| 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 |
|---|---|---|---|
| | 155712 | | 12/04/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COVERED BRIDGE HEALTH CAMPUS | 1675 W TIPTON ST<br>SEYMOUR, IN 47274 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: November 29, 30, December 1, 2, 3, & 4, 2015<br><br>Facility number: 003342<br>Provider number: 155712<br>AIM number: 200403740<br><br>Census bed type:<br>SNF: 22<br>SNF/NF: 39<br>Residential: 26<br>Total: 87<br><br>Census payor type:<br>Medicare: 14<br>Medicaid: 29<br>Other: 18<br>Total: 61<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>QR completed by 34849 on December 13, 2015. | F 0000 | | |

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

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

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| F 0159<br>SS=B<br>Bldg. 00 | 483.10(c)(2)-(5)<br>FACILITY MANAGEMENT OF PERSONAL FUNDS<br>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.<br><br>The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)<br><br>The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br><br>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br><br>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br><br>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. | | | |

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| | The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br>Based on interview and record review, the facility failed to ensure quarterly statements were sent to the resident's responsible party for 50 of 50 residents who had personal funds accounts managed by the facility.<br><br>Findings include:<br><br>During an interview on 12/01/2015 at 10:12 A.M., Resident #21's family member indicated he had not received a statement for Resident #21's personal funds account for a while.<br><br>During an interview on 12/03/2015 at 2:31 P.M., the BOM (Business Office Manager) indicated Resident #21 did have a personal funds account with the facility. He further indicated the facility sent out statements quarterly, but that he was not sure if the September, 2015 statements were sent out for the 50 residents whom the facility managed their personal funds at that time. | F 0159 | Submission of this plan of correction is not an admission by Covered Bridge Health Campus that the deficiencies alleged in this survey are accurate or depict the quality of services provided to the residents of this health care facility. This plan of correction is submitted timely in accordance with state and federal regulatory guidelines. This plan of correction is intended to serve as the health facility's credible allegation of compliance with state and federal regulatory requirements.<br>1. The third quarterly statement for Resident #21 was generated and mailed December 4, 2015. Resident #21's POA was contacted by phone on 12/23/15 and has received the statement.<br><br>**2.** All other residents have a potential of being affected. Third quarter statements for all residents, including Resident #21, were generated and mailed on 12/22/15. Business Office Manger will call each resident/family to ensure satisfaction with the process by | 01/03/2016 |

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| | During an interview on 12/04/2015 at 9:05 A.M., the ED (Executive Director) indicated none of the quarterly statements were sent out in September, 2015. He further indicated they had just changed systems at that time and the new BOM hadn't known to go back into the old system to send the quarterly statements.<br><br>The current facility policy titled, "Resident Trust Fund Policy" and dated 7/01/2010, was provided by the ED on 12/04/2015 at 9:07 A.M. and reviewed at that time. The policy indicated, "...The campus will ensure residents are notified at least quarterly of their transactions..."<br><br>3.1-6(g) | | 1/3/16.<br><br>**3.** Business Office Manager was re-educated by the Executive Director on 12/4/15. A monthly reconciliation report will ensure that statements are mailed out in a timely fashion.<br><br>**4.** The monthly reconciliation report will be signed by both the Business Office Manager and the Executive Director every month to ensure mailing has been completed. The Executive Director will call a minimum of 5 residents/families quarterly for 6 months to ensure compliance with the process. The results of the audits/interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. A member of the Corporate Clinical Support or Divisional Vice President will attend the next 3 months of QA meetings to review audits and recommendations with the Executive Director, Director of Health Services, and Committee members to ensure the process is thorough and effective. | |
| F 0244<br>SS=E<br>Bldg. 00 | 483.15(c)(6)<br>LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed | | | |

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| | policy and operational decisions affecting resident care and life in the facility. | | | |
| | Based on observation, interview and record review, the facility failed to respond to and resolve the grievances brought forth by the Resident Council in a timely manner, related to response time for call lights being answered, for 7 of 11 months of Resident Council Meeting Minutes reviewed and 1 of 1 Resident Council Meeting observation.<br><br>Findings include:<br><br>The Resident Council Meeting minutes were provided, with the permission of the Resident Council President, by Medical Records on 12/02/2015 at 1:30 P.M. and reviewed at that time. Individual residents were not always identified in the meeting minutes.<br><br>Meeting minutes, dated 11/02/2015, indicated the Resident Council President voiced concerns regarding call lights being turned off before the residents were assisted and also indicated long call light wait times.<br><br>Meeting minutes, dated 09/03/2015, indicated three residents voiced concerns regarding call lights being turned off before the residents were assisted and call lights were hard to find. | F 0244 | **1.** Resident #28 was interviewed on 12/18/15 regarding concerns and stated that improvement has been made with receiving assistance timely and that their needs are being met. Resident #11 was interviewed on 12/23/15 and stated that improvement had been made with call light answering times. Resident #27 attended a care plan with his POA on 12/14/15 and stated improvement had been made addressing his concerns timely and was agreeable to letting whomever answered the call light know that he was the person that needed assistance. Resident #27 was also interviewed by the Director of Health Services on 12/23/15 and he stated there has been improvement with getting assistance timely. Resident #19 was interviewed on 12/15/15 and her call light reaches both her recliner chair and bed. **2.** All other residents have a potential of being affected. DHS,Social Services, Executive Director will interview all interviewable residents to ensure needs are being met timely and any concerns are being addressed. All non-interviewable residents families will be contacted to ensure there are no concerns that require follow up. This will be completed by 12/31/15 and concern forms will be initiated as indicated by policy. **3.** All staff | 01/03/2016 |

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| | Meeting minutes, dated 07/01/2015, indicated a resident voiced concern regarding call lights being turned off before the residents were assisted and a "few" residents indicated they had trouble finding their call lights.<br><br>Meeting minutes, dated 06/03/2015, indicated a resident voiced concerns regarding call lights not being answered in a reasonable amount of time.<br><br>Meeting minutes, dated 05/06/2015, indicated a resident voiced concerns regarding call lights not being answered in a reasonable amount of time.<br><br>Meeting minutes, dated 03/04/2015, indicated Resident #28 voiced concerns regarding call lights being turned off by the CNAs (Certified Nursing Assistants) before residents were assisted.<br><br>Meeting minutes, dated 02/04/2015, indicated Resident #28 voiced concerns regarding "seeing and experiencing call lights being turned off" by the CNAs before residents were assisted.<br><br>During an interview on 12/03/2015 at 1:08 P.M., Resident #11, indicated call lights were not answered in a timely manner and it was irritating. | | re-educated by the Director of Health Services, Executive Director or Nurse designee by 1/3/16 on answering call lights timely, to leave the call light on if the resident's request could not be immediately addressed, and that call lights should also remain within reach of the resident.<br>4.Random call light audits and audits for call light placement will be performed by the Director of Health Services or designee as follows: 20 residents per week for 4 weeks, then 20 residents per month for 2 months, then 20 residents per quarter for one quarter to ensure ongoing compliance. All resident concern forms will be discussed in morning meeting until concern is resolved and follow up has been completed ongoing. The Social Service Director will conduct random interviews with 10 residents weekly for 4 weeks and monthly for 3 months to ensure resident satisfaction with call light response times and to ensure any concerns have been addressed and resolved. The Director of Life Enrichment or Assistant(s) will solicit feedback from the Resident Council monthly for 6 months regarding satisfaction with call light responses and concern follow up, and the Executive Director and Social Services Director will review the council minutes to ensure the issues and follow-up are completed. The results of the | |

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| | A Resident Council meeting was observed on 12/04/2015 at 10:29 A.M. Resident #27 indicated when he pushed his call light, the staff came in and assisted his roommate. He further indicated at times, the staff came in, turned off his call light, said "I'll be back in a minute", and then it's 15 to 20 minutes before the staff get back. Resident #19 indicated her call light did not reach all the way to her chair, the cord was not long enough and within her reach when she was in her recliner.<br><br>An interview was conducted on 12/04/2015 at 11:15 A.M. with Activities Associate #7, who usually conducted the Resident Council meetings. She indicated when an issue came up in a meeting, she filled out a Concern Form, gave it the SSD (Social Services Director), then followed up about a week later. She further indicated the SSD usually followed up with the resident who had the issue. If it was a nursing issue, the SSD issued them [nursing department] a copy of the concern, nursing added the plan of action on the concern form and gave a copy to the Activities Department.<br><br>During an interview on 12/04/2015 at 2:21 P.M., the DON (Director of | | audits/interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. A member of the Corporate Clinical Support or Divisional Vice President will attend the next 3 months of QA meetings to review audits and recommendations with the Executive Director, Director of Health Services, and Committee members to ensure the process is thorough and effective. | |

