

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155511	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/17/2015
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NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 13-17, 2015</p> <p>Facility Number: 000446 Provider Number: 155511 AIM Number: 100288720</p> <p>Census bed type: SNF/NF: 35 Total: 35</p> <p>Census payor type: Medicare: 7 Medicaid: 22 Other: 6 Total: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician</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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	<p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a physician responded to notification of an abnormal lab for 1 of 1 resident reviewed for physician notification. (Resident #40)</p> <p>Finding includes:</p> <p>Resident #40's clinical record was reviewed on 4/16/15 at 3:30 p.m. Documentation on a form titled "BM [bowel movement] Monitoring" for the month of April, 2015, indicated the</p>	F 157	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective May 17th, 2015 to the annual licensure survey conducted on April 13, 2015 through April 17, 2015. We respectfully</p>	05/17/2015

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	<p>resident had large loose stools. A lab report for a culture obtained on 4/11/15 and received on 4/13/15, was noted of positive for Clostridium-difficile toxins a and band indicated the MD (medical doctor) was notified.</p> <p>The Director of Nursing (DON) was interviewed on 4/17/15 at 2:30 p.m. The DON indicated there had not been a response from the physician regarding the positive culture sent to the physician and the resident's continued loose stools.</p> <p>A facility policy, identified as current and titled, "Change in a Resident's Condition or Status," was reviewed on 4/16/15 at 11:50 a.m. The policy indicated when a physician was notified of a significant abnormal lab result and no response was received, the physician should be contacted again within 24 hours. On 4/17/15 at 3:00 p.m., the DON indicated that had not been done.</p> <p>3.1-5(a)(3)</p>		<p>request a paper review. We will provide you with any additional information to confirm compliance per your request.</p> <p><b>F157</b></p> <p><b>It is the practice of Terre Haute Nursing and Rehabilitation to assure that the physician/family is notified properly when there is a change of condition.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #40 physician has been notified and new orders received.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents with monthly and stat labs had the potential to be affected and have been reviewed to assure that the physician has been notified. No additional residents were identified.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>An in-service has been conducted with all nurses related to physician</p>	

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F 241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents		notification specifically related to physician's notifications and if no response from physicians nurses will follow up within 24 hours. The IDT team will be randomly reviewing physician notifications as part of the QAPI process to assure that the physician was notified properly.  <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b>  A Performance Improvement Tool has been initiated that randomly observes 5 residents that received labs to make sure the physician has been notified appropriately. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool.  <b>The date the systemic changes will be completed:</b>  May 17,2015		

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	<p>in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to promote independence and dignity during dining for 1 of 2 residents requiring extensive assistance during meals (Resident # 5).</p> <p>Findings include:</p> <p>During the lunch meal on 4/16/2015 at 12:14 p.m., Resident # 5 was observed in the dining room eating. CNA (certified nurse assistant ) #7 was sitting at the table with resident and assisted the resident with her meal. CNA #7 fed the resident with a spoon. When the resident drank from her cup, the CNA took her cellular phone out of her pocket and looked at the phone and typed on the device.</p> <p>CNA # 8 was interviewed on 4/17/2015 at 11:18 a.m. The CNA indicated Resident # 5 had difficulty grasping her cup and needed assistance with getting a hold of the cup. The CNA indicated there were some days that she held her own utensils, but other days she needed to be fed by staff.</p> <p>The quarterly Minimum Data Set (MDS),</p>	F 241	<p><b>F241</b></p> <p><b>It is the practice of this facility to assure that care is promoted for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>C.N.A. # 7 was immediately given a teachable moment on cell phone usage and promoting resident dignity during meals.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents who come to the dining room had the potential to be affected and those coming to the dining room have been reviewed during meal times. No additional residents were identified.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p>	05/17/2015

