

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(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	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 25, 26, 27, &amp; 28, 2016</p> <p>Facility Number: 000437 Provider number: 155520 AIM number: 100273770</p> <p>Census bed type: NF: 39 SNF/NF: 14 Total: 53</p> <p>Census payor type: Medicare: 1 Medicaid: 38 Other: 14 Total: 53</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on February 1, 2016.</p>	F 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(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 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>Based on observation, record review, and</p>	F 0272	Plan of Correction Response for F272 (Revised)	02/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>interview, the facility failed to ensure a comprehensive assessment was accurate for 1 of 29 residents reviewed, as a resident was inaccurately assessed regarding dental issues. (Resident #25)</p> <p>Findings include:</p> <p>On 1/18/16 at 3:07 p.m., Resident #25 was observed with missing and cracked teeth. The resident indicated he did not have any soreness or trouble with eating.</p> <p>The clinical record for Resident #25 was reviewed on 1/27/15 at 9:17 a.m. An admission MDS (Minimum Data Set) assessment, dated 2/23/15, indicated Resident #25 had a BIMS (Brief Interview for Mental Status) score of 11, indicating slight cognitive impairment. The admission MDS assessment indicated the resident had no broken natural teeth.</p> <p>An annual MDS assessment, dated 1/13/16, indicated Resident #25 had no broken natural teeth.</p> <p>A care plan, initiated on 2/9/15, indicated Resident #25 had missing upper and lower teeth and the teeth were in very poor condition.</p> <p>A dietary note, dated 2/6/15, indicated</p>		<p>The MDS of resident #25 was corrected prior to submission. MDS coordinator(s) were in-serviced on accurate dental coding for the MDS. Oral assessments will be conducted according to the MDS schedule. To assure compliance, the D.O.N. or their designee will review three (3) MDS's weekly for accurate dental coding for four (4) weeks, then two (2) MDS's monthly for accurate dental coding for three (3) months and then two (2) MDS's quarterly for three (3) quarters.</p> <p>The MDS Coordinator assumes responsibility for and ensures compliance. The Administrator and Director of Nursing is ultimately responsible for overall compliance. Any documentation regarding the POC for F272 will be available to the surveyors upon their request. Compliance Date: February 17, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(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 0279 SS=D Bldg. 00	<p>Resident #25 had missing teeth.</p> <p>During an interview on 1/27/16 at 2:27 p.m.. the MDS Coordinator indicated she would not mark missing or broken teeth if a resident's teeth were missing or broken on admission. She indicated the resident had not had any difficulty eating.</p> <p>The facility lacked a policy for MDS assessments.</p> <p>3.1-31(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan based on the comprehensive assessment. A care plan was not developed for 1 of 1 resident in a total sample of 2 residents reviewed for hospice care and services. (Resident #18)</p> <p>Findings include:</p> <p>During an observation on 1/26/16 at 8:15 a.m., Resident #18 was observed to be lying in bed. A hospice CNA was in the resident's room and indicated she was preparing to provide care to the resident.</p> <p>During an interview on 1/26/16 at 8:31 a.m., LPN #1 indicated Resident #18 received hospice services.</p> <p>The clinical record for Resident #18 was reviewed on 1/27/16 at 11:03 a.m. Resident #18 had diagnoses including, but not limited to, Non-Alzheimer's</p>	F 0279	<p>Plan of Correction Response for F279 - Revised</p> <p>Upon notification of the deficiency, the MDSCoordinator corrected the appropriate care plans. This was done on Wednesday, January 27,2016. The facility has in-serviced all InterdisciplinaryTeam Member regarding the Policy and Procedure for "Care Plans – Hospice Care". Beginning with Wednesday, February 17, 2016,the Director of Nursing or their designee will monitor within 48 hours of anyresident admitted to hospice care. Forresidents currently receiving hospice services, the care plan will be reviewedfor any updates and compliance weekly for four (4) weeks, then monthly forthree (3) months, then quarterly for three (3) quarters and then quarterly duringthe MDS assessment period.</p> <p>The Director of Nursing assumes responsibility for andensures compliance. The Administrator isultimately responsible for overall compliance.