

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00125579.</p> <p>Complaint IN00125579-Substantiated. Federal deficiencies related to the allegations are cited at F223, F225, and F226.</p> <p>Survey dates: April 1, 2, 3, 4, 5, 11, and 12, 2013</p> <p>Facility number: 000418 Provider number: 155565 AIM number: 100274870</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN</p> <p>Census bed type: SNF/NF 48 Total: 48</p> <p>Census payor type: Medicare 6 Medicaid 36 Other 6 Total: 48</p> <p>This deficiencies reflect state findings</p>	F000000	<p>F0000 -</p> <p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Hickory Creek at Sunset desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective May 10, 2012.</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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	cited in accordance with 410 IAC 16.2. Quality Review completed on 04/18/2013 by Brenda Nunan, RN.				

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure all residents were free from abuse for 1 of 6 residents reviewed for allegations of staff to resident abuse [Resident A].</p> <p>Findings include:</p> <p>Facility abuse investigations were reviewed on 4/5/13 at 1:30 p.m. An investigation report indicated an allegation of CNA #10 calling Resident A a "big fat tick" on 2/1/13 in the dining room area as she transported the resident back to her room after the supper meal. The investigation report indicated CNAs #7, #8, and #9 overheard CNA #10 call the resident the derogatory name. The investigation report indicated CNAs #7 and #9 were overheard on 2/2/13 during the evening shift by LPN #11 discussing the name calling event from 2/1/13. Documentation indicated upon learning of the</p>	F000223	<p>The following is the plan of correction F223</p> <p>It is policy of this facility that Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. It should be noted that the facility Administrator acted immediately upon the report of alleged abuse when it was reported to him on 2/2/13. The facility notified ISDH with an initial report of alleged abuse on 2/3/13 as required by Indiana State Law. The facility did a thorough investigation and by means of that investigation substantiated the complaint. A follow up report was sent to ISDH on 2/7/2013 detailing the investigation findings and outcome of the allegation. As a result of this investigation the Administrator did confirm that CNA #10 received orientation upon hire to this facility on</p>	05/10/2013			

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	<p>allegation, LPN #11 notified the Administrator, Director of Nursing, Assistant Director of Nursing, and Resident A's family. The investigation report indicated CNA #10 was suspended until the investigation of the allegation of abuse was completed. The investigation report indicated CNA #10 admitted to calling the resident a "big fat tick." The facility investigation report indicated CNA #10 verbally abused Resident A on 2/1/13. Records indicated the facility terminated CNA #10 on 2/4/13 for verbal abuse to Resident A.</p> <p>Upon interview of the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/11/13 at 10:30 a.m., both indicated the allegation of verbal abuse by CNA #10 to Resident A occurred on the evening of 2/1/13 after the supper meal. The ADON and DON indicated CNAs #7, #8, and #9 witnessed CNA #10 to call Resident A a "big fat tick." The ADON indicated CNA #10 completed her evening shift on 2/1/13. The ADON and DON indicated the Administrator was not immediately notified of the allegation of abuse by the CNA's who witnessed the incident. The ADON and DON indicated the administrator was notified the following evening, on</p>		<p>2/1/2012 and signed an acknowledgement that she received and reviewed the facility policy for abuse, neglect, and misappropriation of personal property, and that she attended the annual inservice education on the facility's policy Resident Rights and for abuse, neglect, and misappropriation of personal property on 12/4/2012 and 1/26/2013.</p> <p>1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>An investigation was immediately initiated after a suspicion of verbal abuse was reported by L.P.N. #11 to the Administrator and Director of Nurses on 2/2/13. Statements were obtained on 2/2/13 by L.P.N. #11 from C.N.A.s #7 and #9 regarding the allegations against C.N.A. #10. C.N.A. #10 was immediately placed on suspension pending completion of investigation. As a result of the investigative findings, C.N.A. #10 was terminated on 2/4/13 for verbal abuse of resident A.</p> <p>Upon initial allegation, the resident was immediately assessed by L.P.N. #11 and assessment revealed no signs or symptoms of emotional distress. Further investigation and interviews were conducted by</p>		

