: 45 Other: 20 Total: 88 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/18/12 by Suzanne Williams, RN	F0000		

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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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	A. Based on interview and record review, the facility failed to ensure residents and/or their families were given a list of services with charges to make an informed decision on their appeal rights, for 3 of 3 residents reviewed of 3 residents who had been discharged from Medicare benefits. (Resident #47, Resident #121 Resident #143) B. Based on interview and record review, the facility failed to ensure residents and/or families were informed upon admission of items which are covered and items not covered and which the residents may be charged for 1 of 6 residents and/or families interviewed with concerns for charges for personal items of 28 residents interviewed. (Resident #58)	F0156	1).Resident # 47, # 121, and # 143 has been provided a list of services with charges to enable them to make informed decisions on their appeal rights. Resident # 58 was provided with a list of covered and non covered items for which the resident may be charged. In addition a listing of charges for routine personal hygiene items and notification of how reimbursement can be obtained. 2). All new admissions and resident discontinuing Medicare coverage have the potential to be effected. Notification letter on Limitation 0n Charges will be provided to all residents/responsible parties (see attachment A). 3). In-service education will be provided to Case Manager, Admission Coordinator and	06/06/2012

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	Findings include: A. On 5/10/12 at 1:26 p.m., the Business Office Manager provided the Liability/Appeals letter for the following residents: 1. Resident #47 was notified on 4/4/12 that her Skilled Nursing Services would end on 4/6/12. 2. Resident #143 was notified on 3/26/12 that her Skilled Nursing Services would end on 3/30/12. 3. Resident #121's family member was notified on 1/25/12 that her Skilled Nursing Services would end on 1/3012. The notice for Resident #121 indicated it was discussed over the phone with a family member on 1/25/12 and lacked two signatures for verification. The signature of the Power of Attorney was not dated. In interview with RN #1 on 5/11/12 at 1:21 p.m., she indicated she failed to obtain the date and verifications. The notices did not contain a list of services and charges for those services. RN #1 indicated the company uses a standard form, and the residents do not receive a list of charges for services when benefits		Business Office Manager regarding limitation on charges to personal funds and the cost of personal hygiene items as well as the responsibility to provide a list of these charges on admission and when discontinuation of Medicare notification is indicated. 4).Administrator will review each new admission folder to ensure notification has been provided to resident/responsible party regarding covered and non covered services. Business Office Manager will ensure a list of services with charges including personal hygiene products is provided at the time of Medicare discontinuation of services is given. This will be an ongoing daily practice. 5). The Administrator is responsible.	

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	end. B. On 5/9/12 at 3:50 p.m., in interview with a family member for Resident #58, she indicated she did not receive a list of personal items at the time of admission for which the resident may be charged. On 5/10/12 at 1:52 p.m., in interview with the Admissions Coordinator, she indicated, at the time the residents receive their admission packet there was a list of ancillary charges, but no list of non covered charges. She indicated, "family and residents are told to bring in their own stuff, and I do not tell them they can be reimbursed for the difference." Review of the admission packet, at this time, lacked a list of non-chargeable items. The Admissions Coordinator indicated she "didn't deal with that." She indicated she had been the Admissions Coordinator since September and was "not aware of this requirement." On 5/11/12 at 8:50 a.m., during interview with the Administrator, she reviewed the admission packet which lacked a list of personal items and how to be reimbursed. 3.1-4(f)(1)(A)			

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	3.1-4(f)(1)(B) 3.1-4(f)(3)			

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F0242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.			
	Based on record review, observation and interview, the facility failed to ensure residents were monitored for choices and care planned according to the those choices for 3 of 3 residents reviewed for choices of 28 residents interviewed regarding choices. (Resident #7, Resident # 39, Resident #120) Findings include: On 5/9/2012 at 12:25 p.m., the clinical record was reviewed for Resident #7. Diagnoses included, but were not limited to, coronary artery disease, hypertension, gout, anemia, chronic kidney disease, paralytic ileus, status post kyphoplasty of T12. Review of the Minimum Data Set assessment upon admission indicated choices were very important to the resident. In an interview on 05/07/2012 at 2:11	F0242	F 242 1) The Interdisciplinary Team reassessed resident #7 to ensure her choice for what time she would like to get out of bed in the morning were updated on the plan of care and to ensure the resident's choice of schedules. Resident # 39 and resident #120 have discharged from the facility. 2) The IDT will interview all residents regarding free choices and the right to participate in their plan of care and update the resident's plan of care with their individualized choices of schedules. 3) The Staff Development Coordinator or designee will in-service facility personnel on the resident's right to choose with an emphasis on schedules for getting up in the morning and bathing. The IDT will assess each resident at the time of admission and at least quarterly or with significant change to determine choice of schedules and continue develop an individualized plan of care. 4) The Director of Nursing, or her designee, will monitor 50 residents through observation,	06/06/2012

