STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155197	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT ST PAULS	3602 S IRONWOOD DR SOUTH BEND, IN 46614

(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
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: 11/13-11/16/12 and 11/19-11/20/12 Facility number: 000104 Provider number: 155197 AIM number: 100266590 Survey Team: Carol Miller, RN, TC Shelly Vice RN (11/14-11/16/12 and 11/19-11/20/12) Shauna Carlson RN Lora Swanson RN Amber Bloss, Medical Surveyor (11/15-11/16/12 and 11/19-11/20/12) Census Bed Type: SNF/NF: 58 SNF: 14 Residential:118 Total: 190 Census Payor Type: Medicare: 9 Medicaid: 47 Other: 134 Total: 190 Residential sample: 8	F0000	This Plan of Correction constitutes the wriiten allegation of compliance for the defeciencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.Sanctuary at St. Paul's respectfully requests the Plan of Correction and supporting documentation be considered for desltop review.We declare date of compliance of December 19, 2012.	

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 11/28/12 by Suzanne Williams, RN			

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F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observations, record reviews and interview, the facility failed to post the actual hours worked of the nursing staff and it did not include the residents census during the dates of 11/14/12 to 11/20/12.	F0356	Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1: No resident was affected. Q2: How other residents having the potential to be affected by the	12/19/2012

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	This deficiency potentially affected 72 of 72 residents in the facility and their visitors. Findings include: On 11/13/12 at 2:00 p.m. an observation was made of the form posted by the nursing office titled, "Sanctuary at St. Paul's. Daily Report Of Nursing Staff Directly Responsible For Resident Care" dated 11/13/12. This form contained the following information: 'Morning Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8. Afternoon Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8. Night Shift: #Licensed Nursing Staff: 2; # Unlicensed Nursing Staff: 4. The posting did not include the resident census nor the actual hours worked of the nursing staff. On 11/14/12 at 10:30 a.m. an observation was made of the form posted by the nursing office titled, "Sanctuary at St. Paul's. Daily Report Of Nursing Staff Directly Responsible For Resident Care" dated 11/14/12. This form contained the following information: 'Morning Shift: #Licensed Nursing Staff: 5; # Unlicensed Nursing Staff: 8. Afternoon Shift: #Licensed Nursing		same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3: What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Revision of (nursing staff information form) to reflect the actual hours worked per nursing classification and resident census. Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4: The (nursing staff information) form will be posted on daily basis. The Administrator or designee will monitor weekly by observation and report results at the monthly Quality of Care and quarterly MDQI. (See attachment 1) Q5: By what date the systemic changes will be completed; A5. December 19, 2012	

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	Staff: 4; # Unlicensed Nursing Staff: 7+1 orient.(orientee) Night Shift: #Licensed Nursing Staff: 2; # Unlicensed Nursing Staff: 4. The posting did not include the resident census nor the actual hours worked of the nursing staff. On 11/15/12 at 10:30 a.m. an observation was made of the form posted by the nursing office titled, "Sanctuary at St. Paul's. Daily Report Of Nursing Staff Directly Responsible For Resident Care" dated 11/15/12. This form contained the following information: 'Morning Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8. Afternoon Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8+1 orient. (orientee). Night Shift: #Licensed Nursing Staff: 2; # Unlicensed Nursing Staff: 4. The posting did not include the resident census nor the actual hours worked of the nursing staff. On 11/16/12 at 3:00 p.m. an observation was made of the form posted by the nursing office titled, "Sanctuary at St. Paul's. Daily Report Of Nursing Staff Directly Responsible For Resident Care" dated 11/16/12. This form contained the following information:			