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	<p>2/2/13 at approximately 9 p.m., after LPN #11 became aware of the incident.</p> <p>Upon interview of CNA #8 on 4/11/13 at 3:40 p.m., the CNA indicated he overheard CNA #10 on the evening of 2/1/13 state " [Resident A] you are a big fat tick." The CNA indicated he did not report the incident that the time it occurred, but he knew he should have.</p> <p>Upon interview of CNA #7 on 4/11/13 at 3:45 p.m., the CNA indicated CNA #10 indicated in front of her that Resident A was a "big fat tick." CNA #7 indicated Resident A did not respond to the comment by CNA #10. CNA #7 stated she did not report the incident on 2/1/13; however, she did report the incident to 2/2/13 during the evening shift to LPN #11. CNA #7 indicated CNA #10 did not work on 2/2/13.</p> <p>Upon interview of CNA #9 on 4/12/13 at 11:08 a.m., the CNA indicated she heard CNA #10, on 2/1/13 after supper, call Resident A a "big fat tick." The CNA stated she talked with LPN # 11 on 2/2/13 during the evening shift which was from 2 p.m. to 10 p.m.</p>		<p>Director of Nurses and Assistant Director of Nurses with interviewable residents. Additional statements were received from C.N.A. # 7, #8, #9, and L.P.N. #11. Additionally, resident was observed to be following regular routines and the Social Service Director and Guardian Angel assigned to this resident continued to observe for further signs and symptoms of distress. None were noted.</p> <p>A Q.A. process was initiated to analyze the facility policy and procedure regarding allegations of abuse and the processes involved within that policy. Once the analysis was complete, the facility did identify that staff was not fully cognizant of their responsibility to report any and all allegations of abuse to their supervisor and Administrator immediately.</p> <p>As a result of the QA findings, an all-staff in-service was conducted on 2/12/13. All staff, in all departments, were re-educated on the facility's policies: 1) Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property, including the responsibility of all staff to report all allegations of abuse to their supervisor and Administrator immediately, 2) Abuse-Investigation and Follow-Up, 3) The Elder Justice Act, and 4) The Elder Justice Act</p>		

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	<p>Upon interview of LPN #11 on 4/12/13 at 11:34 a.m., the LPN indicated she overheard CNAs #7 and #9 talking about CNA #10 calling Resident A a "big fat tick" on 2/1/13 during the evening shift of 2/2/13. The LPN indicated she asked the CNAs if they had reported the incident and the CNAs stated "no." The LPN indicated she immediately contacted the DON and Administrator. The LPN also indicated she took statements from CNAs #7 and #9 regarding the allegation of verbal abuse on the evening of 2/2/13.</p> <p>Upon review of the clinical record of Resident A on 4/11/13 at 11 a.m., the most recent Minimum Data Set (MDS) assessment was completed on 12/18/12. The assessment identified the resident with severe impairment in cognitive decision making skills, problems with long/short term memory, and total dependence in bathing, and transfers.</p> <p>Upon review of the facility's current policy and procedure titled "Resident Mistreatment, Neglect, Abuse, & Misappropriation of Property" dated 12/1999 (revised 9/2010) on 4/5/13 at 2 p.m., documentation was noted of "...STANDARD Residents will be free from mistreatment, neglect, abuse,</p>		<p>–Reporting Reasonable Suspicion of a Crime against a Resident. Following the in-service, all employees completed an Affirmation of “ No” Observation/Knowledge of Abuse form asking if at any time during their employment they had ever observed, or had knowledge of, any resident having been mistreated, neglected , abused, or having had personal property taken from them. No other previously unreported incidents were identified.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents had the potential to be affected by this deficiency. All alert and oriented residents were interviewed by Social Service Director, Director of Nurses, and Assistant Director of Nurses and follow-up interviews were conducted by facility Guardian Angels to determine if any other residents had been affected by this deficiency. No other concerns or findings were identified. Interviews produced only positive comments.</p> <p>In the future, if the Administrator or other manager becomes aware</p>		

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	<p>misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Definitions...verbal abuse: Defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability..."</p> <p>This Federal tag relates to Complaint IN00125579.</p> <p>3.1-27(b)</p>		<p>of any alleged abuse that was not reported immediately, the Administrator and/or manager will suspend the staff involved immediately and will begin an investigation. In addition, the Administrator and manager will interview the employee(s) who were aware of the alleged abuse and did not report it immediately to the supervisor and Administrator. The employee(s) will receive retraining on the facility policy regarding abuse and neglect and will render progressive disciplinary action, up to termination of employment, for failure to notify the Administrator and supervisor immediately upon becoming aware of possible abuse.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>C.N.A.s # 7, #8, #9 were immediately re-educated. On 2/4/13, all were given verbal warnings, and counseled regarding the importance of following the abuse and neglect policy and immediately reporting any suspicions of abuse or neglect. As a result of the QA review and analysis, the Administrator requested a meeting with the Chief of Police</p>		

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			<p>to discuss the Elder Justice Act and to further review the facility system in place to identify and report alleged abuse and neglect. As a result of this discussion, it was determined that no systematic changes to the facility's current policy and procedure were necessary.</p> <p>The Guardian Angel program is in place in this facility, with a manager assigned to specific residents as their "guardian angel". The Guardian Angel visits his/her residents at least 5 days a week, and specifically asks the resident if he/she has any concerns regarding staff care or treatment. Interviews of families are also done at intervals regarding the resident's care/treatment. Those visits and interviews are brought to the morning management meeting scheduled at least 5 days a week for further review. If there is any concern of alleged abuse identified, the Guardian Angel will notify the Administrator immediately and an investigation will be initiated.</p> <p>Prior to direct resident contact, all new employees will continue to be oriented and educated on the facility's policies of Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property, The Elder Justice Act, and The Elder Justice Act –Reporting Reasonable Suspicion of a Crime</p>	

