

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155611	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/06/2015
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NAME OF PROVIDER OR SUPPLIER  HOOSIER CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 S SUGAR ST BROWNSTOWN, IN 47220
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 2, 3, 4, 5, &amp; 6, 2015</p> <p>Facility number: 000277 Provider number: 155611 AIM number: 100290530</p> <p>Survey team: Julie Dover, RN - TC Rita Bittner, RN Tammy Forthofer, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 83 Total: 92</p> <p>Census payor type: Medicare: 6 Medicaid: 69 Other: 17 Total: 92</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on March 13, 2015, by Debra Holmes, RN.</p>	F 000	<p>Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provision of Federal and State law. Please accept this evidence in lieu of an onsite follow-up visit for recertification and state licensure survey event IDBX4911 on March 6, 2015.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F 431	Hoosier Christian Village does label medications properly in accordance with currently	03/25/2015

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	<p>properly label medications with an open date for 2 of 28 medications observed for 2 of 8 medication storage areas. (South Hall Neighborrhood 3 &amp; North Hall Neighborhood 2)</p> <p>Findings include:</p> <p>1. The South Hall treatment cart was observed with Licensed Practical Nurse (LPN) #6 on 03/05/2015 at 10:10 A.M. Medication labeled Novalog FlexPen for Resident #36 was open with 106 units remaining. The Novalog FlexPen had no open date and had been received from the pharmacy on 04/23/2014. The Novalog FlexPen was located in the top left hand draw of the treatment cart.</p> <p>During an interview on 03/05/2015 at 10:13 A.M., LPN #6 indicated "the Novalog FlexPen should have had an open date and was last administered to the patient today (03/05/2015) at 7:00 A.M. " LPN #6 indicated there was no way of knowing when the Novalog FlexPen was opened and she should have discarded the Novalog FlexPen prior to administration.</p> <p>Record review on 03/05/2015 at 2:20 P.M., indicated Resident #36 had received Novalog FlexPen injections based on a sliding scale. The resident</p>		<p>accepted professional principles.</p> <p>1. On 3-05-15 the Novalog Flexpen for Resident#36 was discarded. The new Novalog Flexpen for Resident #36 was opened and dated. On 3-06-15 all medication carts were audited by the unit managers and D.O.N. to ensure dates opened were included. All medications were noted to include dates opened as needed. On 3-05-15 the Albuteral inhalation Solution for resident #92 was discarded. The new Albuteral inhalation Solution for resident #92 was dated when removed from the foil pouch. On 3-06-15 an audit was completed by the unit managers and D.O.N. on all medications to ensure dates opened were applied per policy. All medications were noted to include dates opened as needed.</p> <p>2. Residents receiving medications to be dated when opened have the potential to be affected by this deficient practice. There were no other medications found without dates opened on labels per policy.</p> <p>3. During the weeks of March 16, 2015 and March 23, 2015 nurses were re-educated by the D.O.N. and Unit Managers on the Packaging and Labeling Policy that included the labeling of the date of issue and expiration date.</p> <p>4. Weekly Audits on Medications carts to ensure compliance with labeling dates opened per policy will be completed weekly for one</p>				

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	<p>received a Novalog FlexPen injection on 03/05/2015 at 7:00 A.M.</p> <p>Manufacturing recommendations indicated once the Novalog FlexPen had been open it could only be used for up to 28 days without refrigeration.</p> <p>2. The North Hall medication cart was observed with Registered Nurse (RN) #8 on 03/05/2015 at 1:25 P.M. Medication labeled Albuteral Sulfate Nebulization Solution 0.083% for Resident #92 contained nine solution vials with no open date documented on the open foil package. The Albuteral Sulfate Nebulization Solution had been received from pharmacy on 12/03/2014.</p> <p>During an interview on 03/05/2015 at 1:27 P.M., RN #8 indicated the Albuteral Sulfate Nebulization Solution vial package had no open date on the opened foil package. She indicated Resident #92 had 9 individual vials left out of 25. RN #8 indicated, "when foil packets are opened they needed to be marked with an open date."</p> <p>Record review on 03/05/2015 at 2:37 P.M., indicated Resident #92 had received Albuteral inhalation nebulizer treatments every six hours. The resident received the last Albuteral Nebulizer</p>		<p>month, then monthly on going by the Unit Managers or delegated staff. Monthly audits will continue to be made by pharmacy to ensure medications are labeled per policy. Audits will be brought to the monthly CQI meetings for further review and recommendations as needed.</p>	