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F 242 SS=D	<p>dated 1/31/2015, indicated the resident had severe cognitive impairment.</p> <p>A Care plan, dated 2/15/2015, indicated the resident had ADL (Activity of daily living) self care performance deficit related to Alzheimer's disease. Interventions included, but were not limited to, "Encourage the resident to participate to the fullest extent possible with each interaction."</p> <p>The facility policy titled, "Cell Phones and Cameras in the Workplace Policy, " dated 9/01/2014, provided by Administrator on 4/17/2015 at 1:50 p.m., included but were not limited to "...Personal cellular phones may not be used during work hours. Cellular phones should not be brought into resident care areas...."</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO</p>		<p>An in-service has been conducted with all employees on the cell phone usage policy and promoting dignity during meal time. The IDT team will be monitoring dining room activity for usage of cell phones and promoting dignity during meal time as part of the QAPI process.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly observes 5 residents with self-care performance deficit that needs help during meals received care in a manner that maintains or enhances their dignity and respect. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions or training as needed based on the outcome of the PI tool.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>May 17,2015</p>		

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Bldg. 00	<p><b>MAKE CHOICES</b></p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure residents' preferences for frequency of bathing/showers were honored for 2 of 3 residents reviewed for choices. ( Resident #12 and #16)</p> <p>Findings include:</p> <p>1. On 4/14/15 at 2:35 p.m., during an interview, Resident #12 indicated he preferred to receive a shower daily as he wanted to be clean.</p> <p>On 4/16/15 at 10:40 a.m., during an interview with Resident #12, he indicated he received a shower every-other-day. He indicated he preferred to be clean everyday. He indicated he was never asked how many showers a week he preferred.</p> <p>On 4/16/15 at 3:30 p.m., a document titled "Shower List," was provided by the Administrator. The document indicated Resident #12 resided in a room scheduled for a shower on evening shift every</p>	F 242	<p><b>F242</b></p> <p><b>It is the practice of this facility to assure that residents are treated in a dignified manner including honoring of choices.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #12 is having their choice honored to have a daily shower and resident # 16 was immediately interviewed regarding shower preferences.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents are receiving services in accordance with their choices. Please see below for measures implemented to prevent reoccurrence.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p>	05/17/2015

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	<p>Tuesday, Thursday, and Saturday.</p> <p>Resident #12's medical record was reviewed on 4/15/15 at 10:00 a.m. A form titled, "Preferences for Customary Routines," dated 1/30/15, indicated the resident's daily preferences indicated the resident preferred a shower in the evenings.</p> <p>A review of the resident's quarterly Minimum Data Set (MDS) assessment, dated 1/30/15, indicated the resident required physical help in part of the bathing activity (one person physical assist) and the resident had no cognitive deficit.</p> <p>During an interview with Resident #16 on 4/13/15 at 11:04 a.m., the resident indicated he was not asked his preference for frequency of showers.</p> <p>Resident #16's clinical record was reviewed on 4/15/15 at 2:34 p.m. A form titled, "PREFERENCES FOR CUSTOMARY ROUTINES," dated 2/14/15, indicated the resident preferred showers in the morning. The form did not indicate how frequently the resident preferred showers.</p> <p>A quarterly assessment, dated 2/19/15, identified the resident had moderate</p>		<p>Reinforcement of the facility policy related assuring that residents receive services in accordance with their choices. The nursing staff has been in-serviced related to assuring that resident's choices are honored as part of services provided. The in-service will specifically address honoring residents' preference of shower time and frequency. SSD and Activity Director were In-serviced on interviewing resident for shower preference and frequency upon admission and quarterly thereafter. Please see below for means of monitoring through observation to assure that the policy is followed in accordance with the regulation.</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></b></p> <p>A Performance Improvement Tool has been initiated that randomly observes 5 residents for honoring of residents' wishes and choices. This tool will specifically observe for residents showering preferences/frequency. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based</p>	