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	'Morning Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8. Afternoon Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8. Night Shift: #Licensed Nursing Staff: 2; # Unlicensed Nursing Staff: 4. The posting did not include the resident census nor the actual hours worked of the nursing staff. On 11/19/12 at 8:00 a.m. an observation was made of the form posted by the nursing office tilted, "Sanctuary at St. Paul's. Daily Report Of Nursing Staff Directly Responsible For Resident Care" dated 11/19/12. This form contained the following information: 'Morning Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 7. Afternoon Shift: #Licensed Nursing Staff: 4; # Unlicensed Nursing Staff: 8. Night Shift: #Licensed Nursing Staff: 2; # Unlicensed Nursing Staff: 4. The posting did not include the resident census nor the actual hours worked of the nursing staff. On 11/19/12 at 8:00 a.m. an interview was conducted with the nursing office secretary. She indicated that she did not keep copies of the 'Daily Report Of Nursing Staff Directly Responsible For Resident Care' and indicated when she is finished with them, "... I			

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	shred them..." On 11/19/12 at 9:00 a.m. an interview was conducted with the nursing office secretary. She provided copies of the 'Daily Report Of Nursing Staff Directly Responsible For Resident Care' forms for 11/13, 11/14, 11/15, 11/16, 11/19 and 11/20/2012. There was not a copy of the 'Daily Report Of Nursing Staff Directly Responsible For Resident Care' for the Saturday, 11/17/12 and the Sunday 11/18/12. There was not a resident census nor a listing of actual hours worked located on the forms. 3.1-13(a)			

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F0371 SS=E	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 observations, interviews and record review, the facility failed to distribute and serve food under sanitary conditions in regard to hand washing and appropriate glove use. This deficiency potentially affected 38 of 38 residents who eat in the second floor dining room of 72 residents in the facility. Findings include: 1 (a). During lunch observation on 11/13/12 from 11:20 A.M. to 12:00 P.M., Dietary Server #1 did not wash hands or change gloves during the tasks of: preparing food, opening the refrigerator and removing food, assisting residents with menus, serving plates of food, touching residents' clothing, carrying plate of food with finger in contact with lunch entree, and carrying a bowl of soup to residents' table with tip of glove in soup. 1 (b). During lunch observation on	F0371	Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1: No resident was affected. Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3: What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Policy revised by clinical team to reflect the current 20 second hand washing CDC guideline recommendation. Inservice all associates with demonstration and return demonstration on hand washing and glove usage.Management team member to provide associate with post test and competency review for hand washing and glove usage. Associate to complete hand washing and glove usage quiz. Incorporate current CDC guidelines into new hire orientation. Q4: How the corrective action(s) will be	12/19/2012

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	11/14/12 from 11:20 A.M. to 11:45 A.M., Dietary Server #1 put on gloves when starting work in the kitchen without washing hands, then opened drawer to remove serving utensil, touched drink cart and pitchers, resident menus, personal clothing, ice machine and inside of ice bucket. 2 (a). During lunch service on 11/14/12 from 11:42 a.m. to 12:15 p.m., Dietary Server #1 was observed wearing disposable gloves. The finger tips of gloves were inside the soup bowls while soup was ladled into the bowl. Dietary Server #1 was observed touching her uniform, handle of refrigerator and resident clothing. Dietary Server #1 did not wash hands or change disposable gloves before returning to serve food. 2 (b). On 11/19/12 at 8:54 a.m., during interview of proper hand washing technique and disposable glove usage, the Dietary Manager indicated appropriate length of time to wash hands was 20 seconds or more. The Dietary Manager indicated disposable gloves should be changed every time a task is changed. On 11/19/12 at 8:56 a.m., during interview of proper hand washing technique and disposable glove		monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; and A4: Dining Service Manager to complete one observation per meal twice weekly. Manager will observe, reinforce and correct as needed. Service notes will be kept and reviewed for trends and results to be reported to Quality of Care monthly and MDQI quarterly. Further action plans to be implemented as decided upon by committee. Q5: By what date the systemic changes will be completed; A5. December 19, 2012	

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	usage, Chef #4 indicated appropriate length of time to wash hands was 20 seconds. Chef #4 indicated disposable gloves should be changed after preparing meat or changing work stations. Chef #4 indicated hands should be washed between changing disposable gloves. On 11/19/12 at 8:58 a.m., during interview of proper hand washing technique and disposable glove usage, Cook #5 indicated appropriate length of time to wash hands was 30 seconds or more. Cook #5 indicated disposable gloves should be changed after preparing meats, vegetables and or changing work stations. Current facility policy "Plastic Gloves for Food and Nutrition Service," received from the Dietary Manager and reviewed on 11/19/12 at 2:00 p.m., indicated "...If, when wearing gloves, food handlers touch their person or other structures not directly involved in what they are doing, gloves must be changed and hands washed before putting on new gloves." 3.1-21(i)(3)			