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	<p>treatment on 03/05/2015 at 12:00 P.M.</p> <p>Manufacturing recommendations indicated once the Albuterol Sulfate Inhalation Solution had been removed from the foil pouch the vial must be used within one week.</p> <p>The "Packaging and Labeling Policy", with an original date of 01/01/2005 and indicated as current, was provided by the Director of Nursing (DON) on 03/05/2015 at 02:15 P.M. The policy indicated " ...Labeling #1 Prescription (legend) drugs are labeled in accordance with State law and include the appropriate accessory and cautionary instructions and the expiration date when applicable. Labeling of prescription drugs shall include the following:...F. Date of issue and expiration date. "</p> <p>3.1-25(k)(6)</p>			

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F 441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>			

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	<p>transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure that staff washed their hands when indicated and according to accepted professional practice for 6 of 18 random observations of hand washing (Residents #19, #31, #11, #4, #54 &amp; #111). The facility also failed to ensure infection control practices and standards were maintained related to carrying clean linens for 2 of 5 random observations. (Staff # 3 and #4)</p> <p>Findings include:</p> <p>1. During an observation on 03/05/15 at 11:01 A.M., Registered Nurse (RN) #2 donned gloves, walked into Resident 19's room and administered a glucometer check (blood sugar). RN #2 walked out of Resident #19's room, removed her gloves, documented the blood sugar results, donned gloves without washing her hands or using hand gel.</p> <p>RN #2 picked up Resident #31's glucometer, walked into Resident #31's room and administered a glucometer check. RN #2 walked out of Resident 31's room, removed her gloves, documented the blood sugar results, donned gloves without washing her</p>	F 441	<p>Hoosier Christian Village has established and maintained 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.</p> <p>1. There were no residents identified to be affected by this alleged deficient practice.</p> <p>2. Residents have the potential to be affected by this alleged deficient practice.</p> <p>3. On March 19, 2015 Nurse #2 was re-educated on the hand washing policy that included hand washing for 20 seconds after each direct or indirect contact for which hand washing is indicated by accepted professional practices. During the weeks of March 16, 2015 and March 23, 2015 staff were re-educated on the hand washing policy. During the weeks of March 16, 2015 and March 23, 2015 staff, including therapy staff, were re-educated on the Handling Clean Linen Policy that included carrying clean linen away from your body and uniform and linens considered being contaminated once it was in a resident's room.</p> <p>4. Nurse Supervisors and D.O.N. will complete random hand washing audits every shift, weekly for one month then every month for three months to ensure</p>	03/25/2015

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	<p>hands or using hand gel.</p> <p>RN #2 picked up Resident #11's glucometer, walked into Resident #11's room and administered a glucometer check. RN #2 walked out of Resident #11's room, removed her gloves, documented the blood sugar results, donned gloves without washing her hands or using hand gel.</p> <p>RN #2 picked up Resident #4's glucometer, walked into Resident #4's room and administered a glucometer check. RN #2 walked out of Resident #4's room, removed her gloves, documented the blood sugar results, donned gloves without washing her hands or using hand gel.</p> <p>RN #2 picked up Resident #54's glucometer, walked into Resident #54's room and administered a glucometer check. RN #2 removed her gloves, washed her hands for five seconds with soap and water, dried her hands with a paper towel, turned off the faucet with her bare hand, walked out of Resident #54's room and documented the blood sugar results on her log sheet.</p> <p>During an observation on 03/06/2015 at 11:16 AM, RN #2 walked into Resident #111's room. After administering the</p>		<p>proper hand washing per policy. Nurse Supervisors and D.O.N. will also complete audits on handling clean linen per policy weekly for one month then every month for three months. Audits will be brought to the CQI committee monthly, for review and further recommendations.</p>	

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	<p>resident's medication, RN #2 washed her hands with soap and water for five seconds then dried her hands with a paper towel and turned the faucet off with her bare hand. RN #2 walked out of Resident #111's room and used the mouse to chart the medication administration on her computer.</p> <p>During an interview on 03/05/2015 at 11:52 AM, RN #2 indicated "hands are to be washed with soap and water or hand gel between contact with every resident". She indicated "after using hand gel for three residents or when hands become soiled they must be washed with soap and water."</p> <p>The facility "Hand Washing Policy", dated 12/2013 and indicated as current, was provided by the Director of Nursing (DON) on 03/05/2015 at 01:15 P.M. The policy indicated hand washing was generally considered the most important single procedure for preventing nosocomial infections (infections acquired in healthcare facilities); it was important that proper procedures were followed. All staff were required to wash their hands after each direct or indirect contact for which hand washing is indicated by accepted professional practices...Gloves were to be worn when in contact with blood, body fluids,</p>			

