STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00179668. Complaint IN00179668 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 17,18,19, 20, and 21, 2015 Facility number: 000338 Provider number: 155441 AIM number: 100287590 Census bed type: SNF/NF: 32 Total: 32 Census payor type: Medicare: 4 Medicaid: 22 Other: 6 Total: 32 Sample: 1 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the rightto contest the findings or allegations as part of any proceedings and submitthese responses pursuant to our regulatory obligations. The facility requeststhat the plan of correction be considered our allegation of complianceeffective September 20th, 2015 to the annual licensure surveyconducted August 17th – August 21st, 2015. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2015
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F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation, interview, and record review, the facility failed to ensure a dignified wheelchair transfer of a resident, by staff, during one of one observations of transfer by wheelchair (Resident # 16). Findings include: Registered Nurse (RN) #1, was observed on 08/17/15 at 12:37 p.m., transporting Resident # 16 to his room by wheelchair. The resident was slumped down in the wheelchair, asleep, with the right foot dragging on the floor bent in a backward position. The resident's sock was observed to be half off of the left foot. RN #1 noticed the feet dragging and turned the wheelchair around. The left sock caught on the front left wheel of the wheelchair, pulling on the left foot. The RN pulled until the sock was free and	F 0241	By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the rightto contest the findings or allegations as part of any proceedings and submitthese responses pursuant to our regulatory obligations. The facility requeststhat the plan of correction be considered our allegation of complianceeffective September 20th, 2015 to the annual licensure surveyconducted August 17th – August 21st, 2015. We respectfully request a paper review. We will provide you with any additional information to confirm compliance per your request. **F241** It is the policy of Corydon Nursing and RehabilitationCenter to ensure that residents' dignity is maintained at all times. **How will the corrective action be accomplished for those**	09/20/2015

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	began transporting the resident dragging his feet down the hall. The Administrator, upon leaving her office, noticed the resident's feet dragging and asked if the resident had a foot support for the wheelchair. The RN indicated the support connector bar for the foot support was taped up, so she assumed none was available. The Administrator pulled the resident's socks up and the RN continued transporting the resident to his room. On 08/19/15 at 8:25 a.m., Resident # 16's clinical record was reviewed. The Minimum Data Set (MDS) Significant Change assessment, dated 02/24/15, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 01, or severe cognitive impairment. The Quarterly MDS assessment, dated 06/24/15, indicated the resident was totally dependent for transfers, toilet use, and personal hygiene. Diagnoses for Resident #16 included, but were not limited to, hypertension, diabetes and dementia. On 08/19/15 at 2:15 p.m., the review of the ADL (Activities of Daily Living) Grid, for July, 2015, indicated the Certified Nursing Assistants (CNA) provided assistance of 2 or more persons for transfers, eating and toilet use.		**residents who are affected by this alleged deficient practice?** Resident #16's dignity is being maintained related towheelchair positioning. RN #1 has been inserviced on dignity and wheelchair positioning for dependent residents. **How will the facilityidentify residents having the potential to be affected by the same deficientpractice?** All residents have the potential to be affected. **What measure will be put into place or systematic changes made to ensure that the deficient practice does not recur?** All nursing staff have been inserviced regarding maintaining residents' dignity. Emphasis was given to wheelchair positioning for dependent residents. Compliancewill be monitored ongoing, with education provided to staff as needed. **How will facility monitor its corrective actions?** A performance improvement tool has been initiated that randomly reviews wheelchair positioning for dependent residents and dignity for all residents. The Administrator or designee will complete this tool weekly x3, monthly x3 andquarterly x3. 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	

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	On 08/19/15 at 2:18 p.m., Resident #16's Care Plan was reviewed. The care plan indicated the resident uses alarming restraints for positioning and increased fall risk. Interventions on 03/26/15 included, but were not limited to, "...Ensure the resident is positioned correctly with proper body alignment while restrained... ...Risk for Fall r/t Confusion, Psychoactive drug use, Gait/balance problems, Incontinence (07/14/14). Interventions-Ensure that the resident is wearing appropriate footwear mobilizing in w/c (07/14/14)...." During an interview on 08/20/15 at 1:13 p.m. RN # 2 indicated, if the resident falls asleep in the wheelchair, the pedals are applied. Normally two people would assist the resident to his room if the resident falls asleep. The RN indicated, "if they become slumped down in their chair, we would reposition them in the wheelchair". The resident's seat belt alarm was like a seat belt in the wheelchair. She indicated the staff check for self release of the seat belt alarm weekly. She also indicated the seat belt alarm was for positioning and fall prevention. During an interview on 08/20/15 at 1:33 p.m., the OTR/L (Occupational Therapy		needed.	