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			<p>against a Resident. An annual in-service of these policies will continue to be provided to all employees per policy.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Results of Guardian Angel visits and interviews, as well as allegations of abuse or neglect will be brought to the monthly QA Committee meeting for further review, discussion, and follow up. Any recommendations made by the Committee will be followed up by a designated manager(s) who will report the results of those recommendations at the next scheduled QA Committee meeting. This process will continue on an on-going basis.</p>	

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225				05/10/2013	

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	<p>review, the facility failed to ensure an allegation of abuse was reported immediately to the Administrator and/or State officials for 1 of 4 allegations of staff to resident abuse (Resident A).</p> <p>Findings include:</p> <p>Facility abuse investigations were reviewed on 4/5/13 at 1:30 p.m. An investigation report indicated an allegation of CNA #10 calling Resident A a "big fat tick" on 2/1/13 in the dining room area as she transported the resident back to her room after the supper meal. The investigation report indicated CNAs #7, #8, and #9 overheard CNA #10 call the resident the derogatory name. The investigation report indicated CNAs #7 and #9 were overheard on 2/2/13 during the evening shift by LPN #11 discussing the name calling event from 2/1/13. Documentation indicated upon learning of the allegation, LPN #11 notified the Administrator, Director of Nursing, Assistant Director of Nursing, and Resident A's family. The investigation report indicated CNA #10 was suspended until the investigation of the allegation of abuse was completed. The investigation report indicated CNA #10 admitted to calling</p>		<p>The following is the plan of correction F223</p> <p>It is policy of this facility that Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. It should be noted that the facility Administrator acted immediately upon the report of alleged abuse when it was reported to him on 2/2/13. The facility notified ISDH with an initial report of alleged abuse on 2/3/13 as required by Indiana State Law. The facility did a thorough investigation and by means of that investigation substantiated the complaint. A follow up report was sent to ISDH on 2/7/2013 detailing the investigation findings and outcome of the allegation. As a result of this investigation the Administrator did confirm that CNA #10 received orientation upon hire to this facility on 2/1/2012 and signed an acknowledgement that she received and reviewed the facility policy for abuse, neglect, and misappropriation of personal property, and that she attended the annual inservice education on the facility's policy Resident Rights and for abuse, neglect, and misappropriation of personal property on 12/4/2012 and 1/26/2013.</p>		

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	<p>the resident a "big fat tick." The facility investigation report indicated CNA #10 verbally abused Resident A on 2/1/13. Records indicated the facility terminated CNA #10 on 2/4/13 for verbal abuse to Resident A.</p> <p>Upon interview of the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/11/13 at 10:30 a.m., both indicated the allegation of verbal abuse by CNA #10 to Resident A occurred on the evening of 2/1/13 after the supper meal. The ADON and DON indicated CNAs #7, #8, and #9 witnessed CNA #10 to call Resident A a "big fat tick." The ADON indicated CNA #10 completed her evening shift on 2/1/13. The ADON and DON indicated the Administrator was not immediately notified of the allegation of abuse by the CNA's who witnessed the incident. The ADON and DON indicated the administrator was notified the following evening, on 2/2/13 at approximately 9 p.m., after LPN #11 became aware of the incident.</p> <p>Upon interview of CNA #8 on 4/11/13 at 3:40 p.m., the CNA indicated he overheard CNA #10 on the evening of 2/1/13 state " [Resident A] you are a big fat tick." The CNA indicated he</p>		<p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>An investigation was immediately initiated after a suspicion of verbal abuse was reported by L.P.N. #11 to the Administrator and Director of Nurses on 2/2/13. Statements were obtained on 2/2/13 by L.P.N. #11 from C.N.A.s #7 and #9 regarding the allegations against C.N.A. #10. C.N.A. #10 was immediately placed on suspension pending completion of investigation. As a result of the investigative findings, C.N.A. #10 was terminated on 2/4/13 for verbal abuse of resident A.</p> <p>Upon initial allegation, the resident was immediately assessed by L.P.N. #11 and assessment revealed no signs or symptoms of emotional distress. Further investigation and interviews were conducted by Director of Nurses and Assistant Director of Nurses with interviewable residents. Additional statements were received from C.N.A. # 7, #8, #9, and L.P.N. #11. Additionally, resident was observed to be following regular routines and the Social Service Director and Guardian Angel assigned to this resident continued to observe for further signs and symptoms of distress.</p>				