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| | Nursing) indicated staff had been inserviced regarding call lights and she had discussed it with the Resident Council President. She further indicated she felt the CNAs and other departments had been good about answering call lights.<br><br>An interview was conducted on 12/04/2015 at 2:49 P.M. with the SSD (Social Services Director). The SSD indicated when she gets a concern form from the Resident Council meetings she logged them in the computer, logged them in a binder and a copy of the concern was given to the department head. Then the department head passed it back with their dates and resolution. The SSD updated the information in the computer with the resolution, then it was passed on to the ED (Executive Director). The ED then filled out his part on the computer indicating the issue had been resolved. She also indicated when a repeated issue came up it would be brought up in the morning meeting and discussed in the QAA (Quality Assessment and Assurance) monthly meeting. QAA then discussed the issue to see if they needed to do anything further with it and come up with a plan. She indicated call lights had come up in both meetings and QAA had provided continuing inservices regarding the call | | | |

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| | light issue.<br><br>The "Service Concern Process" policy and procedure was provided by the ED on 12/04/2015 at 1:30 P.M. and reviewed at that time. The process indicated when a concern had occurred more than once the QA (Quality Assurance) team reviewed the data of the concern log and implemented action plans as needed.<br><br>3.1-3(l) | | | |
| F 0353<br>SS=E<br>Bldg. 00 | 483.30(a)<br>SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of | | | |

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| | this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>Based on observation, interview and record review, the facility failed to ensure sufficient staff was available to answer call lights in a timely manner resulting in residents having to wait long periods for assistance for 7 of 25 residents (Resident #2, #11, #19, #27, #28, #61, and #70) and 7 of 9 staff members reviewed and/or interviewed (Staff #20, Staff #21 Staff #22, Staff #23, Staff #24, Staff #25, and Staff #26).<br><br>Findings include:<br><br>During a dining observation on 11/29/2015 at 5:02 P.M., 13 residents were observed eating in the dining room with only Staff #21 present to assist them all.<br><br>During an observation on 12/03/2015 at 10:07 A.M., Resident #2 requested assistance getting off of the toilet by turning on her call light. Staff #22 was observed flipping through the pages of the Medication Administration Record book throughout the time that the call light was beeping. At 10:23 A.M., | F 0353 | **1.** Residents #11 , #19, #27 , #28 ,and #61 ,were interviewed by the Director of Health Services, Social Services Director, or Executive Director to ensure call lights are being answered in a timely matter in order to meet their needs, and the residents reported satisfaction. Residents #2 and #70 are no longer in the facility.<br><br>**2.** All other residents have the potential to be affected. The Executive Director, Director of Health Services, and Staffing Coordinator will meet to review staffing patterns in an effort to ensure staff are best utilized in response to resident's needs. Nursing staff will be educated to notify the on-call supervisor immediately should unexpected vacancies occur during shifts.<br><br>3. All staff will be re-educated by 1/3/16 on call light responsiveness and to leave the call light on if the resident's request could not be immediately addressed. Staffing will be reviewed by the Executive Director, Director of Health Services, or Staffing Coordinator | 01/03/2016 |

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| | Housekeeper #8 walked into the area, walked down the hallway to Resident #2's room and checked on her needs.<br><br>During an observation on 12/03/2015 at 1:10 P.M., there was only one nurse present in the Memory Care Unit. No aide was observed on this unit. There were 13 residents residing on the unit.<br><br>The Resident Council Meeting minutes were provided by Medical Records on 12/02/2015 at 1:30 P.M. and reviewed at that time with the permission of RC (Resident Council) President. The Resident Council Meeting Minutes for the dates of 11/02/2015, 9/03/2015, 07/01/2015, 06/03/2015, 05/06/2015, 03/04/2015, and 02/04/2015, indicated residents had concerns pertaining to receiving assistance in a timely manner and the means to request assistance [call lights out of reach], and Resident #28 voiced concerns regarding call lights being turned off before residents were assisted.<br><br>A Resident Council meeting was observed on 12/04/2015 at 10:29 A.M. Resident #27 indicated when he pushed his call light, the staff came in and assisted his roommate. He further indicated, at times, the staff came in, turned off his call light, said "I'll be back | | daily. The campus will continue to have an on-call to fill in when a staff member is unable to fulfill their work schedule. If the staffing level is determined to be insufficient, the on-call staff member will be notified. In the instance the on-call employee is unavailable, nursing administration will be responsible to ensure adequate staffing numbers to meet residents' needs.<br><br>**4.** As a means of quality assurance and in an effort to ensure that a sufficient amount of staff is present, the Executive Director or designee will complete the staffing PPD daily for 4 weeks, then weekly for 4 weeks, monthly for 2 months, and quarterly until compliance with ensuring sufficient nursing staff is maintained. Daily rounding on scheduled days of work will be conducted by Executive Director, Director of Health Services, or designee in an effort to ensure sufficient staffing as evidenced by timely response to residents' needs.<br>The results of the audits/interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. A member of the Corporate Clinical Support or Divisional Vice President will attend the next 3 months of QA meetings to review | |

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| | in a minute", and then it's 15 to 20 minutes before the staff return. Resident #19 indicated her call light did not reach all the way to her chair, the cord was not long enough and was not within her reach when she was in her recliner.<br><br>During an interview on 11/29/2015 at 4:32 P.M., Staff #20 indicated it had been more common recently that one nurse will float between Assisted Living and the Memory Care Unit. Staff #20 indicated there were 23 residents in the Assisted Living Unit and 13 residents in the Memory Care Unit. The staff member further indicated that falls have happened before because when they [staff] are in a room assisting a resident, they [staff] cannot watch what is going on outside the room. The staff member indicated there were not enough staff to take care of the residents in Memory Care.<br><br>During an interview on 11/29/2015 at 5:53 P.M., Staff #21 indicated recently it was more normal for one person to work on the Memory Care Unit. The staff member further indicated he/she felt like he/she could not get everything done when there was just one person.<br><br>During an interview on 11/30/2015 at 10:46 A.M., Resident #70 indicated staff | | audits and recommendations with the Executive Director, Director of Health Services, and Committee members to ensure the process is thorough and effective. | |

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| | had advised her there was not enough help to get her up since she required two staff members for assistance. Resident #70 further indicated, at times, it had taken over 30 minutes to receive assistance to use the restroom and even longer when she had requested something to drink.<br><br>During an interview on 12/01/2015 9:53 A.M., Resident #61 indicated there had been several occurrences of long wait times for assistance to use the restroom. Resident #61 was not sure of the exact time length, but indicated it was uncomfortable waiting for assistance.<br><br>During a confidential interview on 12/03/2015 at 12:45 P.M., Staff #23 indicated he/she has had to work the floor to cover several call ins. Staff #23 further indicated he/she could not complete his/her own work on those occasions and had to stay late.<br><br>During an interview on 12/03/2015 at 1:08 P.M., Resident #11, indicated call lights were not answered in a timely manner and it was irritating.<br><br>During a confidential interview on 12/03/2015 at 1:09 P.M., Staff #24 indicated it was not safe to have one aide on the Memory Care Unit during meal | | | |

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| | 155712 | | 12/04/2015 |

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| | time [with thirteen residents residing on this unit].<br><br>During a confidential interview on 12/03/2015 at 1:10 P.M., Staff #25 indicated one nurse and one aide can handle the Memory Care Unit on most days, but on hectic days it was very difficult to monitor and assist all the residents.<br><br>During a confidential interview on 12/03/2015 at 1:33 P.M., Staff #26 indicated there were "good and bad workers". Some of the workers can handle the call lights when working short and some staff cannot keep up with the call lights in a timely manner when working short. There are times when the residents have to wait longer then normal.<br><br>The clinical records for Resident #2, #11, #19, #27, #28, #61, and #70 were reviewed on 12/04/2015 at 1:47 P.M. and indicated the following:<br><br>The Quarterly MDS (Minimum Data Set) assessment, dated 08/25/2015, indicated Resident #2 needed extensive assistance of two staff members for toilet use.<br><br>The Quarterly MDS assessment, dated 09/27/2015, indicated Resident #11 | | | |