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	Registered/Licensed) #1 indicated the resident goes through ups and downs with transfers. The OTR/L indicated, "The goal was for the resident to be picked up again for therapy. After the resident's wheelchair was lifted on 08/05/15, the resident was able to propel himself better by foot. The resident's right foot will sometimes bend back while self propelling. The last in-service to the staff was on transfers, but we can do one in the near future for assisting the resident to transfer by wheelchair, if needed. If the resident falls asleep in the wheelchair, the best thing to do would be to pull the resident to a better sitting position. The staff should remove the tape from the chair and apply the foot supports or use the assistance of another staff member to lift the resident's feet." 3.1-3(t)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure the comprehensive care plan was being	F 0282	**F282** It is the policy of Corydon Nursing and Rehabilitation Center to provide services in accordance	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
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	followed for a resident at risk for dehydration related to diuretic use for 2 of 5 survey days that the resident was observed. (Resident #33) Findings include: The clinical record for Resident #33 was reviewed on 8/19/15 at 2:07 p.m. Diagnoses included, but were not limited to, urinary tract infection, difficulty in walking, cognitive communication deficit, muscle weakness, and dementia. The care plan for dehydration or potential deficit related to diuretic use, dated 2/20/15, indicated staff is to ensure Resident #33 has access to cold water whenever possible. During an observation on 8/20/15 at 9:30 a.m., Resident #33 was sitting in her locked wheelchair, with her legs extended upward and unable to touch the ground. Resident #33's call light and glass of water was on her bed side table positioned behind her and out of the resident's reach. During an observation on 8/20/15 at 11:30 a.m., Resident #33 was sitting in her locked wheelchair, with her legs extended upward and unable to touch the ground. Resident #33's glass of water		with each resident's written plan ofcare. **How will the corrective action be accomplished for those residents who are affected by this alleged deficient practice?** Resident #33 was assessed with no negative outcomes identified. The careplan for Resident #33 has been reviewed and updated to reflect current level of functioning. Resident now receives services in accordance with written plan of care. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** All residents have the potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** Care plansfor all residents at risk for dehydration were reviewed and updated as needed to reflect current level of functioning. C.N.A. assignment sheets were updatedand education provided on any changes. **How will facility monitor its correctiveactions?** A performance improvement tool has been initiated that randomly reviews accuracyof care plans for all residents and ensures that services are provided accordingly. The DON or designee will complete this tool weekly x3, monthly x3and quarterly x3. Any identified issues will be immediately addressed. The Quality Assurance	

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	was on her bed side table positioned behind her and out of the resident's reach. During an observation on 8/21/15 at 9:15 a.m., Resident #33 was sitting in her locked wheelchair, with her legs extended upward and unable to touch the ground. Resident #33's glass of water was on her bed side table positioned behind her and out of the resident's reach. During an observation on 8/21/15 at 11:15 a.m., Resident #33 was sitting in her locked wheelchair, with her legs extended upward and unable to touch the ground. Resident #33's glass of water was on her bed side table positioned behind her and out of the resident's reach. During an interview on 8/21/15 at 11:28 a.m., the Director of Nursing (DON), indicated Resident #33 is not able to reach behind her or propel herself in her wheelchair. She indicated a cup of water should be in front of Resident #33 and within reach of the resident at all times, although the resident does need assistance with drinking. The DON also indicated Resident #33's care plan should have been updated due to the deterioration of Resident #33's health, and the increased need for assistance while the resident is drinking liquids.		Committee will review the tool at the scheduled meetings with recommendations for additional interventions as needed.	

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	155441		08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	During an interview on 8/21/15 at 2:01 p.m., Certified Nurses Assistant (CNA) #3, indicated Resident #33 is not able to reach behind her or propel herself in her wheelchair. 3.1-35(g)(2)			
F 0356 SS=B Bldg. 00	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to			

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	exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure nurse staffing data was posted for 2 of 5 survey days observed. (8/17/15 and 8/19/15) Findings include: During the initial tour on 8/17/15 at 9:30 a.m., the nurse staffing data posted was dated 6/16/15. During an observation on 8/19/15 at 11:30 a.m., the nurse staffing data posted was dated 8/18/15. During an interview with the Administrator on 8/21/15 at 12:11 p.m., she indicated the third shift night nurse was supposed to fill out, and post, the nurse staffing data.	F 0356	**F356** It is the policy of Corydon Nursing and Rehab to poststaffing information as required. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** The DailyNurse Staffing Hours posting was revised to include correct information. Thisform is posted daily at the beginning of each shift. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** All have thepotential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** Nurses havebeen educated on this requirement. **How will facility monitor its correctiveactions?** TheAdministrator or designee will monitor the completion and posting of dailystaffing hours during walking rounds and keep documentation of anynoncompliance and corrective action. Monitoring will continue until fullcompliance is achieved for one full quarter. Results will be Quality AssuranceMeeting	09/20/2015