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	<p>did not report the incident that the time it occurred, but he knew he should have.</p> <p>Upon interview of CNA #7 on 4/11/13 at 3:45 p.m., the CNA indicated CNA #10 indicated in front of her that Resident A was a "big fat tick." CNA #7 indicated Resident A did not respond to the comment by CNA #10. CNA #7 stated she did not report the incident on 2/1/13; however, she did report the incident to 2/2/13 during the evening shift to LPN #11. CNA #7 indicated CNA #10 did not work on 2/2/13.</p> <p>Upon interview of CNA #9 on 4/12/13 at 11:08 a.m., the CNA indicated she heard CNA #10, on 2/1/13 after supper, call Resident A a "big fat tick." The CNA stated she talked with LPN # 11 on 2/2/13 during the evening shift which was from 2 p.m. to 10 p.m.</p> <p>Upon interview of LPN #11 on 4/12/13 at 11:34 a.m., the LPN indicated she overheard CNAs #7 and #9 talking about CNA #10 calling Resident A a "big fat tick" on 2/1/13 during the evening shift of 2/2/13. The LPN indicated she asked the CNAs if they had reported the incident and the CNAs stated "no." The LPN indicated</p>		<p>None were noted.</p> <p>A Q.A. process was initiated to analyze the facility policy and procedure regarding allegations of abuse and the processes involved within that policy. Once the analysis was complete, the facility did identify that staff was not fully cognizant of their responsibility to report any and all allegations of abuse to their supervisor and Administrator immediately.</p> <p>As a result of the QA findings, an all-staff in-service was conducted on 2/12/13. All staff, in all departments, were re-educated on the facility's policies: 1) Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property, including the responsibility of all staff to report all allegations of abuse to their supervisor and Administrator immediately, 2) Abuse-Investigation and Follow-Up, 3) The Elder Justice Act, and 4) The Elder Justice Act –Reporting Reasonable Suspicion of a Crime against a Resident. Following the in-service, all employees completed an Affirmation of " No" Observation/Knowledge of Abuse form asking if at any time during their employment they had ever observed, or had knowledge of, any resident having been mistreated, neglected , abused, or having had personal property</p>		

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	<p>she immediately contacted the DON and Administrator. The LPN also indicated she took statements from CNAs #7 and #9 regarding the allegation of verbal abuse on the evening of 2/2/13.</p> <p>Upon review of the clinical record of Resident A on 4/11/13 at 11 a.m., the most recent Minimum Data Set (MDS) assessment was completed on 12/18/12. The assessment identified the resident with severe impairment in cognitive decision making skills, problems with long/short term memory, and total dependence in bathing, and transfers.</p> <p>This Federal tag relates to Complaint IN00125579.</p> <p>3.1-28(c)</p>		<p>taken from them. No other previously unreported incidents were identified.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents had the potential to be affected by this deficiency. All alert and oriented residents were interviewed by Social Service Director, Director of Nurses, and Assistant Director of Nurses and follow-up interviews were conducted by facility Guardian Angels to determine if any other residents had been affected by this deficiency. No other concerns or findings were identified. Interviews produced only positive comments.</p> <p>In the future, if the Administrator or other manager becomes aware of any alleged abuse that was not reported immediately, the Administrator and/or manager will suspend the staff involved immediately and will begin an investigation. In addition, the Administrator and manager will interview the employee(s) who were aware of the alleged abuse and did not report it immediately to the supervisor and Administrator. The employee(s)</p>		

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			<p>will receive retraining on the facility policy regarding abuse and neglect and will render progressive disciplinary action, up to termination of employment, for failure to notify the Administrator and supervisor immediately upon becoming aware of possible abuse.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>C.N.A.s # 7, #8, #9 were immediately re-educated. On 2/4/13, all were given verbal warnings, and counseled regarding the importance of following the abuse and neglect policy and immediately reporting any suspicions of abuse or neglect. As a result of the QA review and analysis, the Administrator requested a meeting with the Chief of Police to discuss the Elder Justice Act and to further review the facility system in place to identify and report alleged abuse and neglect. As a result of this discussion, it was determined that no systematic changes to the facility's current policy and procedure were necessary.</p> <p>The Guardian Angel program is in place in this facility, with a</p>		

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			<p>manager assigned to specific residents as their "guardian angel". The Guardian Angel visits his/her residents at least 5 days a week, and specifically asks the resident if he/she has any concerns regarding staff care or treatment. Interviews of families are also done at intervals regarding the resident's care/treatment. Those visits and interviews are brought to the morning management meeting scheduled at least 5 days a week for further review. If there is any concern of alleged abuse identified, the Guardian Angel will notify the Administrator immediately and an investigation will be initiated.</p> <p>Prior to direct resident contact, all new employees will continue to be oriented and educated on the facility's policies of Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property, The Elder Justice Act, and The Elder Justice Act –Reporting Reasonable Suspicion of a Crime against a Resident. An annual in-service of these policies will continue to be provided to all employees per policy.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p>	

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			Results of Guardian Angel visits and interviews, as well as allegations of abuse or neglect will be brought to the monthly QA Committee meeting for further review, discussion, and follow up. Any recommendations made by the Committee will be followed up by a designated manager(s) who will report the results of those recommendations at the next scheduled QA Committee meeting. This process will continue on an on-going basis.	