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F0431 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 ensure narcotic medicine was disposed of in the presence of two	F0431	Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A1: No resident was affected.	12/19/2012

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	licensed nurses. This potentially affected 1 of 1 resident who had their narcotic medicine disposed of improperly in a sample of 13 residents who were ordered narcotics in the second floor Rehabilitation hall. (Resident #84) Findings Include: During medication pass observation on 11/16/12 at 10:55 A.M., RN #8 was removing one Norco tablet (medicine for pain) from the medicine blister pack for Resident #84, when it fell onto the top of the med cart. Employee #7 (Educator) placed medicine in a medicine cup and walked into the shower room, which was behind RN #8. Employee #7 stepped behind a closed shower curtain to look for a toilet to flush the medicine but had gone into a shower stall with no toilet. Employee #7 came back out from behind the shower curtain and stepped behind another closed curtain to look for a toilet to flush the medicine. RN #8 was walking into the shower room as Employee #7 flushed the toilet behind the closed shower curtain. Interview with RN #11 (Unit Manager) on 11/15/12 at 2:50 P.M. indicated narcotic wasting is done with two		Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2. None; no negative outcomes. Q3: What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3. Inservice licensed nurses of current policy on medication destruction.Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; A4: Director of Education and/or designee will complete medication pass review with five percent of licensed nurses weekly. Competency will be documented for compliance for data collection. Data will be presented monthly to Quality of Care and MDQI quarterly for six months. Will be re-evaluated by MDQI Committee in six months.Q5: By what date the systemic changes will be completed; A5. December 19, 2012	

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	licensed nurses. Current facility policy for "Disposal of Medications," received from the Assistant Director of Nursing and reviewed on 11/19/12 on 4:00 P.M., indicated "...these controlled substances shall be disposed of by the nursing care center in the presence of...two licensed nurses...." 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 observation, interview and record review, the facility failed to	F0441	Q1: What corrective action(s) will be accomplished for those	12/19/2012

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	ensure staff washed their hands appropriately while passing medications. This deficient practice potentially affected 4 of 18 residents observed during medication pass. (Residents #71, #41, #53, and #10). Findings include: On 11/16/12 at 9:15 A.M., LPN #6 was observed after she gave Resident #71 her medications. She went into the bathroom and washed her hands for 12 seconds. On 11/16/12 at 9:30 A.M., LPN #6 was observed after she gave Resident #41 her medications. She went into the bathroom and washed her hands for 10 seconds. On 11/16/12 at 9:40 A.M., LPN #6 was observed after she gave Resident #53 her medications. She went into the bathroom and washed her hands for 9 seconds. On 11/20/12 at 9:15 A.M., LPN #6 was observed after she gave Resident #10 her medications. She went into the bathroom and washed her hands for 12 seconds. During an interview on 11/6/12 at 10:55 A.M., Employee #7 (Educator)		residents found to have been affected by the deficient practice; A1: No resident was affected. Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; A2: None; no negative outcomes. Q3: What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur; A3: Policy revised by clinical team to reflect the current 20 second hand washing CDC guideline recommendation. Inservice all associates with demonstration and return demonstration on hand washing. Management team member to provide associate with post test and competency review for hand washing and glove usage. Associate to complete hand washing and glove usage quiz. Incorporate current CDC guidelines into new hire orientation. Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; A4: The Director of Education and/or designee will evaluate and monitor hand washing by using glo-germ and return demonstration. Competency checklist will be utilized to document compliance for data collection. Data will be presented monthly to Quality of	