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	155441		08/21/2015

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			monthly.	
F 0371 SS=E Bldg. 00	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, interview and record review, the facility failed to ensure food was stored and prepared under sanitary conditions, as evidenced by pipes, air vents, inside refrigerator, cabinet edges, and ceilings with a moderate build-up of greasy dust which was loose in some areas; opened and unsealed packages of luncheon meats; and the freezer had a heavy build-up of ice which dripped onto food items during 4 of 5 survey days. This deficient practice had the potential to affect 32 of 32 residents who currently resided in the facility. Findings include: During the initial kitchen tour on 8/17/15 between 9:40 a.m. and 10:05 a.m., the following was observed: 1. In the dry foods storage room, an employee's personal purse was observed on top of several bottles of juice on the	F 0371	**F371** It is thepolicy of Corydon Nursing and Rehabilitation Center to ensure that food isstored and prepared under sanitary conditions. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** (1) Personal items were removed from shelving in drystorage. (2) Dietary employees have been inserviced on properstorage of personal items. (3) Packages of luncheon meats were sealed and storedproperly. (4) Dietary employees have been inserviced on properstorage of opened food items. (5) Cobwebs were removed from ceiling. (6) Vent screens inside stove hood have beencleaned. (7) Sprinkler heads, turn valve on fire system, andPVC pipes have been cleaned. (8) The air vent behind the refrigerator, the wallsurrounding the vent, the right side of the refrigerator, and the left wall ofthe air conditioner unit have been cleaned. (9) The	09/20/2015

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	shelf. Cob webs were observed hanging from the ceiling and were blowing in the air from the air vents. Below these cob webs were baskets of snacks - cookies, crackers, and small bags of chips. Cob webs were also observed above the shelving unit on which open boxes of snacks, condiments and juices were stored. 2. Vent screens on the inside stove hood had a moderate build up of gray, greasy dust on the vent slats. The air vents were observed to be on and blowing air in the kitchen. 3. Two of two sprinkler heads, the turn valve on the fire system, and the PVC pipes (white plastic pipes) which ran around kitchen just below the ceiling, had a heavy build up of blackish gray greasy dust on them. 4. In the reach-in refrigerator, one package of ham and one package of turkey were observed unsealed and open to the air. During a follow up observation in the kitchen on 8/18/15 at 11:00 a.m., the following was observed: 5. The same issues which involved the PVC pipes, sprinkler heads and turn		airconditioner vents and the window above the unit have been cleaned. (10) The vents inside theceiling of the reach-in refrigerator have been cleaned. (11) The reach-in freezer holdsappropriate temperature and continues to do so. Accumulation of ice has beenremoved and will be monitored. (12) Open prep table cabinethas been cleaned. (13) All items have been addedto routine cleaning schedules. All dietary staff have been inserviced on thesechanges. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** All residents have the potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** All items have been added to routine cleaning and will be completedaccording to schedule. The Dietary Manager will ensure that these tasks arecompleted and will present the as-worked cleaning schedules to QA Committeeduring monthly Quality Assurance Meetings. **How will facility monitor its correctiveactions?** In addition to the above correction, a performance improvement tool hasbeen initiated that randomly reviews kitchen sanitation. The Administrator ordesignee will complete this tool weekly x3, monthly x3 and quarterly x3. Anyidentified issues will be	

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	valve on the fire system; the vent screens in the stove hood, and cob webs hanging down in the dry storage room, identified on 8/17/15, remained the same. A large pot of chili, uncovered, was observed on the stove simmering and the air was blowing from the vents. 6. The air vent behind and just above the right side of the reach-in refrigerator, the wall surrounding the vent, the right side of refrigerator, and the left wall of the air conditioner unit had a heavy accumulation of gray dust that was observed to be loose and moved in the air flow. 7. The window air conditioner unit vents and the window above the unit had a moderate accumulation of dark greasy dust. 8. Vents on the inside ceiling of the reach-in refrigerator had a heavy accumulation of hanging brownish dust. These vents were 4 - 5 inches above trays of covered glasses of drinks, dishes of pudding and yogurt. 9. The reach-in freezer had a heavy accumulation of ice on the inside back of the unit. The temperature was listed at -10 degrees and items were frozen hard to the touch.		immediately addressed. The Quality AssuranceCommittee will review the tool at the scheduled meetings with recommendationsfor additional interventions as needed.	

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	10. Edges of both sides of the open prep table cabinet in the middle of the kitchen, where pots and pans and dishes were stored, had a heavy build-up of a brown sticky substance that was able to be scraped off with a paper towel. During an interview with Dietary Aide #3 on 8/18/15 at 11:15 a.m., she indicated that the freezer stayed accumulated with the ice all the time and had been like that since she has been working there, over several years. She indicated that it did maintain the proper temperature and that Maintenance has had people check on it at times. She indicated she has also tried to clean the air conditioner unit vents monthly or as she saw they were dirty. During an interview on 8/18/15 at 11:17 a.m., the Dietary Manager indicated someone came in from an outside company to clean the stove hood vents and clean the pipes which connected to the system. She also indicated Maintenance was responsible for cleaning the air vents. During an interview with the Director of Maintenance on 8/20/15 at 11:30 a.m. while in the kitchen, he indicated that the Dietary Manager had told him about the vent behind the refrigerator and so he			

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	cleaned it. He indicated he usually did it monthly and that it had been a month and a week since he last did it. He also indicated Dietary was responsible for the PVC pipes which ran along the walls in the kitchen, but that if they asked him, he would have helped them out since he had the ladder. He was unable to say the last time it had been cleaned as they have not asked him. He indicated he had also told dietary that they could run the hood vents thru the dishwasher for cleaning, if needed. During a follow up kitchen observation on 8/20/15 at 2:10 p.m., the following was observed: 11. The cob webs in the dry storage, the air conditioner window, stove hood vents, inside reach-in fridge, ceiling vents and ice accumulation inside the back of the freezer, remained the same as previously identified on 8/17/15 at 9:40 a.m. and on 8/18/15 at 11:00 a.m. Ice was now observed on the front rack inside the door and two, 2-inch spots and drips were hanging down in the back of the freezer onto a tray of bagged frozen bacon. During an interview with Maintenance on 8/20/15 at 2:20 p.m., he indicated Dietary was responsible for cleaning the inside of			

