STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155792		07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00177072, IN00177229, IN00177594, IN00177696, IN00177894, and IN00178526. Complaint IN00177072 - Substantiated, Federal/State deficiency related to the allegations is cited at F 328. Complaint IN00177229 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00177594 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00177696 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00177894 - Substantiated, Federal/State deficiencies cited at F 241, F 282, F 315, F 323, and F 441. Complaint IN00178526 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: July 21, 22, 23, 24, 2015	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after August 14, 2015.	

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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	Facility number: 012534 Provider number: 155792 AIM number: 201028420 Census bed type: SNF: 6 SNF/NF: 122 Total: 128 Census payor type: Medicare: 14 Medicaid: 85 Other: 29 Total: 128 Sample: 12 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure a dignified living environment by posting a sign with resident care needs in a shared bathroom for 1 of 3 residents reviewed for dignity (Resident K).	F 0241	**F241 – Dignity and Respect of Individuality** It is the intent of this provider to promote care for allr esidents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **What**	08/14/2015

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	Finding includes: During an observation on 7/21/15 at 9:30 a.m., Resident K's roommate was present in the room and reading a book. The roommate indicated she and Resident K shared the restroom. A sign posted in a shared resident bathroom indicated, "To all staff please make sure that you all her [Resident K] to wipe her bottom overtime after using the bathroom especially after a B.M. [bowel movement]. Her hands are contracted and she cannot do it herself." Resident K's record was reviewed on 7/21/15 at 4:00 p.m. Diagnoses included, but were not limited to, aphasia (communication disorder) and hemiplegia. A Minimum Data Set (MDS) assessment, dated 4/29/15, indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The MDS assessment indicated Resident K required extensive assistance with toileting. During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing (DON) indicated she was unaware a sign was posted in Resident K's bathroom and indicated signs regarding resident care should not have been posted in a location		**corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** The sign posted in the bathroom of resident K was removed. The resident profile was reviewed and updated **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** Residents that share a bathroom have the potential to be affected by the same alleged deficient practice. The department managers will visit all resident rooms and remove any signs that are in violation of the residents' rights. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** All staff will be educated on the rights of the residents residing in the facility by the Clinical Education Coordinator. The Customer Care Representatives will complete resident room rounds daily to ensure other signs are not hung. Certified Nursing Assistants will use resident profiles to learn resident specific information. **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**	

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	where it could be read by other people. A Resident Rights policy, dated 1/2006, and identified as current by the DON, indicated, "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...." This federal tag relates to Complaint IN00177894. 3.1-3(t)		**into place** The Social Services Director/designee will complete the Dignity and Privacy CQI tool weekly x four, bi-monthly x two months, and quarterly thereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow a plan of care for repositioning every 2 hours and providing incontinence care when needed for 2 of 3 residents reviewed for plan of care (Residents B and K). Findings include: 1. During an observation on 7/21/15 at	F 0282	**F282 – Services byqualified persons/per care plan** It is the intent of this facility to provide or arrange services using qualified persons in accordance with each resident's written plan of care. **What corrective action(s)will be accomplished for those residents found to have been affected by the alleged deficient practice?** The plans of care for resident B and K were reviewed by the Interdisciplinary	08/14/2015

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	8:55 a.m., Resident B's eyes were closed and she was lying in bed on her back. The head of the bed was elevated 45 degrees. During an observation on 7/21/15 at 10:20 a.m., Resident B was lying in bed on her back with her eyes closed. The head of the bed was elevated 45 degrees. On 7/21/15 at 11:50 a.m., Certified Nurse Aide (CNA)s #1 and #2 indicated they planned to move Resident B from her bed to a Broda chair (tilt and recline positioning chair) via a Hoyer lift (mechanical lift). A moisture proof pad under the resident's buttocks was saturated with urine. Incontinence care was provided prior to moving the resident to the chair. Resident B was placed in the Broda chair in a semi reclined position and transported via the Broda chair to the dining area at 12:30 p.m. During dining observations on 7/21/15 from 12:30 p.m.-1:55 p.m., Resident B's seated position remained semi reclined. The resident was returned to her room at 1:55 p.m. and remained in the Broda chair. During an observation on 7/21/15 at 3:49 p.m., Resident B was in sitting in the Broda chair in a semi-reclined position.		team. The profiles for resident B and K were updated. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** All residents requiring assistance with turning and repositioning and incontinence care have the potential to be affected the alleged deficient practice. Certified Nursing Assistants will receive education on turning and repositioning and incontinence care. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** The Clinical Education Coordinator will complete education for turning and repositioning and incontinence care with the Certified Nursing Assistants during orientation, quarterly, and as needed throughout the year. **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** The Clinical Education Coordinator/designee is responsible for completing the Resident Care Rounds CQI tool weekly x four, bi-monthly x two months, and quarterly thereafter for six months. The results of these audits will be reviewed by	