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement its policies and procedures for immediately reporting an allegation of abuse to the Administrator for 1 of 4 allegations of staff to resident abuse (Resident A).</p> <p>Findings include:</p> <p>Facility abuse investigations were reviewed on 4/5/13 at 1:30 p.m. An investigation report indicated an allegation of CNA #10 calling Resident A a "big fat tick" on 2/1/13 in the dining room area as she transported the resident back to her room after the supper meal. The investigation report indicated CNAs #7, #8, and #9 overheard CNA #10 call the resident the derogatory name. The investigation report indicated CNAs #7 and #9 were overheard on 2/2/13 during the evening shift by LPN #11 discussing the name calling event from 2/1/13. Documentation indicated upon learning of the allegation, LPN #11 notified the</p>	F000226	<p>The following is the plan of correction F223</p> <p>It is policy of this facility that Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. It should be noted that the facility Administrator acted immediately upon the report of alleged abuse when it was reported to him on 2/2/13. The facility notified ISDH with an initial report of alleged abuse on 2/3/13 as required by Indiana State Law. The facility did a thorough investigation and by means of that investigation substantiated the complaint. A follow up report was sent to ISDH on 2/7/2013 detailing the investigation findings and outcome of the allegation. As a result of this investigation the Administrator did confirm that CNA #10 received orientation upon hire to this facility on 2/1/2012 and signed an acknowledgement that she received and reviewed the facility</p>	05/10/2013			

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	<p>Administrator, Director of Nursing, Assistant Director of Nursing, and Resident A's family. The investigation report indicated CNA #10 was suspended until the investigation of the allegation of abuse was completed. The investigation report indicated CNA #10 admitted to calling the resident a "big fat tick." The facility investigation report indicated CNA #10 verbally abused Resident A on 2/1/13. Records indicated the facility terminated CNA #10 on 2/4/13 for verbal abuse to Resident A.</p> <p>Upon interview of the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/11/13 at 10:30 a.m., both indicated the allegation of verbal abuse by CNA #10 to Resident A occurred on the evening of 2/1/13 after the supper meal. The ADON and DON indicated CNAs #7, #8, and #9 witnessed CNA #10 to call Resident A a "big fat tick." The ADON indicated CNA #10 completed her evening shift on 2/1/13. The ADON and DON indicated the Administrator was not immediately notified of the allegation of abuse by the CNA's who witnessed the incident. The ADON and DON indicated the administrator was notified the following evening, on 2/2/13 at approximately 9 p.m., after</p>		<p>policy for abuse, neglect, and misappropriation of personal property, and that she attended the annual inservice education on the facility's policy Resident Rights and for abuse, neglect, and misappropriation of personal property on 12/4/2012 and 1/26/2013.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>An investigation was immediately initiated after a suspicion of verbal abuse was reported by L.P.N. #11 to the Administrator and Director of Nurses on 2/2/13. Statements were obtained on 2/2/13 by L.P.N. #11 from C.N.A.s #7 and #9 regarding the allegations against C.N.A. #10. C.N.A. #10 was immediately placed on suspension pending completion of investigation. As a result of the investigative findings, C.N.A. #10 was terminated on 2/4/13 for verbal abuse of resident A.</p> <p>Upon initial allegation, the resident was immediately assessed by L.P.N. #11 and assessment revealed no signs or symptoms of emotional distress. Further investigation and interviews were conducted by Director of Nurses and Assistant Director of Nurses with interviewable residents. Additional</p>				

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	<p>LPN #11 became aware of the incident.</p> <p>Upon interview of CNA #8 on 4/11/13 at 3:40 p.m., the CNA indicated he overheard CNA #10 on the evening of 2/1/13 state " [Resident A] you are a big fat tick." The CNA indicated he did not report the incident that the time it occurred, but he knew he should have.</p> <p>Upon interview of CNA #7 on 4/11/13 at 3:45 p.m., the CNA indicated CNA #10 indicated in front of her that Resident A was a "big fat tick." CNA #7 indicated Resident A did not respond to the comment by CNA #10. CNA #7 stated she did not report the incident on 2/1/13; however, she did report the incident to 2/2/13 during the evening shift to LPN #11. CNA #7 indicated CNA #10 did not work on 2/2/13.</p> <p>Upon interview of CNA #9 on 4/12/13 at 11:08 a.m., the CNA indicated she heard CNA #10, on 2/1/13 after supper, call Resident A a "big fat tick." The CNA stated she talked with LPN # 11 on 2/2/13 during the evening shift which was from 2 p.m. to 10 p.m.</p> <p>Upon interview of LPN #11 on</p>		<p>statements were received from C.N.A. # 7, #8, #9, and L.P.N. #11. Additionally, resident was observed to be following regular routines and the Social Service Director and Guardian Angel assigned to this resident continued to observe for further signs and symptoms of distress. None were noted.</p> <p>A Q.A. process was initiated to analyze the facility policy and procedure regarding allegations of abuse and the processes involved within that policy. Once the analysis was complete, the facility did identify that staff was not fully cognizant of their responsibility to report any and all allegations of abuse to their supervisor and Administrator immediately.</p> <p>As a result of the QA findings, an all-staff in-service was conducted on 2/12/13. All staff, in all departments, were re-educated on the facility's policies: 1) Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property, including the responsibility of all staff to report all allegations of abuse to their supervisor and Administrator immediately, 2) Abuse-Investigation and Follow-Up, 3) The Elder Justice Act, and 4) The Elder Justice Act –Reporting Reasonable Suspicion of a Crime against a Resident. Following the</p>				