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	the refrigerator which included cleaning the vents in the ceiling of the refrigerator. He indicated he had his refrigeration guy look at the ice in the freezer before and he just said it was from it defrosting and then draining and then would refreeze a bit. He also indicated, "it did look thicker than he was used to seeing and would call his refrigerator guy to come out and look at it". During a follow up observation of the kitchen on 8/21/15 at 10:00 a.m., the same issues as identified on 8/17/15 at 9:40 a.m., on 8/18/15 at 11:00 a.m., and 8/20/15 at 2:10 p.m., were observed and remained unchanged. On 8/21/15 at 10:30 a.m., the Dietary Manager presented a copy of the as-worked cleaning schedules between 3/30/15 and 8/9/15. Review of these schedules indicated deep cleaning the inside of the refrigerator was a weekly task on the first shift and was only completed on the following dates: 3/30/15, 4/12/15, 5/19/15, 6/20/15, 7/14/15, 7/17/15, 7/24/15, and 7/30/15. No other areas of the kitchen identified with issues were listed on the schedules to be part of the daily and/or weekly cleaning. 3.1-21(i)(2)			

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	155441		08/21/2015

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	3.1-21(i)(3)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and			

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	transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure proper hand washing by staff when providing medications for 6 of 6 residents observed for medication administration (Residents #13, #14, #16, #28, #30, and #31) and failed to ensure proper incontinence care was provided to 2 of 2 residents observed for incontinence care (Resident #7 and #14). Findings include: 1. On 08/17/15 at 1:06 p.m., RN (Registered Nurse) # 1, was observed to apply soap and perform handwashing for 10 seconds after the completion of Resident #13's breathing treatment. On 08/17/15 at 1:23 p.m., RN #1 was observed to apply soap and perform handwashing for 5 seconds after administering the medication to Resident #16. On 08/17/15 at 1:31 p.m., RN #1 was observed administering medications by feeding tube to Resident # 14. Upon completion of the medication administration, she applied soap and performed handwashing for 10 seconds.	F 0441	**F441** It is thepolicy of Corydon Nursing and Rehab to ensure infection control guidelines arefollowed for all procedures. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** Residentsare now receiving care in accordance with infection control guidelines,including proper handwashing. All nursing staff have been re-educated on properhandwashing. Emphasis was given to handwashing during med pass and whileproviding care. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** Allresidents have the potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** All nursingstaff have been re-educated on infection control policies. Emphasis was givento handwashing and proper incontinence care. **How will facility monitor its correctiveactions?** Aperformance improvement tool has been initiated to monitor compliance withhandwashing and incontinence care protocols. The DON or designee will completethis tool weekly x3, monthly x3 and quarterly x3. Any	09/20/2015

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	At 1:40 p.m., RN #1 applied hand sanitizer, prepared the medication for Resident #30 and entered the resident's room to administer the medication. On 08/19/15 at 9:11 a.m., LPN (Licensed Practical Nurse) # 1, was observed to apply soap and perform handwashing for 16 seconds after administering medication to Resident #31. On 08/19/15 at 9:49 a.m., LPN #1 was observed helping Resident #9 lift her foot onto the wheelchair for support. LPN #1 then applied soap and performed handwashing for 16 seconds. The LPN then prepared medication for Resident # 28, entered the resident's room and administered the medication. During an interview with LPN #1 on 08/20/15 at 1:07 p.m., she indicated proper hand washing technique was to turn on water, soap up the hands for 30 seconds, rinse, use paper towels to dry, then turn the faucet off with a paper towel. On 08/20/15 at 1:11 p.m., during an interview with RN # 2, she indicated to wash hands she would turn on the water, apply soap, and rub the hand together for 20-30 seconds cleaning the nail beds, the wrists, and palms; rinse the hands from		identified issues will beimmediately addressed. The Quality Assurance Committee will review the tool atthe scheduled meetings with recommendations for additional interventions asneeded.	

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	clean to dirty in a downward position, dry with a paper towel and turn off the water with a paper towel. On 08/19/15 at 1:25 p.m., the Director of Nursing (DON) provided a copy of the current, facility policy on handwashing, which indicated, but was limited to, the following, "1. HANDWASHING - When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, and in case of a resident with a sport-forming organism (e.g., C. Difficile), after going to the restroom, and before eating, perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water. A. Turn on water to a comfortable warm temperature. B. Moisten hands with soap and water and make a heavy lather. C. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction. D. Rinse hands well under running water. E. Dry hands with a clean paper towel. Use the paper towel to turn off the faucet, then discard." 2. Certified Nursing Assistant (CNA) #1 and CNA #2 were observed providing care for Resident #14 on 08/21/15 at 10:29 a.m. The CNAs brought the supplies into the resident's room and			