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F 250 SS=D Bldg. 00	<p>cognitive impairment.</p> <p>A shower list, provided by the Administrator on 4/16/15 at 3:30 p.m., indicated the room in which the resident resided was on the schedule for showers on Tuesday, Thursday and Saturday on the evening shift.</p> <p>During an interview with the Activity Director on 4/16/15 at 3:10 p.m., she indicated she did not ask newly admitted residents how many showers per week they preferred.</p> <p>3.1-3(v)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide services to address wandering behaviors for 1 of 1 resident reviewed with the behavior (Resident #34).</p> <p>Finding includes:</p>	F 250	<p>on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>May 17, 2015</p> <p><b>F250</b></p> <p><b>It is the practice of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being</b></p>	05/17/2015			

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	<p>On 4/14/15 at 10:30 a.m., during observation of a group activity with a volunteer activity worker, Resident #34 was observed aimlessly wandering in the dining/activity room. The resident wandered in the hallways in view of nursing staff. No attempt to engage the resident in any sort of activity was observed.</p> <p>On 4/15/15 10:39 a.m., the resident entered a bathroom that was under construction and attempted to take a broom. The Maintenance Supervisor attempted to redirect her without success and contacted the Assistant Director of Nursing (ADON) who redirected the resident and then left. The resident then picked up a yellow wet floor sign and carried it with her. The resident resumed wandering, entered the Administrator's office with the wet floor sign.</p> <p>On 4/15/15 at 2:10 p.m., Resident #34 was observed coming from Resident #11's room. At 2:20 p.m. the resident opened the door and entered the laundry room. She was redirected by staff from the room, and continued to wander in the hallways.</p> <p>On 4/17/15 between 8:30 a.m. and 9:00 a.m. the resident was observed aimlessly</p>		<p><b>of each resident.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #34 behavior plan has been updated with interventions addressing wandering behaviors.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents with behaviors have been reviewed for behavior plans that include interventions. No other residents were noted to be affected.</p> <p><b><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></b></p> <p>All staff has been in-serviced related to behavior plans/interventions for wandering residents.</p> <p>SSD has been in-serviced on reviewing behaviors daily in morning meeting including review of the clinical record, the behavior tracking sheet, the care plan and the c.n.a. assignment sheet for proper intervention.</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></b></p>	

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	<p>wandering and entered four resident rooms that were not hers. The resident either exited the rooms on her own or staff redirected her from the rooms and she continued to wander. No attempts were made to engage the resident in any sort of activity.</p> <p>On 4/17/15 at 11:30 a.m., the resident wandered into the Administrator's office twice. The Hospitality Aide came in to redirect her. Housekeeper #10 was present and advised the aide if she took the resident by her hand she would go with her, as the resident liked to have some one hold her hand.</p> <p>On 4/17/15 at 11:55 a.m., the resident entered a resident's room behind the Assistant Director of Nursing (ADON). The nurse redirected the resident from the room and closed the door. The resident continued to wander and at 12:18 p.m. entered Resident #12's and #46's room. Resident #12 was in a wheelchair, yelled at the resident to get out, moved towards the resident and reattached a Velcro stop sign across the door of the room. Both residents indicated she frequently entered their room and bothered their things.</p> <p>On 4/14/15 at 10:30 a.m., Resident #45 was interviewed. She indicated Resident #34 had wondered into her room and her</p>		<p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents with behaviors related to any new or worsening behaviors interventions implemented, care planned, brought to morning meeting and added to the c.n.a. assignment sheet. The SSD, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tool. The Quality Assurance committee will also review any negative findings identified related to any nonqualified personnel identified to provide care to a resident with additional recommendations if needed.</p> <p><b><i>The date the systemic changes will be completed:</i></b></p> <p>May 17, 2015</p>	