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	<p>4/12/13 at 11:34 a.m., the LPN indicated she overheard CNAs #7 and #9 talking about CNA #10 calling Resident A a "big fat tick" on 2/1/13 during the evening shift of 2/2/13. The LPN indicated she asked the CNAs if they had reported the incident and the CNAs stated "no." The LPN indicated she immediately contacted the DON and Administrator. The LPN also indicated she took statements from CNAs #7 and #9 regarding the allegation of verbal abuse on the evening of 2/2/13.</p> <p>Upon review of the clinical record of Resident A on 4/11/13 at 11 a.m., the most recent Minimum Data Set (MDS) assessment was completed on 12/18/12. The assessment identified the resident with severe impairment in cognitive decision making skills, problems with long/short term memory, and total dependence in bathing, and transfers.</p> <p>Upon review of the facility's current policy and procedure titled "Resident Mistreatment, Neglect, Abuse, & Misappropriation of Property" dated 12/1999 (revised 9/2010) on 4/5/13 at 2 p.m., documentation was noted of "...J. Investigation: All reported incidents of alleged violations involving mistreatment, neglect, or</p>		<p>in-service, all employees completed an Affirmation of "No" Observation/Knowledge of Abuse form asking if at any time during their employment they had ever observed, or had knowledge of, any resident having been mistreated, neglected, abused, or having had personal property taken from them. No other previously unreported incidents were identified.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents had the potential to be affected by this deficiency. All alert and oriented residents were interviewed by Social Service Director, Director of Nurses, and Assistant Director of Nurses and follow-up interviews were conducted by facility Guardian Angels to determine if any other residents had been affected by this deficiency. No other concerns or findings were identified. Interviews produced only positive comments.</p> <p>In the future, if the Administrator or other manager becomes aware of any alleged abuse that was not reported immediately, the Administrator and/or manager will</p>				

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	<p>abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law (typically within 24 hours of witness/identification)..."</p> <p>This Federal tag relates to Complaint IN00125579.</p> <p>3.1-28(a)</p>		<p>suspend the staff involved immediately and will begin an investigation. In addition, the Administrator and manager will interview the employee(s) who were aware of the alleged abuse and did not report it immediately to the supervisor and Administrator. The employee(s) will receive retraining on the facility policy regarding abuse and neglect and will render progressive disciplinary action, up to termination of employment, for failure to notify the Administrator and supervisor immediately upon becoming aware of possible abuse.</p> <p>1.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>C.N.A.s # 7, #8, #9 were immediately re-educated. On 2/4/13, all were given verbal warnings, and counseled regarding the importance of following the abuse and neglect policy and immediately reporting any suspicions of abuse or neglect. As a result of the QA review and analysis, the Administrator requested a meeting with the Chief of Police to discuss the Elder Justice Act and to further review the facility system in place to identify and</p>		

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			<p>report alleged abuse and neglect. As a result of this discussion, it was determined that no systematic changes to the facility's current policy and procedure were necessary.</p> <p>The Guardian Angel program is in place in this facility, with a manager assigned to specific residents as their "guardian angel". The Guardian Angel visits his/her residents at least 5 days a week, and specifically asks the resident if he/she has any concerns regarding staff care or treatment. Interviews of families are also done at intervals regarding the resident's care/treatment. Those visits and interviews are brought to the morning management meeting scheduled at least 5 days a week for further review. If there is any concern of alleged abuse identified, the Guardian Angel will notify the Administrator immediately and an investigation will be initiated.</p> <p>Prior to direct resident contact, all new employees will continue to be oriented and educated on the facility's policies of Resident Mistreatment, Neglect, Abuse, and Misappropriation of Property, The Elder Justice Act, and The Elder Justice Act –Reporting Reasonable Suspicion of a Crime against a Resident. An annual in-service of these policies will continue to be provided to all</p>		

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			<p>employees per policy.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Results of Guardian Angel visits and interviews, as well as allegations of abuse or neglect will be brought to the monthly QA Committee meeting for further review, discussion, and follow up. Any recommendations made by the Committee will be followed up by a designated manager(s) who will report the results of those recommendations at the next scheduled QA Committee meeting. This process will continue on an on-going basis.</p>		