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	filled a wash basin with warm water. CNA #1 performed handwashing for 20 seconds and donned gloves. CNA #2 performed handwashing for 22 seconds and donned gloves. The CNAs removed the resident's soiled brief, removed their soiled gloves and then both CNAs applied clean gloves. The peri wash was applied to a wet washcloth. The same side of the washcloth was used to clean the creases, the penis and the scrotum. A second washcloth was moistened with water and sprayed with the peri wash and used on the same areas. A third cloth was used on the buttocks, using the same area of the wet washcloth to clean multiple areas. A fourth washcloth was used on the anal area and was folded to wash the inside crease of the buttocks. A fifth wet washcloth was obtained and the resident was rinsed on the creases of the groin, the penis and then the buttocks area. CNA #1 removed her soiled gloves and applied clean gloves. She obtained a dry towel and patted the groin, the penis and the buttocks area dry. A clean brief was applied on the resident. The CNAs then repositioned the resident, rolling him onto his left side. A pillow was placed between the resident's knees. The CNAs then lowered the bed and covered the resident with a sheet. Both CNAs removed their gloves. CNA #1 washed her hands for 16 seconds. CNA # 2			

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	applied clean gloves, gathered the trash and removed it from the room. CNA # 2 returned to the resident's room and washed her hands for 20 seconds. 3. During an observation of CNA #3 while performing perineal care for Resident #7 on 8/20/15 at 11:10 a.m., CNA #3 wiped the middle, left, and right labia three times without folding or changing her washcloth during perineal care. On 08/21/15 at 11:11 a.m., the Director of Nursing (DON) indicated for male incontinence care, "the CNA would gather supplies..., ...start from the tip of the penis first, clean, don't reuse the washcloth, clean the scrotum area... gloves are used, change gloves between cleaning the penis and the rectum... Remove gloves, fresh gloves 3 times during care... The CNA would wash their hands upon entering the room, after removing gloves, and before exiting". On 08/21/15 at 1:23 p.m., the DON provided a copy of the facility policy for Activities of Daily Living-Perineal Care. The policy indicated, but was not limited to: "...2. Wash and dry your hands thoroughly... ...7. Put on gloves... ...10. For a male resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with			

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	urethra and working outward ... ... (2) Wash and rinse urethral area using a circular motion. (3) Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or water to clean the urethra. c. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth .... d. Gently dry perineum following same sequence... ...h. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. i. Dry area thoroughly... ...12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 3.1-18(l)			
F 0458 SS=D Bldg. 00	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation and interview, the facility failed to ensure a room with more than 2 residents had at least 80 square feet per resident for 2 of 2 rooms capable of holding more than 2 residents. This affected Rooms #7 and #11 and 6 of 32	F 0458	**F458** It is thepractice of Corydon Nursing and Rehabilitation Center to ensure that adequatesquare footage of living space is provided to each resident.	09/20/2015

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	residents residing in the facility. Findings include: On 8/21/15 at 1:00 p.m., during an environmental tour, the Maintenance Director measured the square footage of Room 11 at 210 square feet, indicating 74 square feet for each of the three residents residing in Room 11 and he indicated Room 7 was the same square footage. The following was observed: *Room #7, SNF/NF, had the capacity of 3 resident beds and was a total of 210 square feet, equaling 74 square feet per resident. *Room #11, SNF/NF, had the capacity of 3 resident beds and was a total of 210 square feet, equaling 74 square feet per resident. On 8/21/15 at 2:00 p.m., during an interview with the Administrator, she indicated that she did want to continue the room waiver for Room #11 and Room #7. 3.1-19(l)(2)(A) 3.1-19(l)(3) 3.1-19(l)(8)		**How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** No rooms arecurrently being used for more than two residents. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** Residentsresiding in rooms 7 and 11 have the potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** TheAdministrator will apply for a room size waiver for rooms 7 and 11. **How will facility monitor its correctiveactions?** If room sizewaiver is not granted, facility will not place more than two residents in rooms7 or 11.	

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F 0460 SS=D Bldg. 00	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Based on observation and interviews, the facility failed to ensure resident privacy curtains assured full visual privacy when pulled to the fullest extent. This deficient practice affected 12 of 32 residents observed for privacy curtains. (Residents #4, #5, #6, #8, #13, #15, #21, #22, #24, #28, #32, and #34) Findings include: During resident room observations on 8/17/15 between 11:00 a.m. and 11:40 a.m., the following was observed: 1. Resident #15 was missing a privacy curtain. 2. In the room of Residents #21 and #24, there was a 9 inch gap in the curtain	F 0460	**F460** _ It is thepolicy of Corydon Nursing and Rehabilitation Center to ensure that rooms aredesigned to ensure full visual privacy to each resident. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** Residents#4, #5, #6, #8, #13, #15, #21, #22, #24, #28, #32, and #34 now receive fullvisual privacy. Hooks were replaced where needed. Fasteners were added whereneeded in areas where the curtain does not meet the wall. Additional curtainswere hung where needed. All curtains are properly hung with hooks in place andall gaps are now closed. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** Allresidents	09/20/2015