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| | needed extensive assistance of one staff member for toilet use.<br><br>The Quarterly MDS assessment, dated 09/01/2015, indicated Resident #19 needed extensive assistance of two staff members for physical assistance.<br><br>The Quarterly MDS assessment, dated 10/20/2015, indicated Resident #27 needed extensive assistance of two staff members for physical assistance.<br><br>The Quarterly MDS assessment, dated 10/01/2015, indicated Resident #28 needed extensive assistance of two staff members for physical assistance.<br><br>The Quarterly MDS assessment, dated 08/27/2015, indicated Resident #61 needed extensive assistance of one staff member for toilet use.<br><br>The Admission MDS assessment, dated 10/31/2015, indicated Resident #70 needed extensive assistance of two staff members for toilet use.<br><br>During an interview on 12/04/2015 at 2:21 P.M., the DON (Director of Nursing) indicated staff had been inserviced regarding call lights and she had discussed the issue with the Resident Council President. She further indicated | | | |

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| | she felt the CNAs (Certified Nursing Assistants) and other departments had been good about answering call lights.<br><br>3.1-17(a) | | | |
| F 0371<br>SS=F<br>Bldg. 00 | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation, interview and record review the facility failed to ensure food was stored, prepared and distributed under safe and sanitary food handling conditions related to dish machine cycle temperatures, walk-in refrigerator temperatures, dish washing, sanitizing and drying procedures, cleanliness of food preparation area, proper hand washing, glove use, and uncovered garbage cans for one of one kitchen and two of two dining observations. This deficient practice had the potential to affect 61 of 61 residents who received meals prepared in the facility kitchen.<br><br>Findings include: | F 0371 | **1.** Residents #2, #88, and #53, are no longer in the facility; Residents #7, #34, #114, #74, #61, #51, #64 were assessed for any signs or symptoms of foodborne illnesses every shift from 11/30/15 to 12/4/2015 and no symptoms were identified. LPN#3 and CNA#5 were re-educated by Director of Health Services, Assistant Director of Health Services and Executive Director on 12/1/15 on hand washing, glove use during meal service and proper food handling and post tests were completed. On 11/30/15, All meats and dairy products from the walk in refrigerator were discarded and replaced. The Executive Director was educated by the Divisional Vice President on 12/1/15 | 01/03/2016 |

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| | 1. During the initial tour on 11/29/2015 at 4:17 P.M., with FSA (Food Service Assistant) #1, the following was observed: the walk-in refrigerator had a current temperature of 40 degrees F (Fahrenheit) with several documented temperatures on the temperature log sheet above 41 degrees F. The proper temperature range for the walk-in refrigerator was 41 degrees F or below. The dishwasher was observed being ran through a total of three cycles with the wash and/or rinse cycles not reaching safe temperature ranges on all three cycles. The temperature requirement ranges documented on the side of the dish washing machine indicated the wash cycle was to reach a minimum of 155 degrees and the rinse cycle was to reach a minimum of 180 degrees. The first cycle observed had a wash cycle temperature of 146 degrees F and 190 degrees F for the rinse. The second cycle was observed with a wash temperature of 150 degrees F and a rinse cycle of 172 degrees F. The third cycle was observed at a wash temperature of 144 degrees F and a rinse cycle of 176 degrees F. Also observed in the kitchen were two square pans which were wet and placed flat, face down, on a solid metal shelf above the washing table. The kitchen preparation area had three uncovered, large garbage cans, not | | regarding the daily meeting process that includes the monitoring of the temperatures of the refrigerator and dishwasher. **2.** All residents have the potential to be affected. The Director of Health Services and nursing staff assessed all residents for any signs and symptoms of foodborne illness/infections every shift from 11/30/15 to 12/4/15, with no findings. All meals were served on paper until 12/4/15, at which time dishwasher wash and rinse cycle were consistently temping within manufacturer/federal guidelines. **3.** Director of Food Services was re-educated on 12/1/15 regarding proper temperature ranges for both the walk in refrigerator and the dish machine. Kitchen staff were educated on 11/30/15 on proper walk in refrigerator temperatures, and on 12/1/15 for proper dish machine temperatures. Walk in refrigerator temperatures were monitored every 2 hours for 60 hours from 11/30/15-12/3/15 and were consistently measured under 40 degrees. Temperatures are now logged 2 times per day. Any temperatures above 40 degrees are immediately reported to the Director of Food Services and the Executive Director. Dish Machine temperatures were monitored every cycle by Director of Food Services until temperatures were consistently at or above specification ending 12/3/15. Thermostat temperature | |

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| | currently being used, that had visible food particles, empty cups and paper napkins from the previous meal. The entry area by the ice dispenser, had one large garbage can without a lid. The garbage can contained visible food particles and paper napkins and cups from the previous meal.<br><br>During an observation on 11/29/2015 at 5:03 P.M., FSA #1 was standing at the steam table and dropped a white washcloth on the floor. FSA #1 retrieved the washcloth from the floor with her bare hands and placed the washcloth on top of the steam table. Food was present on the steam table. FSA #1 continued to check the temperatures of the gravy and potatoes. FSA #1 was cleaning the thermometer between checking temperatures and dropped the paper trash from the cleaning cloths on the floor. FSA #1 picked up the paper trash off of the floor and held the trash in her hand as she continued to check the temperature of the turkey without washing her hands or using hand sanitizer. FSA #1 picked up the washcloth, which was previously on the floor, and wiped the serving area of the steam table. Then, FSA #1 used the washcloth to lift the tray of turkey out of the steam table and take the tray of turkey to the front dining area. | | was adjusted colder in the walk in refrigerator by a contracted repair company on 11/30/15. Dish machine water temperature was increased to meet/exceed manufacturer guidelines by the contracted repair company. Kitchen staff were educated to notify Director of Food Services immediately if temperatures did not meet specifications on 12/2/15. All Kitchen staff have been educated on proper drying procedure of pans by the Director of Food Services on 11/30/15, placing clean lids on trash cans when not in use, and disposing of any items that come into contact with the floor on by 12/2/15. New can lids were ordered on 12/22/15. Kitchen staff were also educated on proper hand washing procedures, handling of clean dishes, and three compartment sink sanitation on 11/30/15. The Director of Health Services and Executive Director began in servicing all nursing staff on proper hand washing guidelines, proper glove use during meal service, and food handling on 12/1/15 and will be completed by 1/3/15. **4.** All temperatures are logged as described above, and are reported in the morning meeting to the Executive Director to ensure temperatures are acceptable. Random kitchen audits will be performed by the Director of Dining Services or Assistant 2 times per day for 4 | |

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| | During an observation on 11/29/2015 at 5:16 P.M., FSA #2 was running the dishwasher. The water temperature during the wash cycle was 151 degrees F and the rinse cycle was 170 degrees F. FSA #2 indicated the cycle was complete and did not repeat the cleaning cycle.<br><br>During an observation on 11/29/2015 at 6:24 P.M., FSA #2 was running the dishwasher. The wash cycle reached 146 degrees F and the rinse cycle reached 190 degrees F. FSA #2 stacked the clean plates in a pile and held them against her shirt, visibly soiled with yellow stains. FSA #2 carried the stack of plates and placed them on the clean plate cart.<br><br>During an observation on 11/29/2015 at 6:34 P.M., FSA #1 and FSA #2 were observed washing utensils, pots, and pans in the three compartment sink. FSA #1 was washing the dishes in the soapy water and then placing the dishes in the clear water rinse. FSA #2 was picking up the dishes out of the clear water rinse and dipping the dishes in the sanitizing rinse for two seconds. The pots, pans, and utensils were not left in the sanitizing solution for the proper length of time. FSA #2 placed the large pans on a towel to dry. Documented on the wall above the 3 compartment sink were the requirements for sanitizing dishes. The | | weeks, daily for 4 weeks, and then 3 times per week for 4 months for proper drying procedures, trash can use, proper handling of dishes, hand washing, and use of the three compartment sink. Random audits of the nursing staff will be performed by the Director of Health Services or designee for hand washing, proper glove use, and food handling during meal service 2 times per day for 2 weeks , daily for 2 weeks, weekly for 8 weeks, and monthly for 3 months. The results of the audits/interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. In addition this will be monitored on going by the Peer Review Process every 6 months to verify ongoing compliance. A member of the Corporate Clinical Support or Divisional Vice President will attend the next 3 months of QA meetings to review audits and recommendations with the Executive Director, Director of Health Services, and Committee members to ensure the process is thorough and effective. | |