</p> <p>Any documentation regarding the</p>	02/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(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 0371 SS=E Bldg. 00	<p>dementia, Parkinson's disease, depression, hypertension, coronary artery disease, and anorexia. A significant change MDS (Minimum Data Set) assessment, dated 12/9/15, indicated the resident had a BIMS (Brief Interview for Mental Status) assessment completed by the staff indicating severe impairment. The MDS further indicated the resident was receiving hospice services while a resident at the facility.</p> <p>The clinical record lacked documentation of a care plan for hospice.</p> <p>During an interview with the MDS Coordinator on 1/27/16 at 3:15 p.m., the MDS Coordinator indicated she was unaware the facility needed to have a hospice care plan for the resident.</p> <p>The facility lacked documentation of a policy for care plans.</p> <p>3.1-35(a)</p> <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</p>		POC for F279 will be available to the surveyors upon their request. Compliance Date: February 17, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/28/2016	
NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to serve foods under sanitary conditions for 9 of 19 residents observed in the 100 unit dining room. Straws were handled with bare hands and bowls were handled by the rims for 1 of 2 dining observations. (Resident #1, Resident #9, Resident #16, Resident #30, Resident #40, Resident #45, Resident #48, Resident #54, Resident #67)</p> <p>Findings include:</p> <p>1. During an observation on 1/26/16 at 11:56 a.m., CNA #1 was observed to be serving drinks in the 100 unit dining room to Resident #1, Resident #9, Resident #16, Resident #30, Resident #40, Resident #45, Resident #48, and Resident #67. CNA #1 was observed to open each straw, remove the paper covering, and handle the straw with her bare hands before placing the straws in the resident's drinks. Hand sanitizer was used for approximately 10 seconds between residents. CNA #1 was also observed to pull up her pants during the opening of the straws and the serving of drinks.</p>	F 0371	<p>Plan of Correction Response for F371 The facility is in the process of re-educating allCNA's and Nurses regarding the Policy and Procedure for "Assistance withMeals". Staff is required to providereturn demonstration in proper handling and distribution of drinking glassesand straws. This process will becompleted by the close of business on Saturday, February 27, 2016. Beginning with Monday, February 29, 2016, theDirector of Nursing or their designee will monitor this process on a weeklybasis for one month, on a monthly basis for a quarter, and on a quarterly basisgoing forward. The Director of Nursing assumes responsibility for andensures compliance. The Administrator isultimately responsible for overall compliance. Any documentation regarding the POC for F371 will beavailable to the surveyors upon their request. Compliance Date: February 27, 2016</p>	02/27/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. During an observation on 1/26/16 at 12:25 p.m., CNA #1 was observed to deliver a bowl of salad to Resident #54. CNA #1 was observed to lift the bowl by the rim and place it in front of the resident.</p> <p>3. During an observation on 1/26/16 at 12:28 p.m., LPN #1 was observed to deliver a cup of coffee to Resident #48. LPN #1 was observed to deliver the cup by the rim to the resident.</p> <p>During an interview on 1/26/16 at 2:15 p.m., LPN #1 indicated bowls and cups should be handled from the sides and not the rims.</p> <p>During an interview on 1/27/16 at 3:32 p.m., CNA #2 indicated the straw covering should be removed with the paper remaining on the top.</p> <p>A policy titled, "Assistance with Meals, undated and obtained from the DON (Director of Nursing) on 1/28/16 at 2:10 p.m., indicated when handling a straw, remove the bottom portion of the protective covering, leaving the top of straw covered, place straw into the cup/glass and then remove the top protective covering. The policy further indicated all drinking cups should be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/28/2016
NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710		
(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 0431 SS=D Bldg. 00	<p>handled from the bottom and hands were not to be placed near the top of the glass where the resident would be drinking from.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure medications were labeled to include the name of the physician for 1 of 3 medication carts reviewed. (200 Hall Medication Cart, Resident #48)</p> <p>Findings include:</p> <p>On 1/28/16 at 8:33 a.m., the 200 Hall Medication Cart was observed. Four medications, including Vitamin B-12, Calcium with Vitamin D, Multivitamin, and Tylenol Arthritis were observed to only be labeled with Resident #48's name.</p> <p>On 1/28/15 at 9:36 a.m., the DON (Director of Nursing) indicated the pharmacy would not provide a label for medications the pharmacy had not prepared. The DON further indicated she could not label the medication with instructions because that would be labeling pharmaceuticals.