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	between the beds which prevented visual privacy. There also was a 2 foot gap across the foot of beds when pulled for either resident which left the other one exposed. 3. In the room of Residents #6 and #34, there was a 9 inch gap in the curtain between the beds which prevented visual privacy. There was also a 3 1/2 foot gap in the privacy curtain at the foot of the beds when pulled in either direction which left the other resident exposed. 4. In the room of Resident #4, there was an 8 inch gap at the beginning of the curtain between the beds by the heater unit. 5. In the room of Resident #32, there was a 12 inch gap in the curtain between the beds which prevented visual privacy. The curtain was folded back by several pleats at the top of curtain, which were attached to the hooks. During the initial tour on 8/17/15 at 9:30 a.m. and during the environmental tour on 8/21/15 at 9:59 a.m., with the Maintenance Supervisor, the following observations were made: 6. In the room of Resident #8, the privacy curtain exposed six inches on one		have the potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** Curtainaudits will be added to monthly deep cleaning schedule to ensure that curtainsare fastened securely on hooks and remain in good repair. Completed audits willbe submitted to Maintenance Director for needed repairs. Any issues identifiedwill be corrected. Maintenance Director will present completed checklists withcorresponding work orders to QA committee during monthly Quality AssuranceMeetings. **How will facility monitor its correctiveactions?** In addition to the above corrective action, the Administrator will complete a performanceimprovement tool that randomly reviews the condition of privacy curtains infive rooms to ensure that curtains are fastened securely on hooks; thatcurtains may be fastened securely to the wall; that curtains remain in goodrepair. These audits will be performed weekly x3, monthly x3, and quarterly x3.The QAA Committee will review these audit tools at scheduled meetings and offernew recommendations as needed. --	

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	side of the room and six inches on the other side of the room. 7. In the room of Resident #22, there was a 6 inch gap in the curtain between the beds which prevented visual privacy. 8. In the room of Resident #5, there was a 6 inch gap in the curtain between the beds which prevented visual privacy. 9. In the room of Resident #13, the privacy curtain exposed six inches on one side of the room and six inches on the other side of the room. 10. In the room of Resident #28, there was a 6 inch gap in the curtain between the beds which prevented visual privacy. During an interview while on the environmental tour observation on 8/21/15 at 9:59 a.m. with the Maintenance Supervisor, he acknowledged the issues with the privacy curtains. He indicated some of the rooms were missing full curtains and some were missing some hooks that he had forgotten to put up, to secure the curtains to the wall. During an interview on 8/21/15 at 12:20 p.m., with the Administrator, she indicated the facility does not have a			

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	policy or procedure in place for privacy curtains. 3.1-19(l)(6)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide maintenance and housekeeping services to keep the facility clean and in good repair. This deficient practice affected the rooms of Resident's #1, #8, #10, #13, #15, #19, #20, #21, #22, and #28 and had the potential to affect the remaining 22 of 32 residents residing in the facility. Findings include: During the initial tour on 8/17/15 at 9:30 a.m. and during the environmental tour on 8/21/15 at 9:59 a.m., with the Maintenance Supervisor, the following observations were made: 1. Eight out of twenty seven overhead lights in the hallways were cracked.	F 0465	**F465** It is thepractice of Corydon Nursing and Rehabilitation Center to ensure a safe,functional, sanitary, and comfortable environment to residents, staff, and thepublic. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** (1) Cracked overhead lights have been repaired orreplaced. (2) Resident #15's overhead light has been repaired.The wall above the air unit has been repaired and painted. (3) Resident #19's wall has been repaired andpainted. The plaster above the window has been repaired. Window has beenrepaired. (4) Resident #8's electrical outlet and baseboardhave been repaired. Small dark circles on the floor have been repaired. (5) Cobwebs and gray substance have been removedfrom Resident #22's	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Observed in Resident #15's room: Resident #15's main room light would not turn on. The wall above the room's air unit was bowed in the middle and had a stain that was two feet by one foot in diameter. 3. Observed in Resident #19's room: Resident #19's wall had a gray discoloration, measuring one foot, at the right corner under the window. The plaster above the window had a 5 inch opening at the ceiling on the left upper corner of the window. The window was cracked 18 inches on the upper left corner. 4. Observed in Resident #8's room: Resident #8's electrical outlet was protruding half an inch out of the wall. The baseboard was pulling away from the wall for a length of one foot. Resident #8's floor had small dark brown circles measuring six foot by two foot in area. 5. Observed in Resident #22's room: In between the window ledge and the wall, there was a stringy gray substance and cob webs. One foot of paneling on the wall, above the air unit was bowed in the middle. 6. Observed in Resident #1's room:		room. Wall paneling has been repaired. (6) Discolorations have been cleaned from wall underthe window for Resident #1. (7) Baseboard was repaired under sink for Resident#10. (8) Overhead light cover has been replaced forResident #21. (9) Overhead light has been repaired for Resident#20. Discoloration behind bed has been repaired. (10) Resident #13's overheadlight cover has been replaced. (11) Discoloration on wall atcorner of window has been repaired. Plaster has been repaired. Window has beenrepaired. (12) Gray substance and cobwebswere removed from wall of Resident #28. Wall paneling has been repaired. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** Allresidents have potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?** Housekeepingstaff have been inserviced regarding cleaning of cobwebs and areas ofdiscoloration from walls. All staff have been inserviced on turning inmaintenance requests as needed. Maintenance Director has been inserviced onimportance of making rounds and completing preventative maintenance. Environmentalchecklists will be	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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	There were light brown discolorations scattered on the wall under the window. 7. Observed in Resident #10's room: Two inches of the base board under the sink was pulled away from the wall. 8. Observed in Resident #21's room: The ceiling light cover was missing a corner and had a six inch crack in the middle of the cover. Inside the light cover, the bugs were too numerous to count. 9. Observed in Resident #20's room: Resident #20's main room light would not turn on. An area, measuring 1 foot by 2 feet, was discolored behind the residents bed. 10. Observed in Resident #13's room: The ceiling light cover was missing a corner and had a six inch crack in the middle of the cover. Inside the light cover the bugs were too numerous to count. 11. Observed in Resident #34's room: Resident #34's wall had a gray discoloration, measuring one foot, at the right corner under the window. The plaster above the window had a 5 inch opening at the ceiling on the left upper corner of the window. The window was		added to monthly deep cleaning schedule and submitted to MaintenanceDirector upon completion for needed repairs. Environmental checklists andcorresponding work orders will be submitted to QA Committee during monthlyQuality Assurance Meetings. **How will facility monitor its correctiveactions?** In additionto the above corrective action, the Administrator will complete a performanceimprovement tool that randomly reviews the condition of resident care areas toensure that areas are maintained and in good repair. These audits will beperformed weekly x3, monthly x3, and quarterly x3. Findings will be submittedto the QAA Committee for review and further recommendations as needed.	