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| | document indicated the dishes had to be immersed in the sanitizing solution for a minimum of 60 seconds.<br><br>During an observation on 11/29/2015 at 6:37 P.M., FSA #6 was loading silverware into the utensil tray. The silverware was taken directly from the wash cycle, still wet, and placed in the brown silverware serving tray bins for storage.<br><br>During an observation on 11/29/2015 at 6:40 P.M., FSA #6 was running the dishwasher. The wash cycle reached 145 degrees F and the rinse cycle reached 178 degrees F.<br><br>During an observation on 11/30/2015 at 2:00 P.M., three large garbage cans without lids were located in the kitchen area. All three garbage cans contained visible food particles and soiled paper goods.<br><br>During an observation with the DFS on 12/01/2015 at 4:12 P.M., the walk-in cooler was observed to be at 44 degrees F. The DFS was asked to check the internal temperatures of food items inside the refrigerator. The coleslaw temperature was 43.8 degrees F, the sausage links were 47 degrees F, and a piece of cherry pie was 44 degrees F. | | | |

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| | Three large garbage cans were located in the main kitchen area. Two of the three garbage cans contained food items and soiled paper goods from the previous meal. All three of the garbage cans were open and not covered.<br><br>During an interview on 11/29/2015 at 4:19 P.M., FSA #2 indicated the garbage cans are never covered. FSA #2 further indicated the garbage in the cans was from the previous meal.<br><br>During an interview on 11/29/2015 at 4:20 P.M., FSA #6 indicated they had been having difficulties with the wash cycle reaching the required temperatures. FSA #6 further indicated on several occurrences the cycle had to be ran two to three times to reach the proper temperatures.<br><br>During an interview on 11/29/2015 at 4:34 P.M., FSA #2 indicated they were having difficulties with the dispenser on the washing cycle. The dispenser was getting clogged and some of the temperatures for the washing cycles were not reaching the manufacturer's recommendations.<br><br>During an interview on 11/29/2015 at 5:16 P.M., FSA #2 indicated the wash cycle for the dishwasher should get up to | | | |

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| | 160 degrees F and the rinse cycle should get up to 180 degrees F.<br><br>During an interview on 11/29/2015 at 6:24 P.M., the DFS indicated the dishwashing cycle should be at 150 degrees F or higher and the rinse cycle should be 180 degrees F to 185 degrees F. The DFS further indicated the pans should not be placed on towels and should have been on a drying rack. The DFS indicated the silverware needed to be left in the washing trays until dry or stood up in baskets until dry.<br><br>During an interview on 11/29/2015 at 7:27 P.M., the DFS indicated he was not aware of the wash cycles not meeting the proper temperatures. He was aware of the walk-in refrigerator logged temperatures being above 41 degrees F. The DFS further indicated maintenance followed up daily on the walk-in refrigerators, Monday through Friday. The DFS indicated he felt the high temperature readings were due to the timing of the defrost cycle in the walk-in refrigerator.<br><br>During an interview on 12/02/2015 at 10:13 A.M., the ED (Executive Director) indicated the wash cycle of the dishwasher was still not meeting the required temperature range. | | | |

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| | During an interview on 12/03/2015 at 1:24 P.M., the POM (Plant Operations Manager) indicated the facility only had one boiler and the water temperature needed to be 140 degrees going into the dishwashing machine for the proper temperatures to be achieved. The POM further indicated the technician from [name of contracted repair company] had replaced the mixing valve to the designated line that was only for the dishwasher.<br><br>During an interview on 12/04/2015 at 1:22 P.M., the ED indicated he was not aware of the temperature issues until 11/29/2015.<br><br>The current facility policy, dated 04/25/2013 and titled, "Dish machine Guideline", was provided by the DFS on 12/01/2015 at 6:21 P.M. The policy indicated, "...Dish machines will be properly used to ensure cleaning and sanitation of dishes and utensils...Check that temperatures are appropriate: High Temp - wash temp should be 150-165 degrees F, Rinse temp should be at least 180 degrees F...Low or abnormal temperatures will be reported to the Dining Services Manager or Manager in Charge...Dishes must be dry before storing... | | | |

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| | The current facility policy titled, "3-Compartment Sink", was provided by the DFS on 12/01/2015 at 6:21 P.M. The policy indicated "...mmerse [sic] dishes in 3rd sink sanitizing solution for a minimum of 60 seconds..."<br><br>The Owner's Manual for the dish machine used in the facility was provided by the ED on 11/30/2015. The operation specifications indicated the wash cycle temperatures should be "155 degrees F to 160 degrees F". The rinse cycle should be "180 degrees F to 195 degrees F".<br><br>2. A dining observation was conducted on the Memory Care Unit on 11/29/2015 from 5:02 P.M. to 5:55 P.M. At the start of the observation, thirteen residents were observed in the dining area with one CNA (Certified Nursing Assistant) present. CNA #5 assisted Resident #2 in putting on her jacket, retrieved a cup from the medication cart, put ice in it from the ice cooler, and took the cup to Resident #7. The CNA picked up Resident #53's spoon and helped the resident take a bite of food. The CNA did not wash her hands or use hand sanitizer during this entire observation.<br><br>LPN (Licensed Practical Nurse) #3 entered the dining area, picked up the salt | | | |

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| | and pepper shakers, placing her hand over the metal tops of the shakers. The LPN touched Resident #2's back before adding salt and pepper to the resident's food. LPN #3 continued to add salt and/or pepper to the food for Resident #34, Resident #114 and Resident #74. The LPN then assisted Resident #34 with cutting up her food.<br><br>Resident #7 spat her drink on the floor. LPN #3 donned gloves, cleaned up the liquid with paper towels, threw away the paper towels, removed gloves and washed her hands for seven seconds. Resident #7 spat her drink on the floor again. LPN #3 again donned gloves, cleaned up the liquid with paper towels, threw away the paper towels, removed her gloves, washed her hands for 10 seconds, and turned off the water using her bare forearm.<br><br>CNA #5 retrieved, from the kitchen, a bottle of strawberry house shake. CNA #5 filled several residents' cups with house shake, used Resident #88's silverware to cut up some of the resident's food, assisted Resident #53 with cutting up and eating some food, and assisted Resident #34 with eating a bite of food before retrieving a piece of cake from the food cart. CNA #5 then washed her hands for 55 seconds, turned | | | |

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| | the water off with her bare hand, then used paper towels to dry her hands. The CNA fed Resident #88 a few bites of food, fed Resident #53 a few bites of food, got a piece of cake from the cart for a resident, picked up a dirty plate, and took it to the dirty dish tub. CNA #5 then fed a bite of food to Resident #34, salted Resident #34's food and fed the resident a few more bites of food while touching the resident's wheelchair. The CNA then got a plate of food from the food cart, took applesauce from the refrigerator and attempted to feed Resident #88 a bite of food.<br><br>CNA #5 picked up dirty dishes from a table, took the dishes to the dirty dish tub, picked up more dirty dishes and took them to the tub, cut up food for Resident #34, fed a bite of food to Resident #88, tried to feed a bite of food to Resident #53, and took a piece of cake out of the food cart for a resident. The CNA then picked up dirty dishes and took them to the dirty dish tub, poured coffee for two residents, pushed Resident #61 out of the dining area in her wheelchair, picked up dirty dishes and put them in the tub, tapped the top rim of Resident #53's cup and asked the resident to please drink some more. The CNA did not wash hands or use hand sanitizer during this observation. | | | |