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	Her seated position was the same as when she was transferred to the chair at 11:50 a.m. A Hoyer lift was used to return the resident to bed for incontinence care. The incontinence brief was saturated with urine During an interview on 7/21/15 at 3:55 p.m., CNA #4 indicated Resident B had been seated in the chair since lunch and indicated her incontinence brief was wet. Resident B's record was reviewed on 7/21/15 at 3:30 p.m. Diagnoses included, but were not limited to, dermatitis, urinary tract infections, and dysphasia, (swallowing difficulties). A care plan for risk for skin breakdown, dated 3/20/2013 and updated, 6/10/2015, indicated interventions of turn and reposition at least every 2 hours and incontinence care as needed. During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing indicated staff should check a resident who cannot turn on their call light for incontinence every few hours. During an interview on 7/23/15 at 2:01 p.m., the Director of Nursing (DON) indicated Resident B's care plan should have been followed for repositioning.		the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance.	

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	2. During an observation on 7/21/15 at 10:30 a.m., Resident K was observed in a wheelchair in her room. The resident pointed to an assistive communication device on her bed. The device was handed to the resident and she began pushing icons. The resident indicated she needed to go to the bathroom and turned her call light on at 11:15 a.m. The call light was answered at 11:30 a.m. CNA #1 took Resident K to the restroom. CNA #1 transferred Resident K from the wheelchair to the toilet and removed her urine saturated incontinence brief. The CNA told the resident to turn her light on when she was ready to get off the toilet and left the room. CNA #3 responded to the call light and asked Resident K if she was finished on the toilet. The CNA did not wash her hands prior to donning gloves and wiping the resident's perineal area with toilet tissue. The resident's perineal area was not cleansed and a barrier cream was not applied. A clean incontinence brief was placed. The CNA put Resident K's slacks on her and pushed the wheelchair to the sink to allow the resident to wash her hands. During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing (DON) indicated pericare should have been provided when a resident was			

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	incontinent. Resident K's record was reviewed on 7/21/15 at 4 p.m. A Minimum Data Set (MDS) assessment, dated 4/29/15, indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. A care plan for risk for skin breakdown, dated, 4/23/15, and updated 5/13/15, indicated, "...Incontinent care as needed using peri wash and moisture barrier...." An "IDT (Interdisciplinary Team) Care Plan Review" policy, dated 4/2014, and identified as current by the DON, indicated, "...Care plan interventions/changes impacting care provided by CNA's will be communicated to CNA via verbal report and/or Resident Profile...." This federal tag relates to Complaint IN00177894. 3.1-35(g)(2)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive			

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	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 observation, interview, and record review, the facility failed to ensure services were provided to prevent moisture associated skin damage and the possibility of infections for 2 of 3 residents observed for incontinence care (Residents B and K). Findings include: During an observation on 7/21/15 at 8:55 a.m., Resident B's eyes were closed and she was lying in bed on her back. The head of the bed was elevated 45 degrees. During an observation on 7/21/15 at 10:20 a.m., Resident B was lying in bed on her back with her eyes closed. The head of the bed was elevated 45 degrees. On 7/21/15 at 11:50 a.m., Certified Nurse Aide (CNA)s #1 and #2 indicated they planned to move Resident B from her bed to a Broda chair (tilt and recline positioning chair) via a Hoyer lift (mechanical lift). Incontinence care was	F 0315	**F315 No Catheter,Prevent UTI, Restore Bladder** It is the intent of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's critical 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. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** The plans of care for resident B and K were reviewed by the Interdisciplinary team. The profiles for residents B and K were updated. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** All residents who require assistance with incontinence care have the potential to be affected by this	08/14/2015