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	<p>roommate (Resident #22) had grabbed Resident #34's wrists. Resident #45 indicated she had intervened and taken the resident from the room.</p> <p>The Minimum Data Set (MDS) coordinator was interviewed on 4/15/15 at 3:43 p.m. The coordinator indicated she had to keep the door of her office closed due to Resident #34's wandering.</p> <p>The Director of Nursing (DON) was interviewed on 4/16/15 at 10:50 a.m. The DON indicated equipment required for contact isolation could not be kept in Resident #40's room due to Resident #34 wandering into others rooms and taking things. The DON indicated the resident no longer had behaviors.</p> <p>On 4/17/15 at 11:06 a.m., CNA #9 was interviewed as to what interventions the resident would engage in. The CNA indicated the resident liked to fold things, like wash cloths or napkins. She indicated there were no items specific for the resident, and they gave her whatever they could find.</p> <p>On 4/17/15 at 10:58 a.m., Resident #34's clinical record was reviewed. The resident's Admission MDS, dated 3/3/15, coded the resident's cognition as severely impaired. The assessment coded the</p>			

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	<p>resident with daily behaviors of wandering.</p> <p>A Behavior Log Report for 4/9/15 at 9:00 a.m., indicated the resident wandered about the facility was brought to the nurses' station and snack and fluids had been given. On 4/10/15 at 9:45 a.m., the resident wandered about the facility, in and out of residents' rooms, and indicated staff walked with the resident and gave her a snack. No other behaviors were documented on the report.</p> <p>An interdisciplinary plan of care, dated 3/26/15, addressed the behavior of aimlessly wandering. The goal was to keep resident free from falls related to accelerated walking provide rest periods. No interventions were noted on the plan to address wandering behavior.</p> <p>A care plan, provided by the ADON on 4/17/15 at 10:47 a.m., with most recent update of 3/24/15, addressed resident's preferences for news, reading, magazines, listening to music, being around pets, crafts, walking, going outside when whether permitted, and religious/spiritual services.</p> <p>A facility policy, titled "Interdisciplinary Team process", dated 10/2010 included but was not limited to "...Residents who</p>			

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F 279 SS=D Bldg. 00	<p>exhibit inappropriate behaviors should be reviewed daily during the clinical meeting. Review the clinical record, the behavior tracking sheet documentation, the care plan, and the CNA/Resident Care assignment sheet. Be sure that an assessment was completed at the time of the behavior and immediate intervention was implemented. An ID [Interdisciplinary] intervention note should be written at this time in the clinical record. Documentation should include an analysis of the behavior to assure appropriate interventions are implemented. Update the care plan and the CNA/Resident Care assignment sheet at this time...."</p> <p>3.1-34(a)(1) 3.1-34(a)(2)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes</p>			

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	<p>measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview the facility failed to ensure plans of care for urinary catheter and/or a communicable infection were implemented for 2 of 16 residents reviewed for care plans (Resident #36 and #40).</p> <p>Findings include:</p> <p>1. On 4/13/15 at 12:00 p.m., Resident #36 was observed in a wheelchair with a urinary drainage tube and bag.</p> <p>On 4/17/15 at 1:20 p.m., during care, the resident was observed with an indwelling urinary catheter.</p> <p>Resident #36's clinical record was reviewed on 4/16/15 at 2:50 p.m. A physician's order, dated 1/26/15,</p>	F 279	<p><b>F279</b></p> <p><b>It is the practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>A Urinary Catheter care plan has been developed for Resident #36.</p> <p>A Communicable infection care plan has been developed for Resident #40.</p> <p><b><i>Other residents that have the potential to be affected have been</i></b></p>	05/17/2015