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| | CNA #5 assisted Resident #7 to the restroom and returned with the resident a few minutes later, pushing her wheelchair. The CNA then fed a bite of food to Resident #34, wiped a spill off a resident's pants, fed Resident #88 a bite of food, washed her hands for 32 seconds, turned the water off with her bare hands, and used paper towels to dry her hands.<br><br>3. A continuous dining observation was conducted in the Memory Care Unit on 12/01/2015 starting at 5:00 P.M. RN (Registered Nurse) #4 picked up a foam cup that was sitting on the floor and threw the cup in the garbage can. RN #4 did not wash her hands or use sanitizer. The meal cart arrived at 5:16 P.M., RN #4 walked over to the cart and picked up a bag of sandwich buns. With her bare hands RN #4 picked buns out of the sack and placed them on plates for Resident #51, #64, and #53. CNA #5 asked RN #4 for a bun and cheese. RN #4 handed CNA #5 a bun and a piece of cheese with her bare hand. CNA #5 grabbed the bun and cheese with her bare hands, then walked over to Resident #7 and placed the bun and cheese on the resident's plate. RN #4 helped Resident #2 remove her pink coat, then RN #4 washed her hands for 14 seconds. RN #4 then picked up | | | |

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| | the bag of buns and placed a bun on Resident #34's plate.<br><br>CNA #5 poured glasses of cranberry juice for five residents, put the juice back into the refrigerator, poured coffee for three residents, scratched her nose, removed clean cups from the cabinet, poured coffee for four more residents, removed the house shake from the refrigerator, put the house shake back in the refrigerator, picked up Resident #7's silverware and cut her food, cut a bite of food for Resident #61, knelt between Resident #88 and #53, fed Resident #53 a bite of food, and then fed Resident #88 a bite of food. The CNA then received more packaged slices of cheese from the DFS (Director of Food Services), opened a slice of cheese and placed it on Resident #2's plate with her bare hands.<br><br>CNA #5 attempted to feed Resident #53 a bite of food, set the resident's fork down, rubbed her nose, picked up Resident #88's fork, moved food around on the resident's plate and put down the resident's fork, picked up Resident #34's fork and tried to feed her a bite, set down Resident #34's fork and touched the back of her wheelchair, picked up Resident #53's fork and tried to feed her a bite, touched a resident on the arm, opened the food cart, and took desserts to residents. | | | |

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| | CNA #5 assisted Resident #2 with putting her jacket on, tucked the jacket down between the resident and her wheelchair, attempted to feed Resident #88 a bite of food, then set the resident's fork down. The CNA did not wash her hands or use hand sanitizer throughout the entire observation after first washing them before the dinner meal cart arrived.<br><br>During an interview on 12/01/2015 at 5:30 P.M., the DFS indicated staff were to use gloves and not touch food with their bare hands when serving.<br><br>The current facility policy, dated 2009 and titled, "Food Production Guidelines-Sanitation & Safety", was provided by the DFS on 12/01/2015 at 6:21 P.M. The policy indicated, "...1. Hands are washed thoroughly before touching food or equipment... 5. Food is served as soon after preparation as possible and is held at the following temperatures: ...Hold food - Cold = 41 degrees Fahrenheit or below...9. Suitable utensils, such as forks, knives, tongs or scoops shall be provided to minimize handling of food...14. Custards, cream fillings, meat, potato or egg salad or similar products, shall be kept at a safe temperature of 41 degrees Fahrenheit or below..." | | | |

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| | The current facility policy titled, "Guidelines for Handwashing" and dated 03/2013, was provided by the DFS (Director of Food Services) on 12/01/2015 at 6:27 P.M. and was reviewed at that time. The policy indicated, "...All health care workers shall wash their hands frequently and appropriately...shall wash hands at times such as...Before/after preparing/serving meals, drinks...Before/after having direct physical contact with residents..." and also indicated, "Wash well for 20 seconds...Dry hands with paper towels. 11. Turn off faucet with a dry paper towel to avoid recontaminating hands from the faucet..."<br><br>3.1-21(i)(2)<br>3.1-21(i)(3)<br>3.1-21(i)(5) | | | |
| F 0441<br>SS=D<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>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. | | | |

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| | (a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br>Based on observation, interview and record review, the facility failed to ensure proper infection control practices were performed according to accepted professional practice, related to handwashing, sanitizing glucometers and insulin injections for 2 of 3 residents observed during medication administration. (Resident #2 and Resident #64) | F 0441 | **1.** Resident #2 and #64 were assessed for signs or symptoms of infection on every shift for 24 hours. Nurse #3 was immediately relieved and re-educated on glucometer cleaning, infection control policy, handwashing, and subcutaneous injection procedures on 12/1/15 and the Director of Health services is providing ongoing 1 on 1 | 01/03/2016 |

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| | Findings include:<br><br>During an observation on 11/29/2015 at 4:30 P.M., LPN (Licensed Practical Nurse) #3 gathered supplies to check Resident #2's blood sugar. LPN #3 washed her hands for six seconds, donned gloves, swabbed the resident's finger with an alcohol swab, stuck the resident's finger with a lancet, gathered the sample of blood on the glucometer testing strip, cleaned the resident's finger, threw away trash, disposed of the lancet in the sharps container, and removed her gloves. The LPN then washed her hands for seven seconds.<br><br>During an interview on 11/29/2015 at 4:32 P.M., LPN #3 indicated the blood glucose monitor was used for multiple residents.<br><br>During an observation on 12/01/2015 at 4:45 P.M., RN (Registered Nurse) #4 checked Resident #2's blood sugar while in the resident's room. The RN returned to the main living room area and set the blood glucose monitor on top of the medication cart. RN #4 prepared the resident's Humalog (insulin) pen, returned to Resident #2's room, donned gloves, lifted the resident's shirt to expose her lower stomach, injected the insulin | | re-education with this nurse on job specific procedures to be completed by 12/28/15.<br><br>**2.** All other residents have the potential to be affected. All diabetic residents on the memory care unit were assessed for signs and symptoms of infection on 12/1/15 by the Director of Health Services and Legacy Lane Coordinator. All Diabetic residents on Health Center were assessed by Director of Health services or designee on 12/23/15, with no findings<br><br>**3.** All nurses will be educated on proper infection control practices related to hand washing, sanitizing of glucometers, and subcutaneous injections by 1/3/15.<br><br>**4.** Random hand washing audits will be performed by the Director of Health Services or designee as follows: daily times 4 weeks,3 times per week times 4 weeks, weekly times 4 weeks and monthly times 3 months. Audits of glucometer use and sanitation will be performed by the Director of Health Services or designee as follows: daily times 4 weeks,3 times per week times 4 weeks, weekly times 4 weeks and monthly times 3 months. Subcutaneous injections will be randomly audited by the Director of Health Services or designee as follows: daily times 4 weeks,3 | |

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| | into the resident's right lower stomach, removed her gloves, and washed her hands. The RN then wiped the previously used blood glucose monitor down with an alcohol swab, set it back on the medication cart for three seconds, picked up the glucose monitor and other supplies, transported Resident #64 by wheelchair to her room, washed her hands, and donned gloves. RN #4 then swabbed Resident #64's finger with an alcohol swab, stuck the resident's finger with a lancet, and gathered the sample of blood on the glucometer testing strip. The RN indicated there was not enough blood for a reading, removed her gloves, carried the used lancet out of the room using her bare hand and disposed of it in the sharps container, and gathered new supplies. RN #4 then donned clean gloves, swabbed a different finger with an alcohol swab, dropped the new lancet on the floor, picked up the lancet, removed her gloves, donned new gloves, stuck Resident #64's finger with the dropped lancet, gathered the sample of blood on the glucometer testing strip, removed her gloves, threw away the used supplies, carried the used lancet, using her bare hand, to the sharps container, and washed her hands for 24 seconds.<br><br>During an interview on 12/01/2015 at 5:01 P.M., RN #4 indicated she had | | times per week times 4 weeks, weekly times 4 weeks and monthly times 3 months. The results of the audits/interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. A member of the Corporate Clinical Support or Divisional Vice President will attend the next 3 months of QA meetings to review audits and recommendations with the Executive Director, Director of Health Services, and Committee members to ensure the process is thorough and effective. | |