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	provided prior to moving the resident to the chair. CNA) #1 did not wash her hands prior to donning gloves and assisting with incontinence care. The CNA pulled the resident's privacy curtain with her gloved hands, then removed a urine saturated moisture proof pad from under the resident's buttocks. CNA #1 removed her gloves and did not sanitize her hands before donning another pair. The CNA cleansed the resident's front portion of the perineal area, then assisted the resident onto her right side. CNA #2 cleansed the back side of the perineal area. The CNA wiped from the front of the perineal area towards the anus twice, using the same portion of the washcloth. CNA #2 did not change her gloves after cleansing the skin and applied a skin protectant cream over a red rash on the resident's buttocks. An incontinence brief was applied and the resident was placed in a Broda chair (tilt and recline positioning chair) via a Hoyer lift (mechanical lift). At 12:30 p.m., the resident was taken to the dining room. The resident was returned to her room at 1:55 p.m. and remained seated in the Broda chair. During an observation on 7/21/15 at 3:49 p.m., Resident B was in sitting in the Broda chair in a semi-reclined position. Her seated position was the same as		alleged deficient practice. Certified Nursing Assistants will be educated on providing incontinence care to residents. **What measures will beput into place or what systemic changes you will make to ensure that thealleged deficient practice does not recur** The Clinical Education Coordinator will complete incontinence care skills check offs with the Certified Nursing Assistants during orientation,quarterly, and as needed throughout the year. **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** The Clinical Education Coordinator/designee is responsible for completing the Resident Care Rounds CQI tool weekly x four, bi-monthly x two months, and quarterly thereafter for six months. The results of these audits will be reviewedby the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance.	

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	when she was transferred to the chair at 11:50 a.m. A Hoyer lift was used to return the resident to bed for incontinence care. The incontinence brief was saturated with urine During an interview on 7/21/15 at 3:55 p.m., CNA #4 indicated Resident B had been seated in the chair since lunch and indicated her incontinence brief was wet. Resident B's record was reviewed on 7/21/15 at 3:30 p.m. Diagnoses included, but were not limited to, dermatitis, urinary tract infections, and dysphasia (swallowing difficulties). A care plan for risk for skin breakdown, dated 3/20/2013 and updated, 6/10/2015, indicated interventions of turn and reposition at least every 2 hours and incontinence care as needed. A progress note, dated 7/21/15 indicated, " Right buttock moisture area noted." A physician's order, dated 7/21/15 indicated, " Apply Peleverus cream to buttock every shift." A physician's order, dated 7/21/15, Indicated, "Apply Peleverus cream to buttock as needed.."			

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	During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing indicated staff should check a resident who cannot turn on their call light for incontinence every few hours. 2. During an observation on 7/21/15 at 10:30 a.m., Resident K was observed in a wheelchair in her room. The resident pointed to an assistive communication device on her bed. The device was handed to the resident and she began pushing icons. The resident indicated she needed to go to the bathroom and turned her call light on at 11:15 a.m.. The call light was answered at 11:30 a.m. CNA #1 took Resident K to the restroom. CNA #1 transferred Resident K from the wheelchair to the toilet and removed her urine saturated incontinence briefs. The CNA told the resident to turn her light on when she was ready to get off the toilet and left the room. CNA #3 responded to the call light and asked Resident K if she was finished on the toilet. The CNA did not wash her hands prior to donning gloves and wiping the resident's perineal area with toilet tissue. The resident's perineal area was not cleansed and a barrier cream was not applied. A clean incontinence brief was placed. The CNA put Resident K's slacks on her and pushed the wheelchair to the sink to allow the resident to wash her hands.			

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	During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing (DON) indicated pericare should have been provided when a resident was incontinent and indicated Resident K's record was reviewed on 7/21/15 at 4 p.m.. A Minimum Data Set (MDS) assessment, dated 4/29/15, indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The assessment indicated Resident K required extensive assistance with toileting and was totally dependent on assistance for hygiene. A care plan for risk for skin breakdown, dated, 4/23/15, and updated 5/13/15, indicated, "...Incontinent care as needed using peri wash and moisture barrier...." A "Perineal Care" policy, dated 3/2012, and identified as current by the DON, indicated, "...2. Provide for privacy 3. Wash hands. 4. Put on gloves..."...9. Wet and soap folded wash cloth...13. Wash between and outside labia in downward strokes. 14. Alternate from side to side-wipe from front to back ad from center of perineum outward...15. Use a clean area of the wash cloth with each wipe. Do not rewipe are, unless using a clean area of the wash cloth. Change wash cloth as			