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NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112	

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	cracked 18 inches on the upper left corner. 12. Observed in Resident #28's room: In between the window ledge and the wall, there was a stringy gray substance and cobwebs. One foot of paneling on the wall, above the air unit was bowed in the middle. During an interview while on the environmental tour observation on 8/21/15 at 9:59 a.m. with the Maintenance Supervisor, he acknowledged all above issues. During an interview with the Maintenance Supervisor on 8/21/15 at 11:48 a.m., he indicated he knew of most of the issues but just has not had the time to get around to fixing them. He also indicated he does not do checks of the facility, he relies on housekeeping to tell him what is in need of maintenance. During an interview with the Administrator on 8/21/15 at 12:20 p.m., she indicated the facility does not have a policy or procedure in place for maintenance, as they just use an effective program. 3.1-19(f)			

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CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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F 0469 SS=E Bldg. 00	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and record review, the facility failed to provide a pest free environment for 5 of 5 survey days. This deficient practice had the potential to affect 32 of 32 residents residing in the facility. Findings include: During an observation on 8/17/2015 at 9:30 a.m., bugs were observed in 14 of 27 light covers in the resident's hallways. During an observation on 8/17/2015 at 12:25 p.m., a fly was observed on Resident #1's food and on her lap. During an observation on 8/17/2015 at 12:30 p.m., one fly was observed in in the main dining room hallway. During an observation on 8/18/2015 at 1:15 p.m., a spider web was observed under Resident #28's window seal. During an observation on 8/18/2015 at	F 0469	**F469** - It is thepolicy of Corydon Nursing and Rehabilitation Center to maintain an effectivepest control program so that the facility is free from pests and rodents. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** Facilitydoes have pest control program in place specifically to address flies infacility. Facility has consulted with pest control vendor for additionalservices or environmental changes to combat this issue. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** Allresidents have potential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?**	09/20/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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	1:19 p.m., one fly was observed at the nurses station. During an observation on 8/18/2015 at 1:27 p.m., two flies were observed at the nurses station. During an observation on 8/19/2015 at 11:35 a.m., one fly was observed on the residents water pitcher for the front hallway's medication cart. During an observation on 8/20/2015 at 2:13 p.m., one fly was observed on the front hallway. During an observation on the back hallway, with the Director of Nursing present, on 8/20/2015 at 2:28 p.m., one gnat was observed. During an observation on 8/21/2015 at 11:41 a.m., one fly was observed on the front hallway. During an observation on 8/21/2015 at 12:07 p.m., three gnats were observed in Resident #22's room. During an observation in Resident #24's room, with the Administrator present, on 8/21/2015 at 12:45 p.m., two gnats were observed.		Facilitywill comply with suggestions from pest control vendor and add new interventionsas needed. **How will facility monitor its correctiveactions?** Aperformance improvement tool has been initiated to monitor the presence offlies in the building. Administrator or designee will complete audit toolweekly x3, monthly x3, and quarterly x3. Resident feedback will be monitoredvia Resident Council. Results will be discussed during monthly QualityAssurance Meetings with interventions added or removed as needed.	