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	PM, Resident # 7 indicated she does not like to get up so early in the morning, and she is not okay with her schedule and would like to sleep in at times. Review of the Care Plan indicated documentation was lacking related to care planning choices. In an interview with Certified Nursing Aide (CNA) # 2 on 5/9/2012 at 2:25 p.m., she indicated there was a list of residents to get up. She indicated if a resident didn't want to get up, she would come back at a later time and re-ask. In an interview with CNA #3 on 5/9/2012 at 2:30 p.m., she indicated "it's okay if they don't want to get up and I will come back in 10 min and re-ask, and then if they still don't, I will just retry later." In an interview with Registered Nurse (RN) #3 on 5/9/2012 at 2:25 p.m., she indicated "aides come and tell me if residents do not want to get up. We can't bully people into getting up. It's their choice whether they want to get up. I will talk to them about the importance of getting out of bed if they have pneumonia or similar things."		resident interview and record review, monthly for three months, then 50 residents every other quarter, to assure the resident's right to choose schedules has been met. The DNS/Designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting x 3 months then the PI committee will continue to review results of resident interviews every other quarter as part of ongoing monitoring for resident rights and choices. DNS/designee will address concerns as identified during monitoring. 5). The Administrator is responsible for overall compliance.	

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	In an interview on 5/9/2012 at 2:47 p.m., with RN #3 she indicated that the list became obsolete a few months ago and now a CNA comes in early and helps get people up. "We get those who like to get up early, and then we just go down the line and start getting people up. I cant tell you what order because I don't come in until a little later. I am not aware of any residents who want to stay in bed." In an interview on 5/8/2012 at 1:05 p.m., with Resident #39, she indicated "they say when to get up...." In an interview on 5/8/2012 at 2:51 p.m., with Resident #120, he indicated he does not have a choice of bath schedule and that "they just tell you when they are going to give you a bath." On 5/10/12 at 2:50 p.m., in an interview with the Administrator, she indicated after the MDS assessments are filled out by the various entities, that in order to communicate needs to nursing staff, a care plan is implemented. Review of the Residents' Rights -Federal policy, provided by the			

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	Administration on 5/11/12 at 2:15 p.m., indicated, but was not limited to; the Resident has the right to refuse treatment, the right to participate in care planning, free choice, be fully informed in advance about care and treatment. 3.1-3(u)(1)			

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F0247 SS=A	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure prior notice was given before change of roommate for 1 of 28 residents interviewed for notice of roommate change. (Resident #39) Findings include: During interview on 05/08/12 at 1:05 p.m., resident #39 indicated she had not been given notice prior to receiving a roommate. The resident was admitted on 04/06/12 with current room mate admitted on 5/3/12. In interview with the Administrator at 3:21 p.m. on 5/10/12 she indicated she was unable to find documentation to support the resident was notified prior to receiving a roommate. She indicated a resident in a room, without a roommate, would be notified of receiving a roommate on the day the roommate was to be admitted. No notice was given prior to the roommate arriving. On 05/11/12 at 8:30 a.m., the	F0247	F 247 1). Resident # 39 has discharged home. Resident #39 was offered a change in rooms and declined prior to discharge home. 2). All residents without a roommate had the potential to be affected. All residents receiving a new roommate are given as much notice and information about the new person as possible while maintaining confidentiality regarding medical information. 3). The IDT and nursing department have been in-serviced on notifying residents prior to the arrival of a new roommate or change in resident's room while maintaining confidentiality regarding medical information with as much notice as possible. 4). The IDT will conduct 15 resident interviews for 1 month, then 10 resident interviews for 1 month then 5 resident interviews for 1 month regarding notice of room change and change in roommates with regards to notification and report findings in the monthly PI meeting. 50 Resident interviews will continue every other quarter on an ongoing basis and finding reported to PI committe every other quarter. DNS/designee will address any findings that result	06/06/2012

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	Administrator provided the facility policy "Change in Resident Room or Roommate" Bullet #3 indicated the following: "For a resident who is receiving a new roommate, a staff member should give the resident as much notice and information about the new person as possible while maintaining confidentiality regarding medical information." The new roommate was screened prior to admission at the hospital on 05/03/12 and admitted on same date. The resident was not informed on that date she was getting a new roommate. 3.1-3(v)(2)		from the interviews.100% compliance will be determined by PI committee. 5). The Administrator is responsible for compliance.	