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	<p>indicated the resident was to continue with a indwelling urinary catheter due to an open surgical wound.</p> <p>The record did not indicate a plan of care, addressing interventions to prevent UTIs (urinary tract infections).</p> <p>During Interview of the ADON (assistant director of nursing) on 4/17/15 at 10 a.m., the ADON indicated the resident had the catheter since admission on 1/26/15. The ADON indicated a plan of care addressing the urinary catheter was lacking.</p> <p>The MDS (Minimum Data Set) coordinator was interviewed on 4/17/15 at 11:46 a.m. The MDS coordinator indicated she was responsible for implementing careplans and forgot to implement a plan concerning the resident's indwelling urinary catheter.</p> <p>During interview of the DON (director of nursing), on 4/17/15 at 2:00 p.m., the DON indicated the MDS coordinator was responsible for implementing plans of care.</p> <p>3.1-35(a)</p>		<p><b>identified by:</b></p> <p>All resident CAAS have been reviewed and care plans implemented for any identified areas.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The Interdisciplinary team/MDS Coordinator has been in-serviced on developing a comprehensive care plan for each resident that includes measurable goals and timetables to meet a residents medical, nursing , mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 Residents Comprehensive assessments/CAAS for care plan implementation. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. Any identified issues will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meetings with</p>		

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F 315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review the facility failed to ensure 2 of 2 residents reviewed for Foley catheters were provided care in a manner to prevent urinary tract infections. (Residents #40, and #36)</p> <p>Findings include:</p>	F 315	<p>recommendations for additional interventions as needed based on review of the outcomes of the PI tool. The Quality Assurance committee will also review any negative findings identified related to any nonqualified personnel identified to provide care to a resident with additional recommendations if needed.</p> <p><i>The date the systemic changes will be completed:</i></p> <p>May 17,2015</p> <p><b>F315</b></p> <p><b>It is the practice of Terre Haute Nursing and Rehabilitation to assure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal</b></p>	05/17/2015

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	<p>1. On 4/16/15 at 10:30 a.m., LPN #5 was observed to assist Resident #40 to remove sweat pants. The nurse removed the resident's pants, threading the Foley catheter bag and tubing through the pant leg. A few minutes later CNAs (certified nursing assistants) #2 and #3 returned with the slacks. The staff members reapplied the resident's slacks and repositioned the resident in the bed. The Foley catheter was observed to be pulled taught and not to be secured to prevent pulling.</p> <p>Resident #40's clinical record was reviewed on 4/16/15 at 3:30 p.m. A hospital Infection/Antibiotic report, dated 3/15/15, indicated the resident had a history of urinary tract infection.</p> <p>A plan of care, dated 4/5/15, addressed the problem of "At risk of developing urinary tract infection due to catheter use. Approaches included, but were not limited to, "Prevent tension on urinary meatus from catheter."</p> <p>2. On 4/13/15 at 12:00 p.m., Resident #36 was observed in a wheelchair in the dining room. The resident's urinary drainage tubing extended down on to and along the floor. The resident's tubing was observed again on the floor at 1:00 p.m.</p>		<p><b>bladder function as possible.</b></p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #36 and #40 were immediately issued leg straps. Resident # 36 catheter was immediately re-positioned so that the tubing nor the drain bag touched the floor.</p> <p>A teachable moment was given to c.n.a. #2 and #3 over Urinary Catheter Care. <b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents with Catheters have been reviewed to assure the catheter tubing nor the drain bag were on the floor and that the catheter remained secure with a leg strap to reduce friction and movement of the insertion site. No other residents were identified.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All Nursing staff In-serviced on Urinary Catheter Care to prevent infection of the resident's urinary tract specifically related to leg strap usage and preventing the tubing and drain bag from touching the floor.</p>	

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	<p>while sitting by the pay phone.</p> <p>The resident's urinary drainage tubing was observed on the floor on 4/14/15 at 1:00 p.m., and on 4/17/15 at 12:32 p.m.</p> <p>On 4/17/15 at 1:20 p.m., CNA #3 transferred Resident #36 from a wheel chair to the bed. After the resident was in bed, the CNA lowered the resident's sweat pants. The resident's urinary catheter was observed to be put tight. The CNA indicated the resident was suppose to have a leg strap to prevent the catheter from being stretched.</p> <p>A facility policy and procedure was provided from the Administrator on 4/17/15 at 1:50 p.m., titled "Catheter Care, Urinary". The policy indicated the purpose of this procedure was to prevent infection of the resident's urinary tract. The following approaches were noted, but not limited to, "Be sure the catheter tubing and drainage bag are kept off the floor" and "Ensure that the catheter remains secured with a leg strap to reduce frictions and movement at the insertion site."</p> <p>3.1-41(a)(2)</p>		<p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents with catheters for use of leg straps and proper positioning of tubing and drain bag. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed.</p> <p><b>The date the systemic changes will be completed:</b></p> <p>May 17, 2015</p>	