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	indicated facility policy, and the way she teaches staff, was to wash hands for 15 seconds. Current facility policy for "Hand Hygiene in the Long Term Care Setting," received from the Assistant Director of Nursing and reviewed on 11/19/12 at 4:00 P.M., indicated "...Wash well under running water for a minimum of 15 seconds...." 3.1-18(l)		Care and MDQI quarterly for six months. Will be re-evaluated by MDQI Committee in six months.Q5: By what date the systemic changes will be completed; A5. December 19, 2012	
R0000	These state residential findings are cited in accordance with 410 IAC 16.2-5.	R0000	This Plan of Correction constitutes the wriiten allegation of compliance for the defeciencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.Sanctuary at St. Paul's respectfully requests the Plan of Correction and supporting documentation be considered for desltop review.We declare date of compliance of December 19, 2012.	

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R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview, observation and record review, the facility failed to ensure a resident was free from neglect while being transported in the facility van, resulting in the resident falling over in her wheelchair and sustaining a fracture. This deficiency affected 1 of 1 resident who received a fractured finger in a sample of 8. (Resident #50) Findings include: The record of Resident # 50 was reviewed on 11/19/12 at 9:00 a.m., and indicated Resident # 50's diagnoses included, but were not limited to, congestive heart failure, chronic obstruction pulmonary disease, asthma, and cardiac pacemaker. Review of an "Unplanned Occurrence Report," received from the Assistant Director of Nursing on 11/19/12 at 9:30 a.m., indicated on 11/6/12 at	R0052	Q1: What corrective action(s) will be accompkished for those residents found to have been affected by the deficient practice:A1: Wheelchair used for transport is no longer avaible for use.Q2: How other residents having the potential to be affected by the same practice will be identified and what corrective action(s) will be taken:A2: An audit of all wheelchairs was conducted. No wheelchairs identified had the straight bar.Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur;A3: The Assisted Living Director completed a demonstration/return demonstration on 11/6/2012 with Van Driver #2. All van drivers were inserviced on van safety and proper securing techniques of wheelchairs in the vans. Q4: How the corrective action(s) will be monitored to ensure that the deficient practice will not recur ie., what quality assurance program will be put into place;A4: Quarterly competencies will be completed for each van driver by	12/19/2012

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	1:45 p.m., Resident #50 had been transported to a Physician's appointment in the facility van by Van Driver #2. The report further indicated Van Driver #2 had slammed on the van brakes to avoid an accident and the resident's "...wheelchair tipped backwards and landed on the floor..." The resident indicated she had finger pain. The Van Driver #2 indicated he had strapped the resident's wheelchair in like he always did using the 5 point harness system with the wheelchair brakes engaged. The report further indicated "all harnesses and brakes were still connected/engaged when WC (wheelchair) tipped over." The re-enactment indicated all the harnesses and the wheelchair brakes were found to be in proper working condition. The Assisted Living Director indicated during the investigation of the incident "... where the front of the harnesses were placed allowed them (the harness) to slide backward approximately 6 inches then with the force of the slamming of the van brakes, allowed the wheelchair to tip backwards." The report also indicated the "...hook was placed on straight bar with no stopping point other than the back of the w/c." The report further indicated the Assisted Living Director had		the Director of Environemental Services and or designee. Van drivers will be educated immediately for any item that is not completed correctly during the competency. Data obtained from the compentency will be summarized and reported to the MDQI Committee quarterly.Q5: By what date the systemic changes will be completed:Q5: November 20, 2012.	

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	instructed Van Driver #2 "...in the proper way to strap that particular wc in to avoid any further issues." The Radiology Report dated 11/6/12, indicated the resident had a displaced middle phalanx (finger) oblique fracture. On 11/19/12 at 10:30 a.m., in an interview with Van Driver #2 in regard to the incident with Resident #50, he indicated he had always strapped the residents he transports with the 5 point harness system and had never had a problem in the past. The van driver further indicated he would never use this wheelchair again because of the incident that had occurred. On 11/19/12 at 10:45 a.m. an interview with the Housing Administrator indicated the wheelchairs are inspected every month. The Housing Administrator indicated he had been unable to locate this wheelchair involved in this incident. On 11/19/12 at 11:00 a.m., Resident #50's third and fourth fingers on her left hand were observed buddy-taped together and the resident had no complaints of pain.			