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| | checked with the ADON (Assistant Director of Nursing) and been told it was alright to use alcohol swabs to clean the glucometer.<br><br>During an interview on 12/01/2015 at 5:12 P.M., the ADON indicated it was ok to use alcohol swabs to clean the glucometer if there were no bleach wipes available.<br><br>During an interview on 12/02/2015 at 9:59 A.M., the ADON indicated the facility's policy was to use bleach wipes to clean the glucometer, not alcohol swabs.<br><br>During an interview on 12/03/2015 at 1:01 P.M., the DON (Director of Nursing) indicated the proper procedure when checking blood glucose was to gather supplies, wash hands, don gloves, swab the resident's finger, stick the finger, take the blood glucose, wash hands, throw away gloves and dispose of sharps, and clean the glucometer. She indicated the glucometer should be cleaned with a bleach wipe and left to dry for three minutes. The DON also indicated hands should be washed for 20 seconds or more. The DON indicated the proper procedure for administering an insulin injection was to check the order, wash hands, draw up the insulin, wash | | | |

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| | hands again, don gloves, swab the injection site, administer the insulin, dispose of the needle in the sharps container, take off gloves, and wash hands.<br><br>The current facility policy titled, "Subcutaneous Medication Administration" and dated 2/01/2010, was provided by the ADON on 12/02/2015 at 10:02 A.M. and reviewed at that time. The policy indicated, "...Cleanse skin with alcohol sponge, using circular motion from center of chosen site until an area about 3 inches in diameter has been prepared..."<br><br>The current facility policy titled, "Guidelines for Handwashing" and dated 03/2013, was provided by the DFS (Director of Food Services) at 6:27 P.M. and reviewed at that time. The policy indicated, "...Health Care Workers shall wash hands... Before/after having direct physical contact with residents...after removing gloves, worn per Standard Precautions for direct contact with...specimens, resident equipment..." and also indicated, "...Wash well for 20 seconds...using a rotary motion and friction..."<br><br>The current, undated facility policy titled, "Glucometer Cleaning Guidelines", | | | |

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| | was provided by the ADON on 12/01/2015 at 5:20 P.M. and reviewed at that time. The policy indicated, "...If glucometers are used from one resident to another they should be cleaned and disinfected after each use...disinfect after each use the exterior surfaces following the manufacturer's directions using...a dilute bleach solution...Alcohol should not be used..."<br><br>3.1-18(a)<br>3.1-18(l) | | | |
| F 0456<br>SS=E<br>Bldg. 00 | 483.70(c)(2)<br>ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION<br>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br>Based on observation, interview and record review the facility failed to ensure the dishwasher and walk-in refrigerator were in safe operating condition, according to manufacturer's instructions for use, for one of one facility kitchen observed.<br>Findings include:<br>1. During the initial tour of the facility kitchen on 11/29/2015 at 4:17 P.M., with | F 0456 | **1.** On 11/30/15, the thermostat was adjusted in the walk in refrigerator by a contracted repair company, and temperatures were logged every two hours for 60 hours to ensure temperature was meeting federal regulation. All recorded temperatures were below 41 degrees. The contracted repair company adjusted the intake water temperatures for dishwasher on 12/4/15 to meet the need of machine and the Director of Dining Services | 01/03/2016 |

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| | FSA (Food Service Assistant) #1, the following was observed: the walk in refrigerator had several documented temperatures above 41 degrees F (Fahrenheit) on the log sheet. The proper temperature range for the walk-in refrigerator was 41 degrees F or below. The dishwasher was observed being ran through a total of three cycles. The wash or rinse cycle did not reaching safe temperature ranges on all three cycles. The first cycle was observed at the temperature of 146 degrees F for the wash and 190 degrees F for the rinse. The second cycle was observed with a wash temperature of 150 degrees F and a rinse cycle of 172 degrees F. The third cycle was observed at 144 degrees F for the wash cycle and 176 degrees F for the rinse cycle. The temperature requirement ranges documented on the side of the dish machine indicated the wash cycle was to reach a minimum of 155 degrees and the rinse cycle was to reach a minimum of 180 degrees.<br>During an observation on 11/29/2015 at 5:16 P.M., FSA #2 was running the dishwasher. The water temperatures during the wash cycle was 151 degrees F | | monitored dishwasher through every cycle from 11/30/15-12/4/15 to ensure temperatures met requirement during wash and rinse cycles. Director of Food Services and Director of Plant Operations were educated by the Executive Director on 12/1/15 on specifications for walk-in refrigerator temperatures and dishwasher, wash and rinse cycles, and they were directed to report to the Executive Director immediately if any temperatures do not meet specifications at any time. **2.** All residents have the potential to be affected. The Director of Health Services and nursing staff assessed all residents for any signs and symptoms of foodborne illness/infection every shift from 11/30/15 to 12/4/15, with no findings. From 11/30/15 through 12/3/15, when dishwasher was determined to be out of compliance, all meals were served on paper. All kitchen staff were educated by Director of Food Services on 12/1/15 to notify Director of Food Services and Executive Director immediately if temperatures did not meet specifications at any time. Walk in refrigerator thermostat was adjusted colder by the contracted repair company on 11/30/15, and all meats and dairy were discarded and replaced on 11/30/15 as well. **3.** Walk in refrigerator | |

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| | and the rinse cycle was 170 degrees F. Another cycle was ran at 6:22 P.M., the dishwashing cycle was 146 degrees F and the rinse cycle was 190 degrees F.<br>During an observation with the DFS (Director of Food Services) on 12/01/2015 at 4:12 P.M., the walk-in refrigerator was observed to be at 44 degrees F. The DFS was asked to check the internal temperatures of random food items inside the refrigerator. The coleslaw was at 43.8 degrees F, the sausage links were 47 degrees F and a piece of cherry pie was at 44 degrees F.<br>During an interview on 11/29/2015 at 4:20 P.M., FSA #6 indicated they had been having difficulties with the wash cycle not reaching the required temps. FSA #6 further indicated on several occurrences the cycle had to be ran two to three times to reach the proper temperatures.<br>During an interview on 11/29/2015 at 4:34 P.M., FSA #2 indicated they were having difficulties with the dishwasher temperatures for the washing cycles not reaching the manufacturer recommendations.<br>During an interview on 11/29/2015 at | | temperatures were recorded and reviewed every 2 hours for 60 hours from 11/30/15-12/2/15 by rotating department leaders and all were documented less than 41 degrees. Temperatures will be logged 2 times per day ongoing and reviewed daily by Executive Director or Director of food Services or designee to ensure temperature is in appropriate range per federal guidelines. Any temperatures above 40 degrees are immediately reported to the Director of Food Services and the Executive Director. Dish Machine temperatures were monitored every cycle by Director of Food Services until temperatures were consistently at or above specification ending 12/3/15. Dishwasher temperatures for wash and rinse cycles are now logged 3 times per day and reviewed by Director of Food Services, Executive Director or designee. Thermostat temperature was turned colder in the walk in refrigerator on 11/30/15 by the contracted repair company. Dish machine water temperature was increased to meet/exceed manufacturer guidelines on 12/3/15.<br>**4.** Logged temperatures for Walk in refrigerator and dish washer (wash and rinse cycle) will be reviewed daily by Executive Director, Director of Food Services or Assistant ongoing. The results of the audits/interviews will be reported, | |

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| NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS | | STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN 47274 | |

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| | 5:16 P.M., FSA #2 indicated the wash cycle should get up to 160 degrees F and the rinse cycle should get up to 180 degrees F.<br>During an interview on 11/29/2015 at 6:24 P.M., the DFS indicated the dishwashing wash cycle should be at 150 degrees F or higher and the rinse cycle should be 180 degrees F to 185 degrees F.<br>During an interview on 11/29/2015 at 7:27 P.M., the DFS indicated he was not aware of the wash cycles not meeting the proper temperatures. He was aware of the logged temperatures being above the 41 degrees F range in the walk-in refrigerator. The DFS further indicated the A.M. cook was responsible for taking daily temperatures upon arrival. The A.M. cook arrived around 5:00 A.M. The A.M. cook was responsible to report any temperatures above 41 degrees F directly to the DFS. The DFS indicated maintenance follows up daily, Monday through Friday. The DFS indicated he felt the high temperature readings were due to the timing of the defrost cycle in the walk-in refrigerator. The DFS indicated the defrost cycles ran four times | | reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. A member of the Corporate Clinical Support or Divisional Vice President will attend the next 3 months of QA meetings to review audits and recommendations with the Executive Director, Director of Health Services, and Committee members to ensure the process is thorough and effective. | |