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F 441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</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</p>			

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	<p>accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to maintain an infection control program to prevent spread of infection for 1 of 1 observation of group activity (Resident #45, #32, #9, and #8) and 1 of 1 resident reviewed for a communicable infection (Resident #40).</p> <p>Findings include:</p> <p>1. On 4/13/15 at 10:30 a.m., Residents #45, #32, and #9 were observed participating in a ball toss activity. Resident #8 was in the activity area seated at the dining table. An activity volunteer was in charge of the activity. Resident #8 was observed to have a runny nose and was provided tissues. Resident #8 wiped drainage from the nose with the tissues and placed the contaminated tissues on the tablecloth. Two times the activity volunteer picked up the soiled tissues with bare hands and and put them into a plastic bag. The volunteer did not wash or sanitize hands before resuming the ball toss activity. The activity volunteer handled a pink ball labeled "therapy" and tossed it to the</p>	F 441	<p><b>F441</b></p> <p><b>It is the practice of this facility to assure that all procedures are conducted in a manner that is in accordance with infection control guidelines maintaining a program that prevents the spread of infection during group activity.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Activity Volunteer was given a teachable moment over the use of gloves, hand washing and changing soiled table linen.</p> <p>LPN #5, C.N.A.'s # 2, and 3 were given a teachable moment over infection control procedures for residents with communicable infection ie c-diff.</p> <p>Resident #45, 32, 9, and 8 hands were washed and therapy ball disinfected immediately.</p> <p>Housekeeper #12 given teachable moment over cleaning room of c-diff</p>	05/17/2015

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	<p>Residents #45, #32, and #9. At the end of the activity the volunteer returned the ball to the therapy room. The tablecloth was not changed prior to the noon meal. Two other residents were observed seated at the table for lunch.</p> <p>The DON (Director of Nursing) and Administrator were interviewed on 4/17/15 at 4:00 p.m. The staff indicated the Housekeeping/Activity Supervisor was responsible for training of the activity volunteers which included infection control practices. The Administrator indicated the supervisor had not received any special training in regard to infection control practices.</p> <p>2. On 4/13/15 at 10:30 a.m. Resident #40 was observed in his room. The resident's roommate (Resident #14) was also present in the room. Two large cartons were observed in the middle of the floor covered with a sheet. The cartons were for the disposal of soiled linens and trash, utilized for contact isolation. No signage was observed indicating persons should check with the nurse before entering the room.</p> <p>On 4/16/15 at 10:30 a.m., Resident #40 indicated his pants were too tight, LPN #5 removed the resident's slacks. The nurse's uniform was in contact with the</p>		<p>resident, isolation cart and signage procedures.</p> <p>Signage was placed on Residents #40 and #14's door.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents could potentially be affected. All residents are receiving services in a manner which promotes acceptable infection control. Please see system changes and means of monitoring below.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>An in-service has been conducted for nursing staff related to proper infection control practices specifically related to isolation, signage and notification of Housekeeping, Laundry and other staff of a communicable infection. Staff will be notified via Morning Meeting and Signage.</p> <p>Housekeeping staff has been in-serviced on proper cleaning of resident's rooms with communicable infections and placing isolation cart with protective supplies in the patient room.</p> <p>All staff has been in-serviced on</p>	