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to maintain equipment free of hazards by using pillows on an air mattress as an intervention to protect a resident from falls and siderail hazards. This had the potential to adversely affect the health and welfare of 1 of 8 sampled residents. (Resident #126). Findings include: Clinical record review on 11/19/12 at 9:30 A.M. for Resident #126 indicated diagnoses included, but were not limited to, dementia, depression, and macular degeneration. The nurses	R0148	: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;A1: No injury or negative outcome for resident #126. Manuafacturers recommendations for the Select Air Bed was obtained and reviewed. Based on the manufacturers information, the use of pillows is NOT contraindicated with this bed. The residents weight is 88.8lbs and according to the manufacturers recommendations the correct comfort level is 4. The bed is set to 4. The bed was checked by the Therapy One Technician. Bedrails were discontinued. (see attachement	12/19/2012

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	notes from 5/13/12 to 11/12/12 documented Resident #126 had falls on 6/15/12, 8/2/12, 9/29/12, and 10/21/12. All falls were from the bed to the floor. The nurses notes on 8/2/12 indicated "Entered room noted resident sitting on floor with left arm on bed between mattress and side rails..." During an interview with Unit Manager of Shepherd Memory Unit on 11/19/12 at 9:45 AM, she indicated they began using pillows next to Resident #126 to protect her from injury from falls or side rails. During an observation of Resident #126 on 11/19/12 at 9:55 AM, she was observed sleeping on an air mattress in a low bed position with an extra pillow on her right side. When pressed, the air mattress was observed to have give to it. During another interview with Unit Manager of Shepherd Memory Unit on 11/20/12 at 10:20 AM, she stated she vaguely remembers the air of Resident #126's mattress was reduced in an attempt to prevent falls. She stated Resident #126 seemed to "bounce" from the mattress. No documentation was found to either confirm nor deny the reduction in air		with manufacturers recomendation.)Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A2: No other residents were affeted. No negative outcome.Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;A3: Equipment provider to submit manuafacturers recommendations to Administratior and or/DON prior to equipment being set up for any resident. The information will be reviewed and education will be provided to our staff prior to use. A log will be kept to identify third party equipment and special instructions. A meeeting with Hospice is scheduled to discuss an educational plan for their clinical staff to meet standards regarding third party equipment recomendations.Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assuance program will be put into place;A4: The log will be reviewed monthly by the Admministrator and Executive Director. Data will be summarized and presented at the quarterly MDQI Committee for further recommendations.Q5: By what date the systemic changes will be completed;A5: 12/19/2012	

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	pressure from the mattress. She stated pillows were placed on the side Resident #126 was facing. During an observation on 11/20/12 at 10:30 AM, Resident #126 was observed sleeping leaning to the right with her head on a pillow with two additional pillows between her and the siderail, one next to her face and the other one next to her torso area. During an interview with Employee # 13 (from the company providing and maintaining the air mattress), he indicated he was unaware of falls or any safety issue with the siderails regarding Resident #126. He indicated the air pressure of the mattress is set to the weight of the individual resident and if this is adjusted, the therapeutic benefits are lost. He indicated he would recommend a new mattress assessment for Resident #126 due to falls and her arm being stuck between mattress and siderail on 8/2/12. He indicated siderail pads could be provided at minimum to address siderail safety issues and potentially a different mattress would decrease her fall risk. He said he would not recommend pillows as a safety precaution on an air mattress.			

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	During an interview on 11/20/12 at 2:45 PM with Clinical Director of the contracted Hospice provider, she indicated they were not notified of the falls on 9/29/12 or 10/21/12 but did a Fall Risk Assessment on 8/2/12. She said if there was any concern about the mattress the vendor should have been contacted. She stated they did not implement the use of pillows as a safety precaution and was unaware of their use on Resident #126's bed.			