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review, interview and observation, the facility failed to ensure a bruise of unknown origin was monitored for 1 of 4 residents reviewed for non pressure skin condition concerns in a sample of 4 who met the criteria for non pressure skin condition. (Resident #164) Findings include: On 5/8/12 at 8:50 a.m., Resident #164 was observed lying in bed, and a bruise which was blue and green was noted to the top of the left hand. The clinical record for Resident #164 was reviewed on 5/8/12 at 2 p.m. The resident was admitted to the facility on 5/3/12 with a diagnosis of fractured hip. The initial skin assessment completed on admission lacked any reference to bruising on the top of the left hand. On 5/10/12 at 8:35 a.m., Licensed	F0309	1) Resident #164 had a bruise to the left hand assessed, measured, documented on a Non-Pressure Skin form on 05/10/2012. MD and family were notified and resident #164 was not harmed. 2) A skin assessment for all residents has been completed and any non-pressure skin concerns identified have been documented and are being monitored. All residents will have a skin assessment completed upon admission and at least weekly to identify any skin concerns and to determine the progress of healing, presence of complications, and the status of the skin surrounding the area. 3) The SDC/designee is in-servicing all nursing staff on Non-Pressure Ulcer Prevention and Care and Pressure Ulcer/Non-Pressure Ulcer Assessment. All residents will have the skin assessment completed by 2 nurses upon admission and weekly to ensure accurate documentation and assessment for 3 months. Both nurses will sign the assessment. The DNS/designee will be	06/06/2012

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	Practical Nurse (LPN) #1 was observed to provide a treatment to Resident #164. At this time, LPN #1 was queried as to the bruising on the left hand, and she indicated she was not aware of the area. The area was measured as 8x5 centimeters. Review of a Change of Condition form, dated 5/10/12 at 9:30 a.m., included, but was not limited to, "This nurse was providing care to res with drsg (dressing) changes. A bruise to left hand /FA (forearm) was noted. Res (resident) stated I don't know how I got it. I bruise easy. This nurse questioned res on abuse. Res denied any abuse. N.O. (new order) received and noted. Interviewed all 3 CNAs (Certified Nursing Aides) and staff in an attempt to determine cause of bruise. Care Plan updated monitor area q. (every) shift. for changes. geri sleeves to BUE (bilateral upper extremities) as tolerated." 3.1-37(a)		monitoring all skin assessments 5 times per week for 1 month, twice a week for 1 month, then weekly for 1 month. 4) The DNS/Designee will monitor100% Resident skin assessments 5 times a week for accuracy and appropriate monitoring implemented for one month, then twice weekly for one month, then weekly for one month. The DNS/Designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting x 3 months. If after a period of 3 months 100% compliance(based on the results of the audits) has been maintained, the PI committee will determine if further monitoring is required. Any findings identified through monitoring of skin assessments will be addressed through education and inservicing. 5) The DNS is responsible for compliance.	

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on record review, interview and observation, the facility failed to provide treatment to promote healing for 1 of 4 residents reviewed for pressure ulcer treatment in a sample of 4 who met the criteria for pressure ulcer treatment. (Resident #164) Findings include: The clinical record for Resident #164 was reviewed on 5/8/12 at 8:50 a.m. The signed physician Admission orders for May 2012 included, but were not limited to "Mepilex to Stage I to coccyx q. day & prn, Granulex to buttock/coccyx q. shift." On 5/10/12 at 8:35 a.m., LPN #5 was observed, during a dressing change, to spray the coccyx/buttock area with granulex and after drying the area, applied Mepilex to the coccyx area.	F0314	1). Resident #164's stage one pressure ulcer has not deteriorated. The MD updated resident #164's orders to apply Grannulex to area on buttocks around the Mepilex applied on the Coccyx. Family informed on change in treatment and plan of care updated. 2). All residents with a pressure ulcer have had the MD order for the treatment verified with the Treatment Administration Record for accurate documentation of treatment implemented and any concerns clarified with the MD. All nurses have completed skills validation for Clean Dressing Change. 3). The SDC/Designee has in-serviced all nurses on Pressure Ulcer Care and Clean Dressing Change with attention to providing accurate documentation of treatment provided. 4). The DNS/Designee will monitor all pressure ulcer treatment orders and the Treatment Administration Record for accurate implementation of treatments for	06/06/2012