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	needed...." This federal tag relates to Complaint IN00177894. 3.1-41(a)(2)			
F 0323 SS=D Bldg. 00	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 a safe mechanical lift transfer for 1 of 1 resident reviewed for accidents and hazards (Resident B). Finding includes: On 7/21/15 at 11:50 a.m., Certified Nurse Aide (CNA)s #1 and #2 indicated they planned to move Resident B from her bed to a Broda chair (tilt and recline positioning chair) via a Hoyer lift (mechanical lift). The Hoyer sling was placed under Resident B and the hooks attached. CNA #1 operated the lift controls and raised the resident 2 feet above the bed. CNA #2 supported the resident's lower extremities while the lift	F 0323	**F323 –Free of Accident Hazards/Supervision/Devices** It is the intent of this provider to 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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The plans of care for resident B and K were reviewed by the Interdisciplinary team and the profiles were updated. Certified Nursing Assistants were educated on mechanical lifts. **How other residents having the potential to be affected by the same deficient practice will be**	08/14/2015

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123	

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	was being raised. Once the resident was raised from the bed, the Hoyer was moved from over the bed to the middle of the room. The resident was suspended above the hard surface floor. CNA #1 remained positioned behind the lifts controls. CNA#2 walked away from the resident and retrieved Resident B's Broda chair from the corner of the room. The resident was suspended in air without a "spotter" to ensure stability and safety for 1 minute while the CNA retrieved and positioned the Broda chair near the lift. The resident was moved over the Broda chair and lowered into the chair. During an interview on 7/21/15 at 12:00 p.m., CNA #2 indicated she usually supported the resident while in the sling, but forgot to move the chair before the resident was raised with the lift. During an interview on 7/21/15 at 3:49 p.m., CNA #5 indicated Resident B recently rolled out of bed over bolsters and scraped her left knee. During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing (DON) indicated two staff were required for Hoyer transfers and indicated the CNA should not have left the resident suspended in air without a "spotter" to ensure safety.		**identified and what corrective action(s) will be taken:** All residents requiring assistance of a mechanical lift for transfers have the potential to be affected by the alleged deficient practice. All staff will receive education on mechanical lifts by the Clinical Education Coordinator. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All Certified Nursing Assistants will receive education on using mechanical lifs upon hire, quarterly, and as needed throughout the year. **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 in place:** The Director of Nursing/designee is responsible for completing the Mechanical Lift Transfer CQI tool weekly x four, bi-monthly x two months,and quarterly thereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	Resident B's record was reviewed on 7/21/15 at 3:30 p.m. A Minimum Data Set (MDS) assessment, dated 6/1/15, indicated Resident B required extensive assistance for transfers. A care plan for self care deficit, dated 3/20/13, and updated 6/10/15, indicated Resident B required a Hoyer lift with transfers. A "Mechanical Lift" policy, dated 3/2012, and identified as current by the DON, indicated, "...One staff should guide resident as other staff operates the lift...." This federal tag relates to Complaint IN00177894. 3.1-45(a)(2)			
F 0328 SS=D Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;			

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	Respiratory care; Foot care; and Prostheses. Based on record review and interview, the facility failed to ensure a BiPAP (bilevel positive air pressure) machine was ordered and utilized for a new resident to the facility who was to use a BiPAP at night for 1 of 3 residents reviewed for respiratory needs (Resident D). Findings include: The record for Resident D was reviewed on 7/22/15 at 1:45 p.m. Resident D's diagnoses included, but were not limited to, ischemic heart disease, asthma, acute respiratory failure, and cerebral thrombosis with infarction. The hospital History and Physical, dated 4/30/15, indicated the patient had been requiring BiPAP most of the day prior to admission due to her respiratory status. The hospital discharge summary, dated 4/30/15, indicated "p.r.n. (as needed) BiPAP at night." A form titled "[facility name] Admission Alert" in the resident's record indicated under "Special Needs" the need for BiPAP with humidifier.	F 0328	**F328 –Treatment/Care for Special Needs** It is the intent of this provider to ensure that residents receive the proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, Ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory Care; Foot Care; and Protheses. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will betaken:** All new residents requiring a BiPap machine have the potential to be affected by this alleged deficient practice. Licensed Nurses were educated on reviewing admission orders and ordering equipment for residents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nurses were educated on admission orders and ordering equipment for residents by the Clinical Education Coordinator. The licensed nurses will review	08/14/2015