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observations and interviews, the facility failed to ensure kitchen areas, common dining areas, and equipment were free from excessive wax buildup on tile floor, chipped glass splash guard on tray line, dirty stainless steel on the tray line and ice machine, drink machines free from standing juice and coffee overrun, and base boards clean and free from dirt and scuff marks. This had the potential to affect 56 residents out of 126 who reside in the residential facility. Findings include: During a dining room tour on 11/15/12 at 11:00 a.m. with the Dietary Manager, the following was observed: 1. Vineyard Dining Room: a. The tile floor was streaky and sticky. b. The splash guard on the steam tray had substantial dried splatter and was chipped on lower left area. c. The stainless steel along the tray	R0154	Q1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;A1: No resident was affected.Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A2: No residents were affected. No negative outcomes.Q3: What measures will be put into place or what systemic changes will be made to ensure that the defcient practice does not reoccure;A3: The Dining Room cleaning list has been updated to reflect identified areas. Daily cleaning has been increased from one time per day to two times per day. The floor is to be stripped and on a quarterly rotation. Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur i.e., what quality assurance program will be put into place;A4: Dining Room Manager to audit floors 3 days per week for each meal and document on the log. Data will be reviewed monthly by the Director of Dining Services to identify trends and implement action plans as necessary. Data	12/19/2012

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	line was dirty with smudges and fingerprints. d. The stainless steel and baseboard below the serving line had scuffs, dirt, and rust. e. The juice machine and coffee dispenser had standing liquid overflow and splatter. f. The base boards surrounding and the door of the dirty dish storage area was scuffed and splattered. 56 residents reside on this unit. On a follow up tour on 11/16/12 at 10:50 AM, with the Dietary Manager, the following was observed: 1. Vineyard Dining Room a. The tile floor remained sticky. During an interview on 11/16/2012 at 11:15 AM with the Dietary Manager, she indicated the tile floor was 6 years old, a request to have the floor replaced had been made, and though the floor was to be cleaned nightly, it was probably sticky due to the cleaner used by Housekeeping staff and she would contact them to resolve the issue.		will be summarized and presented to the MDQI Committee quarterly.Q5: By what date the systematic changes will be completed:A5: 12/19/2012	

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observations and interviews, the facility failed to ensure safe food storage by storing opened food items in 2 refrigerators and 1 freezer in 2 dining areas without dating the items. This had the potential to affect 109 residents of 126 that reside in the facility. Findings include: During a dining room tour on 11/15/12 at 11:00 a.m. with the Dietary Manager, the following was observed: 1. Vineyard Dining Room: a. An opened bag of spinach was undated in the freezer. 56 residents reside on this unit. Upon interview on 11/15/12 at 11:25 AM with the Dietary Manager, she agreed the item should have been dated. She threw the bag of spinach away immediately. During an additional dining room tour on 11/16/12 at 10:50 AM with the Dietary Manager, the following was	R0273	: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;A1: No resident was affected.Q2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;A2: No residents were affected. No negative outcomes.Q3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur;A3: An in-service will be held with all staff members in regards to proper food storage as it relates to proper dating procedures. A notice will be posted on all freezer and refrigerator units in the dining rooms to remind staff of these policies.Q4: How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur i.e., what quality assurance program will be put into place;A4: Dining Room Manager and or designee will check cold storage areas for compliance with dates 3 days per week for each meal and document on the log.Data will be reviewed monthly by the Director	12/19/2012

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	observed: 1. Vineyard Dining Room a. An opened bag of shredded carrots was undated in the refrigerator. b. An opened bag of cubed cheese was undated in the refrigerator. During an interview on 11/16/2012 at 11:15 AM with the Dietary Manager, she indicated the items should have been dated and immediately threw the items away. During a dining room tour on 11/16/12 at 11:30AM with the Dietary Manager, the following was observed : 1. Assisted Living Dining Room Floor 3 a. A hot dog wrapped in cellophane was undated. 53 residents reside on this floor. During an interview on 11/16/12 at 11:40AM with the Dietary Manager, she indicated the hot dog should have been dated and threw it away immediately.		of Dining Services to identify trends and implement action plans as necessary. Data will be summarized and presented to the MDQI Committee quarterly.Q5: By what date the systemic changes will be completed:A5: December 19, 2012.	