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	Review of the Medication Record for May 2012 included, but was not limited to, "5/3/12 Mepilex to Stage 1 to coccyx q (every) day and prn," which indicated treatment completed 5/3/12 through 5/10/12. "Granulex to buttock/coccyx q. shift noc (night), days, evening" was charted as completed 5/3/12 through 5/10/12. Documentation was lacking the Mepilex had been changed prn and to apply the granulex every shift. LPN #9, who works on the evening shift, was interviewed on 5/10/12 at 2:35 p.m. She indicated when she does the treatment, she would have to change the Mepilex prn (as needed). Documentation was lacking the Mepilex had been changed prn on the night and evening shifts. 3.1-40(a)(1) 3.1-40(a)(2)		pressure ulcers 5 times a week for one month, then twice weekly for one month, then weekly for one month. The DNS/designee will observe completion of pressure ulcer treatment 5 times per week for 1 month then twice weekly for a month then weekly for a month. The DNS/Designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if 100% compliance has been achieved, based on the results of the audits, regarding treatment of pressure ulcers and documentation. If after a period of 3 months, 100% compliance has been maintained the PI committee will determine if further monitoring is required. DNS/designee will address any findings through observation and monitoring with education and inservice. 5). The DNS is responsible for compliance.	

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation and interview, the facility failed to ensure expired medications were discarded for 1 of 2 opened foil pouches of respiratory medication and 1 of 5 medication carts reviewed for drug storage, affecting 2 residents whose medications were randomly observed. (Residents #68 and Resident #69) Findings include: 1. The facility's medication room was observed with Registered Nurse (RN) #2 on 5/9/12 at 2:30 p.m. In the cabinet was a box of inhalant	F0425	1). Resident #68 and resident #69 did not receive any doses of the expired medications and were not harmed. 2). An audit of the medication room and all medication carts has been completed and any medications with special expiration date requirements have been removed and returned to pharmacy or destroyed per policy and procedure. All respiratory medications have been labeled with the date the foil is opened and insulin discarded 28 days after the insulin is opened. 3). The SDC/Designee is in-servicing all nurses on Medications with Special Expiration Date	06/06/2012

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	medications containing open foil pouches of medication. The pouch in 1 box contained 16 vials of medication. On the pouch was a label indicating in handwriting an open date of 8/11/11. In the other box was an opened pouch containing 3 vials of an inhalant medication. The pouch did not indicate that date when opened. During interview on 5/9/12 at 2:55 p.m., RN #2 indicated she had spoken with the facility's pharmacist who told her inhalant medications should be discarded seven days after the foil pouch is opened. She indicated the pharmacist will begin to apply a label to all boxes of inhalant medications to indicate the instructions. 2. The 300 hall medication cart was observed on 5/10/12 at 2:15 p.m., with RN #3 and Licensed Practical Nurse (LPN) #4. In the drawer of the medication cart was a medication bottle containing a vial of Humalog insulin for Resident #69. A label on the medication bottle indicated the vial was opened on 4/3/12. The label indicated the Humalog expired 28 days from the open date. During interview at this time, RN #3 indicated Humalog had been ordered		Requirements and Insulin with Special Expiration Date Requirements. 4). The DNS/Designee will audit all medication storage rooms and carts for proper storage to include the date packages and insulin are opened and proper destruction of expired medications once weekly for one month, then twice a month for a month, then once a month for a month. The DNS/Designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if 100% compliance with storage of medications and Medications dated appropriately has been achieved based on the results of the audit. If after a period of 3 months 100% compliance is achieved, the PI commitee will determine if further monitoring is required. Any findings will be addressed by the DNS/Designee with education and in-servicing. 5). The DNS is responsible.	