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	<p>resident's bed during the care. The nurse removed the residents pants, and threaded the Foley catheter bag and tubing through the pant leg. The nurse removed gloves and exited the room. A few minutes later CNAs (certified nursing assistants) #2 and #3 returned with the slacks. The staff members donned gloves, but did not wear gowns, and placed the slacks on the resident and repositioned the resident in the bed. Both staffs' uniforms were in contact with the bed during the care. The staff removed gloves, washed hands and exited the room.</p> <p>The CNAs were interviewed after the observation of provision of care. Both staff indicated they only wore gloves when they provided care for the resident. If it was required could get yellow gowns from the soiled utility room.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 4/13/15 at 10:00 a.m. The nurse indicated the resident had Clostridium Difficile (c-diff infection is a bacteria overgrowth and release of toxins that attack the lining of the colon that can be spread to others).</p> <p>On 4/13/15 at 11:00 a.m., CNA #1 was interviewed. The CNA indicated she did not think there were any residents that required isolation precautions currently.</p>		<p>hand washing.</p> <p>The facility nursing administration/ and or designee will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy as well as activity volunteers providing group activities.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated on the following: DON to randomly observe 5 residents related to following of proper infection control procedures. The observations will include proper isolation based on the organism identified including random observations of 5 employees on different shifts for proper hand washing and observations of volunteers during group activity.</p> <p>Housekeeping supervisor or designee will randomly observe cleaning of rooms for those residents with c-diff, checking for proper signage and isolation carts stocked with protective supplies.</p> <p>The Director of Nursing, or designee, will complete these tools weekly x3,</p>	

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	<p>The CNA indicated there had been a resident with c-diff but was no longer in precautions. The CNA indicated the only precautions for the infections she had seen was gloves.</p> <p>On 4/16/15 Housekeeper #12 was interviewed. The housekeeper indicated she was not aware of any resident with special precautions in the building. When asked how she would have been made aware of any special precautions she indicated someone would tell her. The housekeeper was interviewed as to what cleaning agents would be used for c-diff and provided a product named "Mainline Hospital Germicide" Disinfectant Cleaner. The product label identified the types of organisms it was effective for sanitation and did not include c-difficile. Bleach was observed in the housekeeping closet. When the housekeeper was asked what that would be utilized for, she indicated sometimes it was used on the floor, if there had been urine on the floor or sometimes on toilets.</p> <p>The Housekeeping Supervisor was interviewed on, 4/16/15 at 11:15 a.m., and indicated bleach 1:10 solution was utilized for rooms of residents with c-diff.</p> <p>The DON was interviewed on 4/16/15 at</p>		<p>monthly x3, then quarterly x3. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools.</p> <p><b><i>The date the systemic changes will be completed:</i></b></p> <p>May 17, 2015</p>	

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NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN 47807
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	<p>10:50 a.m. The DON indicated the resident had been admitted with c-difficile on 3/15/15. The DON indicated the resident was in contact precautions and gowns and gloves should have been worn when dressing the resident. The DON indicated the personal protective equipment would normally be inside of the resident's room, but due to wandering residents had not been done. The DON indicated the gowns were kept in the soiled utility room.</p> <p>Resident #40's clinical record was reviewed on 4/16/15 at 3:30 p.m. Documentation on a form titled "BM [bowel movement] Monitoring: for the month of April, 2015, indicated the resident had large loose stools. A lab report for a culture obtained on 4/11/15 and received on 4/13/15, was noted of positive for c-difficile toxins a and b.</p> <p>The facility's undated policy, titled "Policies and Practices-Infection Control," and identified as current by the DON on 4/16/15 at 11:50 a.m., included but was not limited to, "... All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee</p>			