</p>	F 0431	<p>Plan of Correction Response for F431 The facility is in the process of in-servicing all Nurses regarding the Policy and Procedure for "Labeling of Medication Containers". This process will be completed by the close of business on Saturday, February 27, 2016. Beginning with Monday, February 29, 2016, the Director of Nursing or their designee will monitor this process on a weekly basis for one month and in conjunction with the pharmacy audit, monthly going forward. The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance. Any documentation regarding the POC for F431 will be available to the surveyors upon their request. Compliance Date: February 27, 2016</p>	02/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710
--	--

(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 0441 SS=D Bldg. 00	<p>On 1/28/16 at 1:55 p.m., the DON indicated the facility did not have a policy in place for over-the-counter medication labeling.</p> <p>3.1-25(1)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/28/2016
NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>their food, if direct contact will transmit the disease.</p> <p>(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, interview, and record review, the facility failed to maintain infection control practices during care of residents for 1 of 5 residents observed for care. Hands were not washed or sanitized before, during, or after providing pericare. (Resident #18)</p> <p>Findings include:</p> <p>During an observation on 1/27/16 at 9:20 a.m., LPN #1 and CNA #1 were observed to enter Resident #18's room. No hand hygiene was performed. LPN #1 applied gloves. CNA #1 attached the Hoyer lift to the sling and assisted Resident #18 into the bed. CNA #1 applied gloves. After assisting Resident #18 into bed, LPN #1 removed her gloves and washed her hands for 5 seconds. Resident #18's brief was removed and CNA #1 was observed to wash, rinse, and dry the resident's groin and periarea. Resident #18 was observed to have feces on the</p>	F 0441	<p>Plan of Correction Response for F441 The facility is in the process of educating all CNA's and Nurses regarding the revised "Policy and Procedure for Handwashing Hygiene". The Director of Nursing or their designee is in the process of observing this group of employees during various types of resident care to include toileting, peri-care, bathing, dressing changes, etc. The DON or their designee is documenting the type of care observed and that infection control procedures are followed accordingly. This process will be completed by the close of business on Saturday, February 27, 2016. Beginning with Monday, February 29, 2016 the Director of Nursing, or their designee will monitor this process on a weekly basis for one month, on a monthly basis for a quarter, and on a quarterly basis from this point forward. The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall</p>	02/27/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/28/2016
NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>washcloth when pericare was provided. After completing the pericare, LPN #1 removed her gloves and washed her hands for 5 seconds. CNA #1 removed her gloves and performed hand hygiene at that time. LPN #1 and CNA #1 assisted Resident #18 up in the bed, repositioned the resident with pillows, placed a wedge under the resident's lower extremities, and covered the resident with a sheet and blanket. LPN #1 washed her hands for 5 seconds with the water running over her soapy hands. CNA #1 removed the dirty linens, which were in a plastic bag, and disposed of them. No hand hygiene was performed by CNA #1 before or after exiting the resident's room.</p> <p>During an interview with CNA #1 on 1/27/16 at 10:17 a.m., CNA #1 indicated hands were to be washed for 1 (one) minute and hands should be sanitized and rubbed together until they are dry.</p> <p>During an interview on 1/28/16 at 11:50 a.m., the Administrator and DON (Director of Nursing) indicated they were unaware of the most recent guidelines for handwashing and hand sanitizer use.</p> <p>A policy titled, "Handwashing/Hand Hygiene" undated, and obtained from the DON on 1/28/16 at 1:53 p.m., indicated hands should be washed at least 15</p>		<p>compliance. Any documentation regarding the POC for F441 will be available to the surveyors upon their request. Compliance Date: February 27, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155520	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/28/2016
NAME OF PROVIDER OR SUPPLIER  BRAUN'S NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN 47710		
(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	
	(fifteen) seconds before and after resident contact and personal care.  3.1-18(b)(1) 3.1-18(l)				