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and record review, the facility failed to transfer 1 of 2 residents in random observations of mechanical lift transfers in accordance with Manufacturer's directions [Resident #7].</p> <p>Finding includes:</p> <p>On 4/4/13 at 2:20 p.m., Resident #7 was observed to be transferred with an Invacare Reliant 450 mechanical lift by CNAs #1 and #2. The resident was lifted from a wheelchair, the lift was pulled back from the wheelchair and the resident lowered below chair height, and turned perpendicular to the mast. The resident was then transferred to the bed.</p> <p>Resident #7's clinical record was reviewed on 4/12/13 at 2:00 p.m. The Minimum Data Set [MDS] assessment, dated 8/17/12, coded the resident as non-ambulatory, required extensive assistance of two for transfers. A plan of care dated, 8/24/12, indicated the resident was at</p>	F000323	<p>The following is the plan of correction F323</p> <p>It is the standard practice of this facility to follow our policy and procedure for Hoyer Lifts and operate in accordance with manufactures guidelines</p> <p>1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Manufacturer's guidelines for the Invacare Reliant 450 mechanical lift used for Resident #7 state "When moving the patient lift away from the bed, turn the patient so that he/she faces assistant operating the patient lift". Resident did not receive injury during transfer and all nursing personnel have been educated regarding appropriate procedure for Hoyer Lift transfers per facility policy and manufacturer's guidelines on 4/17/13 during nursing in service.</p> <p>1.Describe how the facility reviewed all clients in the facility that could be affected by the</p>	05/10/2013			

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	<p>risk for falls due to inability to utilize legs and dependency on a hooyer lift for all transfers which required two staff members present for all transfers.</p> <p>The Manufacturer's directions, provided by the Administrator on, 4/11/13 at 2:00 p.m., included, but was not limited to: "5. When moving the patient lift away from the bed, turn patient so that he/she faces assistant operating the patient lift."</p> <p>3.1-45(a)(1)</p>		<p>same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>The facility has 9 residents that are transferred using the Hoyer Lift and could be affected by the same practice. No other residents have been identified being transferred outside of manufacturer's guide lines or outside of company policy and procedure during ongoing skills check offs.</p> <p>However, if the DON, Staff Development, or Charge Nurse should observe a resident being transferred inappropriately when staff is using a mechanical lift, the manager will stop the process immediately and will assist the staff in completing it in a safe way to prevent injury to the resident. Once the resident is safe, the DON, Staff Development nurse, or Charge Nurse will re-train the staff at that time as to the acceptable method or using the mechanical lift in accordance with manufacturer's guidelines. Staff will be required to complete a successful return demonstration in using the mechanical lift appropriately. Progressive disciplinary action may be taken for continued noncompliance.</p> <p>1.Describe the steps or systemic changes the facility has</p>		

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			<p>made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>Daily Hoyer Lift skills check offs will be completed 5 times weekly times two weeks observed by D.O.N. and Staff Development nurse. Upon completion of skills check off all nursing personnel will have demonstrated consistent use of proper technique. Random check offs will continue weekly for the next two months. All newly hired nursing personnel will complete Hoyer Lift skills check off. Any identified concern in completing this process appropriately will be followed up as indicated in question #2.</p> <p>1.Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The D.O.N. and Staff Development nurse will report the results of their re-training and observations of return demonstrations in the use of the mechanical lift to the monthly QA Committee for further review and recommendations. Any recommendations made by the Committee will be followed up the DON and/or Staff Development nurse who will report the results of those recommendations at the</p>	

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			next scheduled QA Committee meeting. This will continue on an on-going basis.	

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to prepare pureed food under sanitary conditions for 1 of 1 observation of the puree process.</p> <p>Finding includes:</p> <p>On 4/11/13 at 10:15 a.m., Dietary aide #3 was observed preparing six servings of pureed chicken. With gloves on and using tongs the aide placed six 3 ounce chicken breasts into the puree machine. The staff added one and 1/4 cup of broth. The aide placed the lid on the machine, touching the exterior of the machine and turned the machine on. The aide stopped the machine and while wearing the same gloves removed two slices of bread from a loaf of bread, tore into pieces and placed in the mixture. The aide ran the machine again, touching the exterior surfaces, stopped the machine, removed the left glove and applied a new glove, removed another slice of</p>	F000371	<p>The following is the plan of correction F371</p> <p>It is policy of this facility that the facility will store, prepare, distribute, and serve food under sanitary conditions.</p> <p>1.Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Dietary Aide #3 was re-educated by Dietary Manager on proper procedures for glove changing during food preparation on 4/11/13 following the surveyor's observation of the dietary aide deviating from facility policy while preparing the pureed chicken.</p> <p>All dietary staff have been in-serviced by the Dietary Manager on the facility's policies regarding 1) Dietary Services, 2) Employee Health Standards, and 3) Dietary Department- Infection</p>	05/10/2013			