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	<p>secretions and non-intact skin. However, gloves were not a substitute for hand washing. Hands were to be washed as indicated above even when gloves were worn. When hands washing was indicated, in most cases a vigorous, brief, at least 10 seconds, rubbing together of all surfaces of lathered hands, followed by thorough rinsing under a stream of water is recommended. If hands had obvious contamination on them, more time was required. After thorough rinsing, hands should be dried with a clean paper towel. The water faucet should be turned off with a paper towel to avoid recontamination of the hands.</p> <p>Recomendations by the Centers for Disease Control and Prevention for proper handwashing included the following, "...lather your hands by rubbing them together with the soap...scrub your hands for at least 20 seconds."</p> <p>2. On 03/03/2015 at 1:45 P.M., Physical Therapy Assistant (PTA) #3 was observed carrying multiple towels and sheets with her bare arms up against her shirt from the North hallway. The towels and sheets were held up against her shirt as she walked towards the Rehabilitation Department. PTA #3 walked into the Rehabilitation Department and placed the towels and sheets on the clean linen cart</p>			

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	<p>and covered the cart with a blanket.</p> <p>During an interview on 03/06/2015 at 10:36 A.M., PTA #5 indicated all linens carried were to be kept away from shirt and covered with a towel when transported in the hallway. While stored on the clean linen cart in the Rehabilitation Department linens were to be covered with a blanket. She indicated the sheets are used on the mats, the towels are used for hot packs and used to wipe off the residents or ultrasound equipment.</p> <p>3. During an observation on 03/06/2015 at 11:00 A.M., CNA #4 walked out of Resident #13's and #7's room with a white towel in her right hand. She then walked into Resident #32's and #134's room with the same white towel in her right hand and closed the residents door after she entered the room.</p> <p>The "Handling Clean Linen Policy", dated 2013, and indicated as current was provided by the Director of Nursing (DON) on 03/06/2015 at 12:12 P.M. The policy indicated... " 5. Pass linen to a single room at a time. Carry linen away from your body and uniform. 6. Do not return clean linen from the resident's room to the cart. The linen was considered contaminated once it was in a</p>			

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F 999  Bldg. 00	resident's room. "  3.1-18(b) 3.1-18(l) 3.1-19(g)(2)  3.1-14 Personnel  (t) A physical examination shall be required for each employee of a facility within one month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The results shall be	F 999	Hoosier Christian Village ensures that at the time of employment, or within one month prior to employment, and at least annually thereafter, employees and nonpaid personnel of the facility shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one to three weeks after the first step. The frequency of repeat	03/25/2015

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	<p>recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must ensure the following:</p> <p>(1) At the time of employment, or within one month prior to employment, and at least annually thereafter, employees and nonpaid personnel of the facility shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be preformed one to three weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure the second step of a two-step tuberculosis (TB) skin test was given to a new employee for 2 of 10 employee files reviewed for tuberculosis testing. (Employees #2 and #7)</p> <p>Findings include:</p>		<p>testing will depend on the risk of infection with tuberculosis.</p> <p>1.No residents were found to be affected by this alleged deficient practice.</p> <p>2.Residents have the potential to be affected by this alleged deficient practice. On March 3,2015, a calendar was created by the Human Resource Director with documentation that included the date of employees first step PPD given, and date second step PPD will be due. This calendar will be updated upon each new employee hire by the Human Resource Director, and reviewed daily for compliance.</p> <p>3.Human Resource Director will contact the new employee to inform them the date of the second step PPD and expected compliance. The Human Resource Director will notify the department supervisor to ensure each employee receives second step PPD the next scheduled date of employment.</p> <p>4.Weekly audits of the PPD calendar will be completed by the Business Office Manager or Administrator to ensure compliance for one month. The calendar will be brought to the monthly CQI committee meetings to monitor for compliance and any further recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER  HOOSIER CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 S SUGAR ST BROWNSTOWN, IN 47220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Employee #2 was hired on 4/24/2014. She was given her first tuberculin skin test on 4/9/2014 and was documented as a negative reading. There was no documentation of the second step tuberculin skin test.</p> <p>2. Employee #9 was hired on 12/8/2014. She was given her first tuberculin skin test on 12/5/2014 and was documented as a negative reading. There was no documentation for the second step tuberculin skin test.</p> <p>During an interview with the Human Resource Clerk (HRC) on 3/3/2015 at 10:10 A.M., she indicated she could not find the second step tuberculin skin test in either employee file. She further indicated she would check with the employees if they had a copy of the second step. If the employee didn't have a copy then a second step of the two-step tuberculin skin test would be given.</p>			