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| | a day at 5:00 A.M., 11:00 A.M., 4:00 P.M., and 9:00 P.M.<br>During an interview on 12/01/2015 at 11:00 A.M., the maintenance manager indicated he checks the temperatures in the walk-in refrigerator around 7:00 A.M. to 7:30 A.M.<br>During an interview on 12/02/2015 at 10:13 A.M., the ED (Executive Director) indicated the wash cycle of the dishwasher was still not meeting the required temperature range.<br>During an interview on 12/03/2015 at 1:24 P.M., the POM (Plant Operation Manager) indicated the facility only had one boiler and the water temperature needed to be 140 degrees F going into the dishwashing machine for the proper temperatures to be achieved. The POM further indicated the technician from [name of contracted repair company] had replaced the mixing valve to the designated line for the dishwasher.<br>During an interview on 12/04/2015 at 1:29 P.M., the POM indicated he knew there was some fluctuating temperatures above the required range. The POM further indicated as long as the temperatures did not hold for any length | | | |

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| | of time he felt it was not a concern. The POM indicated he believed the temperatures were checked when the walk-in refrigerator was in high use and staff were in and out frequently. He also indicated he did go back and recheck the temperature, but never documented those temperatures at that time.<br>Record review, on 11/29/2015 at 6:25 P.M., of the "Refrigerator/Freezer Temperature Worksheet", dated November 2015 and provided by the DFS, indicated the walk-in refrigerator temperature was above 41 degrees F on the following dates: November 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, 27, 28, and 29, 2015.<br>The "Refrigerator/Freezer Temperature Worksheet" dated October 2015, indicated the walk-in refrigerator temperature was above 41 degrees F on the following dates: October 1, 2, 4, 5, 7, 8, 10, 11, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 25, 26, 27, 28, and 31, 2015.<br>On 12/03/2015 at 2:45 P.M., the "Daily Temperature Log November 2015" was provided by the maintenance manager and reviewed at that time. The document | | | |

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| | indicated the walk-in refrigerator temperature was above 41 degrees F on the following dates: November 2, 3, 4, 5, 9, 10, 11, 13, 17, 18, and 25, 2015. The temperature was not documented on the following dates: November 1, 7, 8, 14, 15, 21, 22, 26, 27, 28, 29, and 30, 2015.<br>The "Daily Temperature Log October 2015" indicated the walk-in refrigerator temperatures were above 41 degrees F on the following dates: October 5, 6, 7, 8, 9, 13, 16, 19, 20, 21, 22, 23, 26, 27, and 29, 2015. The temperature was not documented on the following dates: October 3, 4, 10, 11, 12, 17, 18, 24, and 25, 2015.<br>The current facility policy dated 2009 and titled, "Food Production Guidelines-Sanitation & Safety", was provided by the DFS on 12/01/2015 at 6:21 P.M. The policy indicated, "...Hold food - Cold = 41 degrees F or below...Custards, cream fillings, meat, potato or egg salad or similar products, shall be kept at a safe temperature of 41 degrees F or below..."<br>The current facility policy dated 04/25/2013 and titled, "Dish Machine Guideline", was provided by the DFS on | | | |

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| | 12/01/2015 at 6:21 P.M. The policy indicated, "...Dish machines will be properly used to ensure cleaning and sanitation of dishes and utensils...Check that temperatures are appropriate: High Temp - wash temp should be 150-165 degrees F, Rinse temp should be at least 180 degrees F...Low or abnormal temperatures will be reported to the Dining Services Manager or Manager in Charge...Dishes must be dry before storing..."<br>The Owner's Manual for the dish machine used in the facility was provided by the ED on 11/30/2015. The operation specifications indicated the wash cycle temperatures should be, "155 degrees F to 160 degrees F". The rinse cycle should be, "180 degrees F to 195 degrees F".<br>3.1-21(i)(3) | | | |
| F 0520<br>SS=E<br>Bldg. 00 | 483.75(o)(1)<br>QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to | | | |

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| | identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>Based on observation, interview and record review, the facility failed to identify concerns and successfully implement a plan of action to correct quality deficiencies related to hand washing, glucometer cleaning, walk-in refrigerator temperatures, staffing, and responding to resident grievances. This deficient practice had the potential to affect 61 of 61 residents who reside in the facility.<br><br>Findings include:<br><br>1. During an observation on 11/29/2015 at 4:30 P.M., LPN (Licensed Practical Nurse) #3 gathered supplies to check Resident #2's blood sugar. LPN #3 washed her hands for six seconds, donned gloves, swabbed the resident's finger with an alcohol swab, stuck the resident's finger with a lancet, gathered | F 0520 | 1.The results of the audits/interviews will be reported, reviewed, and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months. It is the mission of the facility's Quality Assurance Committee to develop and implement a plan of action to assure the provision of accepted standards of clinical practice to implement proper handwashing, glucometer cleaning, walk-in refrigerator temperatures, staffing and responding to resident grievances. The QA meetings will be scheduled weekly times 2 months then monthly ongoing. These meetings will include the Director of health Services, Executive Director, Medical Director/ARNP and 3 other team members.<br><br>2. All residents have the potential to be affected by the deficient | 01/03/2016 |

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| | the sample of blood on the glucometer testing strip, cleaned the resident's finger, threw away trash, disposed of the lancet in the sharps container, and removed her gloves. The LPN then washed her hands for seven seconds.<br><br>2. During an observation on 12/01/2015 at 4:45 P.M., RN (Registered Nurse) #4 checked Resident #2's blood glucose while in the resident's room. The RN returned to the main living room area and set the blood glucose monitor on top of the medication cart. RN #4 prepared and administered the resident's Humalog (insulin) pen. The RN then wiped the previously used blood glucose monitor down with an alcohol swab, set it back on the medication cart for three seconds, picked up the glucose monitor and other supplies, transported Resident #64 by wheelchair to her room, washed her hands, and donned gloves. RN #4 then swabbed Resident #64's finger with an alcohol swab and performed a blood sugar check using the same blood glucose monitor.<br><br>3. During an observation with the DFS (Director of Food Services) on 12/01/2015 at 4:12 P.M., the walk-in refrigerator was observed to be at 44 degrees F. The DFS was asked to check the internal temperatures of random food | | practice.<br><br>3. The Executive Director and Director of Health services will be in serviced by the Divisional Vice President on the regulatory requirements of the QA committee with an emphasis of a thorough QA meeting.<br><br>4. The focus of the next 6 months of QA meetings will be on infection control, staffing, responding to resident grievances, a thorough QA process by following the policy and procedure for the QA process, in addition to any other opportunity noted by the committee. A member from Compliance, Operations, and/or clinical support will attend the next 3 QA meetings to review audits and recommendations with Executive Director, Director of Health Services and committee members to ensure the QA process is thorough and effective. | |

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| | items inside the refrigerator. The coleslaw was at 43.8 degrees F, the sausage links were at 47 degrees F and a piece of cherry pie was at 44 degrees F.<br><br>During an interview on 12/04/2015 at 1:29 P.M., the POM indicated he knew there was some fluctuating temperatures above the required range. The POM further indicated as long as the temperatures did not hold for any length of time he felt it was not a concern. The POM indicated he believed the temperatures were checked when the walk-in refrigerator was in high use and staff were in and out frequently. He also indicated he did go back and recheck the temperature, but never documented the temperatures at that time.<br><br>Record review, on 11/29/2015 at 6:25 P.M., of the "Refrigerator /Freezer Temperature Worksheet", dated November 2015 and provided by the DFS, indicated the walk-in refrigerator temperature was above 41 degrees F on the following dates: November 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 24, 25, 27, 28, and 29, 2015.<br><br>The "Refrigerator / Freezer Temperature Worksheet", dated October 2015, indicated the walk-in refrigerator | | | |