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NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112	

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	During an observation in Resident #4's room, with the Administrator present, on 8/21/2015 at 12:46 p.m., one fly was observed. During an observation on the front hallway, with the Administrator present, on 8/21/2015 at 12:47 p.m., one fly was observed. During an interview with Resident #3 on 8/21/2015 at 12:07 p.m., he indicated the flies bother him when they land on his face, and the flies and gnats have been around for most of the summer. During an interview on 8/21/2015 at 12:08 p.m., Licensed Practical Nurse (LPN) #1, indicated that she has noticed flies in the residents rooms. During an interview with Resident #25 on 8/21/2015 at 12:34 p.m., he indicated the flies bother him when they land on his head, and there has been an increase in flies during the past month. During an interview on 8/21/2015 at 12:11 p.m., the Administrator indicated there has been an increase in flies due to the increase in the temperature, doors being left open and the rainfall. She also indicated that she did not have a policy and procedure in place regarding pest			

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CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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	control. 3.1-19(f)(4)			
F 9999 SS=E Bldg. 00	1. STATE RULE 3.1-14(a) Based on record review and interview, the facility failed to ensure employee personnel files were complete to include references for 2 of 8 employee files reviewed. (LPN #5 and Dietary Aide #2) Findings include: Review of the employee personnel files on 8/21/15 at 10:00 a.m. indicated the following forms were missing: 1. Licensed Practical Nurse (LPN) #5 was hired into the Nursing department on 06/09/15, references were missing. 2. Dietary Aide #2 was hired into the Dietary department on 10/15/14, references were missing. During an interview with the Business Office Manager on 8/21/15 at 11:40 a.m., she indicated that she had no further documents to show for the missing employee records and was unsure why	F 9999	**F9999** It is thepractice of Corydon Nursing and Rehabilitation Center to ensure employeepersonnel files are complete. **How will the corrective action beaccomplished for those residents who are affected by this alleged deficientpractice?** All currentemployee files have been reviewed to ensure that references, job-specificskills orientation checklists, and TB skin test results are in place. **How will the facility identify residentshaving the potential to be affected by the same deficient practice?** All have thepotential to be affected. **What measure will be put into place orsystematic changes made to ensure that the deficient practice does not recur?**	09/20/2015

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CORYDON NURSING AND REHABILITATION CENTER	315 COUNTRY CLUB RD CORYDON, IN 47112

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	these items were missing from the files. 2. STATE RULE 3.1-14(q)(7) Based on record review and interview, the facility failed to ensure new employees received Job Specific Orientation before beginning to work their job duties. This deficient practice affected 2 of 6 new employee files reviewed. (LPN #5 and Dietary Aide #1) Findings include: Review of the employee personnel files on 8/21/15 at 10:00 a.m., indicated the following employees were missing their Job Specific Orientation: 1. Licensed Practical Nurse (LPN) #5 was hired into the Nursing department on 06/09/15. 2. Dietary Aide #1 was hired into the Dietary department on 10/15/14. During an interview with the Business Office Manager on 8/21/15 at 11:40 a.m., she indicated that she was unable to locate the Job Specific Orientations for these employees. 3. STATE RULE 3.1-14(t)(1) Based on record review and interview,		The hiringprocess has been changed to ensure that references are completed prior to joboffer. The hiring process has been changed to ensure that second-step TB skintest results are obtained prior to beginning work. The hiring process has beenchanged to ensure that job-specific skills checklists are completed for allemployees in orientation. All hiring managers have been inserviced on theserequirements. **How will facility monitor its correctiveactions?** Aperformance improvement tool has been initiated that randomly reviews fivecurrent employee files to ensure that references were completed prior to joboffer; that TB skin tests were completed prior beginning work; that jobspecific skills checklists were completed curing orientation process.Administrator or designee will complete these tools weekly x3, monthly x3, andquarterly x3. Any issues identified will be corrected and additional trainingprovided as needed. Audit tools will be presented for review during monthlyQuality Assurance Meetings with recommendations for new interventions asneeded.	

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	the facility failed to ensure new employees had received a first and/or second step Tuberculin test (PPD) and had the results read before beginning their job duties. This deficient practice affected 3 of 5 new employee files reviewed for PPD testing. (CNA #10, CNA #11 and Dietary Aide #1) Findings include: Review of the employee personnel files on 8/21/15 at 10:00 a.m., indicated the following employees were missing a first and/or second Tuberculin (PPD) test: 1. Dietary Aide #1 was hired into the Dietary department on 10/15/14 and was missing a second step PPD test. 2. CNA #10 was hired into the Nursing department on 10/24/14 and was missing a first and second step PPD test. 3. CNA #11 was hired into the Nursing department on 6/25/15 and was missing a first and second step PPD test. During an interview with the Business Office Manager on 8/21/15 at 11:00 a.m., she indicated that nursing administered the PPDs and was not sure why these employees did not receive one before they started work.			

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	On 8/21/15 at 12:52 p.m., the Director of Nursing presented a copy of the facility's current policy titled, "Tuberculosis Screening for Employees". This policy included, but was not limited to, "Purpose: To promote resident and employee safety and well-being by screening employees for tuberculosis and initiating appropriate follow-up...Policy: 1. Tuberculin skin testing (TST): A.. New employees: 1. New employees who have been made a conditional offer of employment shall be screened for presence of infection with M. tuberculosis using the Mantoux TST. Skin testing will employ the two-step procedure. (If the reaction to the first test is less than 10 mm (millimeters), a second test will be given one to three weeks later)..."			