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	for Resident #69, and no doses of the medication had been administered. 3.1-25(o)			

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F0441 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 interview, record review and observation, the facility failed to	F0441	1). Resident # 164, 121, 151 and 85 have had no signs or	06/06/2012

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	follow infection control practices related to glove use during personal care, handwashing during a dressing change, linen handling during meal service and disposing of soiled linen. This deficient practice affected 4 residents who were randomly observed for infection control. (Resident #164, Resident #121, Resident #151, Resident #85) Findings include: 1. On 05/10/12 at 1:45 p.m., Certified Nursing Assistant (CNA) #1 and Licensed Practical Nurse (LPN) #6 were observed providing personal care to Resident #121. The CNA and LPN were observed to wash their hands and put on gloves. CNA # 1 asked resident if she needed to use the toilet and the resident indicated "yes". CNA #1 used toilet tissue and a wet wipe to provide peri care to the resident. Without changing her gloves and handwashing CNA#1 was observed to prepare the resident's bed linen and transfer her from the bedside commode back to her wheelchair. She then removed her gloves, Handwashed and transferred the resident to her bed. On 05/10/12 at 2:48 p.m., during an interview, RN #4 Unit Manager		symptoms present of a Healthcare Acquired Infection since 05/10/2012 related to deficient infection control practices. 2). All residents have the potential to be affected. All staff in-servicing has been completed for Infection control work practices and hand hygiene/hand washing. 3). The SDC/Designee has completed in-servicing all employees on Infection Control Work Practices, Work Practices: Laundry, Hand Hygiene/Hand washing, Transmission Based Precautions, and Medication administration with emphasis on infection control practices related to glove use during personal care, when hand hygiene is to be performed, handling of linens, and medication administration. All nurses will complete a medication pass observation with the SDC/designee by June 6, 2012 and all employees will complete a hand washing skills validation with the SDC/designee by June 6, 2012. 4). The IDT will complete infection control rounds three times a week on all shifts for one month, then twice a week for one month and then once a week for a month. The infection control rounds will include observation of 2 staff on each hall on each shift once a week for handwashing, hand hygiene and use of gloves. All findings will be addressed immediately for correction. The DNS/Designee will complete	

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	indicated Resident #121 was kept in "prophylactic" contact isolation due to her urine had grown VRE, MRSA [Vancomycin Resistant Enterococcus, Methicillin Resistant Staphylococcus Aureus], and other organisms although she would receive an antibiotic. On 05/11/12 at 2:00 p.m., during an interview CNA#1 indicated one should handwash before and after glove use and after completing perI-care. 2. During the dining observation on 5/7/12 between 12 noon and 12:30 p.m., the Admissions/Marketing person was passing clothing protectors to the residents while holding them up against her clothing in her left arm. 3. On 5/10/12 at 8:35 a.m., LPN #5 was observed to wash her hands 8 seconds prior to gathering supplies		Medication Pass Observations twice a week for a month, then once a week for a month and then twice a month. The DNS/Designee will review results of the infection control rounds and medication observations at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if 100% compliance with hand hygiene, laundry work practices, and transmission based precautions has been achieved based on the results of the rounds. If 100% compliance is not achieved at this time the PI committee will extend the rounds weekly for 3 more months. Then if after a period of 6 months 100% compliance is maintained, the PI committee will determine if further monitoring is required. Any findings identified through rounds will be addressed through inservicing and education. 5). The Administrator is responsible for compliance.	

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	for a dressing change for Resident #164. After removing the dressing, LPN #5 again washed her hands for 10 seconds dried her hands and donned gloves. After completing the wound care she removed her gloves and went to wash her hands which was timed for 10 seconds, dried her hands and donned gloves. On 5/11/12 at 9:20 a.m., the Interim Director of Nursing provided the Hand Hygiene/Handwashing policy and procedure revised 8/31/11. The policy/procedure included, but was not limited to: "Procedure: 2. Rub hands together with vigorous friction for 20 seconds (The amount of time is (sic) takes to sing "Happy Birthday" through twice) or as designated by state regulations, ..." 4. The medication pass for Resident #85 was observed on 5/11/12 at 9:24 a.m. LPN #8 prepared oral medications by dispensing them into a souffle cup. During reconciliation, LPN #85 indicated she had nine instead of ten oral medications in the souffle cup. LPN #85 looked on the surface of the medication cart, observed an oral medication, and used her bare fingers to pick up the medication and place it in the souffle cup for administration to Resident #85. During the medication pass, RN			

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	#85 donned gloves and administered a nasal spray into the resident's nostrils, and the gloves were doffed. Without washing her hands or using hand sanitizer, RN #85 returned to the medication cart and placed the nasal spray in the medication cart. Surveyor: Navetta, Dottie E. 5. During a dressing change observation on 5/11/2012 at 9:00 a.m., for Resident #151 who was in droplet isolation precautions, it was noted that unfolded linens and an unfolded hospital gown were laying over on a window shelf in the corner. When inquiry was made as to how long the linens were sitting there, the Certified Nursing Aide # 4 indicated she was not sure but probably were from his bath yesterday. 3.1-18(l)			