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	<p>bread from the loaf with the left hand and tore the slice into pieces with both hands then added to the mixture. The aide then resumed the puree process.</p> <p>A facility policy titled "Dietary Services," dated October, 2004, included but was not limited to: "13. The facility will store, prepare, distribute, and serve food under sanitary conditions. 7. G. Use single-use gloves for one task. If the gloves are damaged or soiled or when interruptions occur in the process, they must be discarded."</p> <p>3.1-21(i)(3)</p>		<p>Control.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>A review of residents' physician orders shows that there are 11 residents that receive a pureed diet. All 11 of these residents have the potential to be affected by this deficiency; however, no other resident has been identified as being affected.</p> <p>In the future, if the Dietary Manager, Administrator, or other facility manager observes that a dietary employee has not followed the facility's policies for appropriate food preparation and handling, he/she will stop the employee immediately and retrain him/her on the appropriate methods of food preparation and handling. The food will be discarded if there is a concern that it has been prepared or handled inappropriately and new food will be prepared. In addition, progressive disciplinary action will be rendered for those instances of continued noncompliance.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that</p>	

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			<p>the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>The Dietary Manager will closely monitor the food preparation process, including the dietary employees' proper use of gloves. While supervision of food preparation is a common practice in the facility, the Dietary Manager will be putting special focus on glove techniques at least 5 times per week for 2 weeks, then weekly for 2 weeks, and then monthly for 2 months. She will document her findings on her QA checklist and will bring the results of her findings to the next scheduled interdisciplinary morning management meeting for discussion and review. If any concerns are identified, the Dietary Manager will follow through as indicated in question #2.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The Dietary Manager will bring the results of her observations to the monthly QA Committee meeting for review and recommendations for further process improvement by the committee members for the next</p>	

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			2 months. The QA Committee may decide to stop the written observations and reporting to the Committee once the staff has demonstrated 100% compliance. However, the Dietary Manager will continue to observe the dietary staff's work and demonstration of following the facility policies for food preparation and handling on an ongoing basis.	

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F000441 SS=D	<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 accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure</p>	F000441	The following is the plan of	05/10/2013			

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	<p>hand hygiene was maintained to prevent cross contamination for 2 of 2 random observations of staff touching residents' skin and linens without wearing gloves, or washing hands before touching other surfaces [Resident #7, Resident #46, and Resident #23].</p> <p>Findings include:</p> <p>1. On 4/4/13 at 2:20 p.m., CNAs #1 and #2 were observed to transfer Resident #7 from a wheelchair to bed with a mechanical lift. The staff were not wearing gloves. After positioning the resident on the bed, the staff turned the resident from side to side and removed the cloth mechanical lift sling from underneath the resident. The CNAs positioned the resident's legs on a pillow and adjusted the linens. During the process, staff were in contact with the resident's skin and linens. After completion of the task the staff removed the mechanical lift from the resident's room, took the lift down the hall and were observed at the nurses' station. The staff did not wash hands after physical contact with the resident and resident's linens.</p>		<p>correction F441</p> <p>It is the standard and policy of this facility to establish and maintain an infection control program including policies and procedures in regards to proper hand hygiene.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Nursing staff was in serviced on policy and procedure for appropriate times for hand washing along with repercussions of improper infection control and cross contamination on 4/17/13.</p> <p>1. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>All residents have the potential to be affected by this practice. The DON, Staff Development nurse, and other managers will observe for appropriate handwashing practice on the part of all staff as part of their routine, frequent rounds throughout the facility. If inappropriate handwashing or lack of handwashing is observed,</p>	
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			<p>the employee will be stopped at that time, and instructed on proper handwashing. Once that is done and the resident is cared for, the DON or Staff Development nurse will follow up with the employee involved and will render progressive disciplinary action for continued noncompliance.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>In addition to the inservice that was done on 4/17/13, hand washing skills check offs will be completed 5 times weekly for two weeks observed by D.O.N. and Staff Development nurse. Upon completion of skills check off all nursing personnel will have demonstrated consistent use of proper technique and be able to verbalize appropriate times for hand hygiene per facility policy and procedures. Random check offs will continue weekly times two months. All newly hired nursing personnel will complete Hand Washing skills check off. Any identified concerns in hand washing will be addressed as outlined in question #2.</p> <p>1. Describe how the corrective action(s) will be monitored to</p>		

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	<p>2. On 4/5/13 at 11:10 a.m., CNA (Certified Nursing Assistant) #6 repositioned resident #46 without wearing gloves. The CNA left the resident's room without washing her hands and adjusted Resident #23's oxygen tubing.</p> <p>A Facility policy and procedure titled, "Handwashing/Alcohol-Based Hand Rub", was received on 4/11/13 at 11 a.m., from the DON (Director of Nursing). Documentation indicated but was not limited to, "...personnel should always wash their hands (even when gloves are worn)...before and after each resident contact; After</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The DON and Staff Development nurse will bring the results of their handwashing observations and return demonstrations to the monthly QA meetings for further review, discussion, and follow-up. Any recommendations made by the Committee will be followed up the DON and/or Staff Development nurse who will report the results of those recommendations at the next scheduled QA Committee meeting. This will continue on an on-going basis.</p>		

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	touching a resident or handling his/her belongings...." 3.1-18(l)				