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	The May, 2015, Recapitulation of Admission Physician Orders did not indicate an order for a BiPAP machine or its use. The May, 2015 MARs (Medication Administration Records) did not indicate the use of a BiPAP machine. During an interview with Resident D's family member on 7/21/15 at 10:40 a.m., the family member indicated the family had asked a nurse about the BiPAP machine and when would it be there. The family member indicated the unidentified nurse's response was "it's a long weekend." The family member indicated the facility never got a BiPAP machine for Resident D. During an interview with the DNS (Director of Nursing Services) on 7/23/15 at 9:15 a.m., she indicated she was unable to find evidence a BiPAP machine had been ordered or used for Resident D. She also indicated at her previous facility if a BiPAP machine could not be obtained prior to a resident's admission, the admission would not be accepted, or the family frequently offered to bring the machine from home until one could be obtained by the facility. She indicated she did not know why that was not done		admission orders with the primary care physician upon admission and order needed equipment at the time of admission. The Interdisciplinary team will review the admission orders the next business day to ensure orders are correct and necessary equipment has been received. **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 in place:** The Director of Nursing will complete the Admission/Readmission Procedure CQI tool weekly times four, bi-monthly times two months and quarterly thereafter for six months. The Medical Records Nurse/designee is responsible for completing the Post Admission Review tool weekly x four,bi-monthly x two months, and quarterly thereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance.	

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	in this facility, and it was her expectation that it would be done. This federal tag relates to Complaint IN00177072. 3.1-47(a)(6)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.			

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	(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 ensure adequate hand sanitation for 2 of 3 residents reviewed for infection control during incontinence care (Resident K and B). Findings include: 1. During an observation on 7/21/15 at 10:30 a.m., Resident K was observed in a wheelchair in her room. The resident pointed to an assistive communication device on her bed. The device was handed to the resident and she began pushing icons. The resident indicated she needed to go to the bathroom and turned her call light on at 11:15 a.m.. The call light was answered at 11:30 a.m. CNA #1 took Resident K to the restroom. CNA #1 transferred Resident K from the wheelchair to the toilet and removed her urine saturated incontinence briefs. The	F 0441	**F441 – Infection Control, Prevent Spread, Linens** It is the intent of this provider to establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All nursing staff were educated on the hand washing procedure. **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:** All residents have the potential to beaffected by this alleged deficient practice. The Clinical Education Coordinator completed Handwashing skills check off with all staff. **What measures will be put into place or what**	08/14/2015

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	CNA told the resident to turn her light on when she was ready to get off the toilet and left the room. CNA #3 responded to the call light and asked Resident K if she was finished on the toilet. The CNA did not wash her hands prior to donning gloves and wiping the resident's perineal area with toilet tissue. 2. On 7/21/15 at 11:50 a.m., Certified Nurse Aide (CNA)s #1 and #2 indicated they planned to move Resident B from her bed to a Broda chair (tilt and recline positioning chair) via a Hoyer lift (mechanical lift). Incontinence care was provided prior to moving the resident to the chair. CNA) #1 did not wash her hands prior to donning gloves and assisting with incontinence care. The CNA pulled the resident's privacy curtain with her gloved hands, then removed a urine saturated moisture proof pad from under the resident's buttocks. CNA #1 removed her gloves and did not sanitize her hands before donning another pair. The CNA cleansed the resident's front portion of the perineal area, then assisted the resident onto her right side. CNA #2 cleansed the back side of the perineal area. The CNA wiped from the front of the perineal area towards the anus twice, using the same portion of the washcloth. CNA #2 did not change her gloves after cleansing the skin and applied a skin		**systemic changes will be made to ensure that the deficient practice does not recur:** All staff were educated and completed hand washing skills check offs with the Clinical Education Coordinator. Skills check offs will be completed upon hire, quarterly, and as needed with staff. **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 inplace:** The Clinical Education Coordinator/designee is responsible for completing the Infection Control Review tool weekly x four, bi-monthly x two months, and quarterly thereafter for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed to ensure compliance.	

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	protectant cream over a red rash on the resident's buttocks. During an interview on 7/22/15 at 4:09 p.m., the Director of Nursing (DON) indicated staff should wash their hands before providing resident care. A "Hand Hygiene" policy, dated 2/2010, and identified as current by the DON, indicated, "...Moment of required hand hygiene: Before patient...." This federal tag relates to Complaint IN00177894. 3.1-18(l) .			