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	<p>training shall be appropriate to the degree of direct resident contact and job responsibilities. ...1. Routine Infection Control Place residents with CDI (c-difficile infections) in contact precautions. Notify the housekeeping and laundry department of the resident with CDI. Ensure caregivers have been notified of the CDI. This facility utilizes signage to communicate to staff and visitors to report to the Nurse before entering room; The posted sign will not be specific to the mode of transmission nor the type of disease...Equipment Use dedicated equipment (blood pressure cuff, thermometer, stethoscope). An isolation cart will be placed in the patient room and will contain appropriate protective supplies. Gloves/Gowns Don gloves upon entering resident's room...Gowns should be worn with gloves for all interactions that may involve contact with the resident, contaminated equipment, or potentially contaminated areas within the resident's environment...."</p> <p>An undated facility policy, titled "Handwashing," identified as current by the Administrator on 4/17/15 at 1:50 p.m., included but was not limited to, "Policy: Handwashing should be performed: As promptly as possible after contact with blood, body fluids,</p>			

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F 465 SS=E Bldg. 00	<p>secretions, excretions, and equipment or articles contaminated by them, whether or not gloves are worn....When otherwise indicated to avoid transfers of microorganisms to other residents and environments...."</p> <p>3.1-18-(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a comfortable living environment for 2 of 3 nursing units (North and South hallways).</p> <p>Findings include:</p>	F 465	<p><b>F465</b></p> <p><b>It is the practice of Terre Haute Healthcare and Rehab to assure that residents' environment is safe, functional, sanitary and comfortable.</b></p>	05/17/2015

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	<p>During an environmental tour on 4/17/15 beginning at 10:02 a.m., the following observations were made:</p> <p>1. North hallway:</p> <p>a. In room #2, the cable wall plate was missing above the TV for bed A.</p> <p>b. In room #3, a hole was observed in wall behind the door to the room where the door knob has been pushed into the wall .</p> <p>2. South hallway:</p> <p>a. In room #12, an unpainted/unfinished plastered area observed on wall behind chest of drawers at the foot of bed A.</p> <p>b. In room #13 an unpainted/unfinished plastered area was observed over bed B.</p> <p>c. In room #14, broken floor tiles were observed at the left corner of the head of bed B. The area was measured by Housekeeping Supervisor and measured 14 inched in length and 4 inches at it's widest point.</p> <p>d. In room #16, multiple boxes and items were observed stacked in front of the right side of the closet doors.</p>		<p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>North Hallway</p> <p>Room #2 cable wall plate replaced.</p> <p>Room #3 Hole patched and area painted.</p> <p>South Hallway</p> <p>Room #12 plastered area on wall behind chest of drawers at foot of bed A Painted and finished.</p> <p>Room #13 over bed B area painted and finished.</p> <p>Room #14 broken floor tiles replaced by bed B.</p> <p>Room #16 Boxes placed up off of floor making closet more accessible.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All resident rooms have been reviewed to assure that the environment is free from hazards, unpainted areas, unbroken tiles and cable wall plates are intact.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p>	

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	<p>In an interview during the environmental tour beginning on 4/17/15 at 10:02 a.m., the Housekeeping Supervisor indicated the previous resident in the South hallway, room #13 (no longer at the facility) hit the wall and caused the hole. The Housekeeping Supervisor indicated the items in South hallway, room #16 belonged to the resident in bed A. She indicated facility staff sent items home with the resident's sister, but the resident brought the items back to the facility after she visited the sister on the weekend.</p> <p>3.1-19 (f)</p>		<p>The Maintenance staff has been in-serviced on preventative maintenance program.</p> <p>All staff has been in-served on recording any hazards, unpainted unfinished walls, broken tiles, missing cable wall plates, or any other maintenance issues found.</p> <p>There will be routine monitoring via rounds by Administrator and Housekeeping to assure that the environment is free from hazards, unpainted unfinished walls, broken tiles, missing cable wall plates, or any other maintenance issues found.</p> <p><b><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></b></p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to a safe, comfortable environment. The tool will specifically address unpainted unfinished walls, broken tiles, hazards, and cable wall plates and Maintenance Log for other staff inquiries. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any areas identified via the audit will be immediately</p>	

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			corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.  <b><i>The date the systemic changes will be completed:</i></b>  May 17,2015		