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| | temperature was above 41 degrees F on the following dates: October 1, 2, 4, 5, 7, 8, 10, 11, 13, 14, 15, 16, 17, 18, 19, 21, 22, 23, 25, 26, 27, 28, and 31, 2015.<br><br>On 12/03/2015 at 2:45 P.M., the "Daily Temperature Log November 2015" was provided by the maintenance manager and reviewed at that time. The document indicated the walk-in refrigerator temperature was above 41 degrees F on the following dates: November 2, 3, 4, 5, 9, 10, 11, 13, 17, 18, and 25, 2015. The temperature was not documented on the following dates: November 1, 7, 8, 14, 15, 21, 22, 26, 27, 28, 29, and 30, 2015.<br><br>The "Daily Temperature Log October 2015" indicated the walk-in refrigerator temperatures were above 41 degrees F on the following dates: October 5, 6, 7, 8, 9, 13, 16, 19, 20, 21, 22, 23, 26, 27, and 29, 2015. The temperature was not documented on the following dates: October 3, 4, 10, 11, 12, 17, 18, 24, and 25, 2015.<br><br>4. During a dining observation on 11/29/2015 at 5:02 P.M., 13 residents were observed eating in the dining room with only Staff #21 present and assisting the residents.<br><br>During an observation on 12/03/2015 at | | | |

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| | 10:07 A.M., Resident #2 had requested assistance getting off of the toilet by turning on her call light. Staff #22 was observed turning the pages of the Medication Administration Record book throughout the time the call light was beeping. At 10:23 A.M., Housekeeper #8 walked into the area, walked down the hallway to Resident #2's room and checked on the resident.<br><br>During an observation on 12/03/2015 at 1:10 P.M., there was only one nurse and no aide present in the Memory Care Unit. Thirteen residents reside on this unit.<br><br>A Resident Council meeting was observed on 12/04/2015 at 10:29 A.M. Resident #27 indicated when he pushed his call light, the staff came in and assisted his roommate. He further indicated, at times, the staff came in, turned off his call light, said, "I'll be back in a minute", then it's 15 to 20 minutes before the staff return. Resident #19 indicated her call light did not reach all the way to her chair, the cord was not long enough and was not within her reach when she was in her recliner.<br><br>During an interview on 11/29/2015 at 4:32 P.M., Staff #20 indicated it had been more common recently that one nurse will float between Assisted Living and | | | |

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| | the Memory Care Unit. Staff #20 indicated there were 23 residents in the Assisted Living Unit and 13 residents in the Memory Care Unit. The staff member further indicated that falls have happened before because when they [staff] are in a room assisting a resident, they [staff] cannot watch what is going on outside the room. The staff member indicated there were not enough staff to take care of the residents in Memory Care.<br><br>During an interview on 11/29/2015 at 5:53 P.M., Staff #21 indicated recently it was more normal for one person to work on the Memory Care Unit. The staff member further indicated he/she felt like they couldn't get everything done when there was just one person.<br><br>During an interview on 11/30/2015 at 10:46 A.M., Resident #70 indicated staff had advised her there was not enough help to get her up since she required two staff members for assistance. Resident #70 further indicated, at times, it had taken over 30 minutes to receive assistance to go to the restroom and even longer when she had requested something to drink.<br><br>During an interview on 12/01/2015 9:53 A.M., Resident #61 indicated there had | | | |

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| | been several occurrences of long waiting times for assistance to use the restroom. Resident #61 was not sure of the exact time length, but indicated it was uncomfortable waiting for assistance.<br><br>During a confidential interview on 12/03/2015 at 12:45 P.M., Staff #23 indicated he/she has had to work the floor to cover several call ins. Staff #23 further indicated he/she could not complete his/her own work on those occasions and had to stay late.<br><br>During an interview on 12/03/2015 at 1:08 P.M., Resident #11, indicated call lights were not answered in a timely manner and it was irritating.<br><br>During a confidential interview on 12/03/2015 at 1:09 P.M., Staff #24 indicated it was not safe to have one aide on the Memory Care Unit during meal time. Thirteen residents reside on this unit.<br><br>During a confidential interview on 12/03/2015 at 1:10 P.M., Staff #25 indicated one nurse and one aide can handle the Memory Care Unit on most days, but on hectic days it was very difficult to monitor and assist all the residents. | | | |

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| | During a confidential interview on 12/03/2015 at 1:33 P.M., Staff #26 indicated there were "good and bad workers". Some of the workers can handle the call lights when working short and some staff can not keep up with the call lights in a timely manner when working short. There are times when the residents have to wait longer then normal.<br><br>During an interview on 12/04/2015 at 2:21 P.M., the DON (Director of Nursing) indicated staff had been inserviced regarding call lights and she had discussed this issue with the Resident Council President. She further indicated she felt the CNAs (Certified Nursing Assistants) and other departments had been good about answering call lights.<br><br>The Resident Council Meeting minutes were provided, with the permission of the Resident Council President, by Medical Records on 1202/2015 at 1:30 P.M. and reviewed at that time.<br><br>Meeting minutes, dated 11/02/2015, indicated the Resident Council President voiced concerns regarding call lights being turned off before the residents were assisted and also indicated long call light wait times. | | | |

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| | Meeting minutes, dated 09/03/2015, indicated three residents voiced concerns regarding call lights being turned off before the residents were assisted and call lights were hard to find.<br><br>5. The Resident Council Meeting minutes were provided, with the permission of the Resident Council President, by Medical Records on 1202/2015 at 1:30 P.M. and reviewed at that time.<br><br>The Resident Council Meeting Minutes for the dates of 11/02/2015, 9/03/2015, 07/01/2015, 06/03/2015, 05/06/2015, 03/04/2015, and 02/04/2015, indicated residents had voiced concerns pertaining to receiving assistance in a timely manner and the means to request assistance [call lights out of reach], and Resident #28 voiced concerns for call lights being turned off before residents were assisted.<br><br>An interview was conducted on 12/04/2015 at 11:15 A.M. with Activities Associate #7, who usually conducted the resident council meetings. She indicated when an issue came up in a resident council meeting she filled out a Concern Form, gave it the SSD (Social Services Director), then followed up about a week later. She further indicated the SSD usually followed up with the resident | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 12/04/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS | | STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN 47274 | |

| (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 |
|---|---|---|---|---|
| | who had the issue. If it was a nursing issue, the SSD issued them [nursing staff] a copy of the concern, nursing added the plan of action on the concern form, and gave a copy to the Activities Department.<br><br>An interview was conducted on 12/04/2015 at 2:49 P.M. with the SSD (Social Services Director). The SSD indicated when she gets a concern form from the Resident Council meetings she logged them in the computer, logged them in a binder, a copy of the concern was given to the department head, the department head passed it back with their dates and resolution, and then the SSD updated the information in the computer with the resolution. The concern was passed on to the ED (Executive Director) who filled out his part on the computer indicating the issue had been resolved. She also indicated when a repeated issue came up it would be brought up in the morning meeting and discussed in the QAA (Quality Assessment and Assurance) monthly meeting. She indicated QAA discussed the issue to see if they needed to do anything further with it and come up with a plan. She indicated call lights had come up in both meetings and QAA had provided continuing inservices regarding the call light issue.<br><br>During an interview on 12/04/2015 at | | | |

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| | 2:21 P.M., the DON (Director of Nursing) indicated staff had been inserviced regarding call lights and she had discussed the issue with the Resident Council President. She further indicated she felt the CNA's and other departments had been good about answering call lights.<br><br>During an interview on 12/04/2015 at 3:15 P.M., the ED (Executive Director) indicated the walk-in refrigerator temperatures had not been brought to the attention of the QAA, but they should have been. He further indicated the department heads bring their concerns for their areas to morning meetings and to QAA meetings. He indicated items that are talked about each month are falls, wounds, medications, coumadin, infections, decline in activities of daily living.<br><br>In the Quality Assessment and Assurance meeting, the DON (Director of Nursing) and the ED described the most common issues they have been dealing with and what their plan of action has been to correct those issues. Despite the attempts to correct the aforementioned issues, the facility's plan has not been effective, as evidenced by continuing deficiencies in the areas of hand washing, glucometer cleaning, walk-in refrigerator | | | |

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|---|---|---|---|---|
| | temperature, staffing, and responding to resident grievances.<br><br>3.1-52(b)(2) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Residential Census: 26<br><br>Sample: 7<br><br>Covered Bridge Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. | R 0000 | | |