

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2012
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NAME OF PROVIDER OR SUPPLIER LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1029 E 5TH ST CONNERSVILLE, IN47331
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F0000	<p>This visit was for the Investigation of Complaint IN00101614 and IN00101712.</p> <p>Complaint IN00101614 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F309 and F323.</p> <p>Complaint IN00101712 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: January 18, 19, and 20, 2012</p> <p>Facility number: 000316 Provider number: 155491 AIM number: 100286370</p> <p>Survey team: Barbara Gray RN TC Leslie Parrett RN</p> <p>Census bed type: SNF/NF: 118 Total: 118</p> <p>Census payor type: Medicare: 13 Medicaid: 72 Other: 33</p>	F0000	<p>Preparation or execution of this plan of correction (POC) does not constitute an admission or assent by the provider to the truth, accuracy or veracity or the alleged or conclusions set forth in the Statement of Deficiencies (SOD). The POC is prepared and executed solely because it is required under law.</p> <p>Lincoln Centers for Rehabilitation and Healthcare acknowledges receipt of the SOD and alleges that it is in compliance.</p> <p>Accordingly, the POC is submitted as alleged compliance as of Feb 6, 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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	<p>Total: 118</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/24/12 by Suzanne Williams, RN</p>				

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the physician of a resident's change in condition and report medications being held related to lethargic conditions, for 1 of 3 residents reviewed for medications, in the total sample of 6. (Resident #A).</p>	F0157	<p>F 157 Notify of Change It is the policy of this facility to comply with regulatory requirement Notify of Change.</p> <p>1.) Resident A no longer resides at the facility.</p> <p>2). The facility has conducted a review of medication</p>	02/06/2012	

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	<p>Findings include:</p> <p>Resident #A's record was reviewed on 1/18/12 at 1:47 P.M. Diagnoses included, but were not limited to, quadriplegia, C-5 and C-6 cervical spine injury, and chronic pain syndrome.</p> <p>Resident #A's physician recapitulation order for 1/1/12 through 1/31/12, included, but was not limited to, the following medication orders: 1.) 11/18/11 - Alprazolam 0.5 milligram (mg) tablet every 6 hours. (for anxiety) 2.) 10/14/11 -Baclofen 20 mg table every 6 hours. (relaxes muscles) 3.) Hydrocodone-APAP 10-325 mg table 4 times a day. (relieves pain) 4.) Morphine sulfate SA 30 mg tablet every 12 hours. (relieves pain) 5.) Zanaflex 4 mg tablet - 2 tablets every 6 hours. (reduces spasticity) 6.) Cymbalta 60 mg capsule every morning. (antidepressant) 7.) Lyrica 25 mg capsule 3 times a day. (anticonvulsant)</p> <p>Resident #A's admission Minimum Data Set assessment dated 10/27/11, indicated Resident #A had impaired movement of his bilateral upper and lower extremities, required extensive assistance of 2 persons for transfer, personal hygiene, and toileting, extensive assistance of one person to dress, and did not walk.</p>		<p>administration records and no other residents have been affected.</p> <p>3.) Licensed staff re-educated on the facility policy and procedure related to physician notification and medication administration.</p> <p>During daily clinical meeting the IDT will review 24 hour report for residents with changes of condition and or medication being held to ensure proper physician notification.</p> <p>DON or designee will QA monitor medication administration records 3 times weekly x 1 month then weekly x 1 month then monthly.</p> <p>4. Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations.</p> <p>5.) Allegation of Compliance: Feb 6, 2012.</p>		

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	<p>A local hospital note for Resident #A dated 6/25/11, indicated the following. "The patient who is known to our service with a prior hospitalization secondary to a similar presentation in the fall of 2010. At that time the patient was found to have an acute narcotic overdose. The patient is on chronic pain medications secondary to autonomic dysreflexia as a result of a C5-C6 spine injury in 2004."</p> <p>A physician's progress note for Resident #A dated 11/27/11, indicated the following: "The patient has quadriplegia secondary to C5-C6 spine injury involving his upper extremities well. He has good control over the upper extremities. He is wheelchair bound. He has chronic pain problems. He is on many medications. The patient is not happy and he wants stronger pain medications, which we are not going to give. Otherwise, the patient is also on many medications for his rigidity and other things."</p> <p>Nursing notes documented for resident #A, indicated the following: 10/16/11 at 10:00 A.M. - The resident was very upset with the doctor when the doctor stated, instead of giving him more medication, he would refer him to a pain clinic.</p>			

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	<p>10/22/11 at 1:00 P.M. - The resident was too lethargic to wake up and eat. His lunch was still in his room.</p> <p>10/22/11 at 1:30 P.M. - The resident was clearly sleeping well. The resident had aroused slightly by calling his name 3 times. The resident's lunch was still sitting in front of him untouched. 12:00 Noon routine medications were held.</p> <p>10/22/11 at 3:30 P.M. - The resident was still sleeping well. The writer would continue to monitor the resident.</p> <p>11/16/11 at 5:00 A.M. - The resident had reported to the CNA that yesterday while visiting family he was accused by his grandmother of stealing 15 of her pain pills. The resident had been falling asleep very easily. The writer and CNA had attempted to wake the resident up last night for a shower. The resident was very lethargic. The resident had went outside. The writer had let the resident back in and he had fallen asleep at the door within a matter of seconds. The resident was assisted to bed. The Director of Nursing was notified.</p> <p>1/7/12 at 9:00 A.M. - The resident was slumped over the left side of his wheelchair sleeping. The resident was too lethargic to eat breakfast. The resident was too lethargic to take his medications. 9:00 A.M., medications were held.</p> <p>1/7/12 at 12:00 P.M. - The resident was still laying over in his wheelchair</p>			

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	<p>sleeping. The resident did not arouse when staff were calling his name.</p> <p>1/12/12 at 6:00 P.M. - The resident's mother had brought the resident belongings into the facility, then she had brought the resident in. The resident's eyes were glossy and droopy, and his speech was slurred.</p> <p>1/12/12 at 6:06 P.M. - The resident's medications were taken to his room. The resident seemed to be under the influence of "something" to the writer. 6:00 P.M., medications were given at the request of the resident and the resident's mother. The writer would monitor the resident.</p> <p>1/12/12 at 7:00 P.M. - The resident was passed out in his wheelchair and could not hold his eyes open. The resident was like that every time he went on a leave of absence with his mother.</p> <p>1/16/12 at 12:00 A.M. - The resident was sleeping in his wheelchair. The writer called the resident's name 4 times for his 12:00 A.M., medications. The resident continued to sleep. 12:00 A.M., medications were held.</p> <p>1/17/12 at 9:00 A.M. - Staff attempted 3 times to awaken the resident. He was snoring loudly. 9:00 A.M., medications were held.</p> <p>1/17/12 at 10:00 A.M. - The resident continued to be in his wheelchair snoring. Staff were unable to awaken the resident. 9:00 A.M., medications were held as a</p>			

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F0309 SS=D	<p>nursing judgement.</p> <p>The facility was unable to provide physician's notification for Resident #A when he was suspected to be under the influence of "something" on 1/12/12 and when he was too lethargic to take his medications, resulting in his medications being held, on 10/22/11, 1/7/12, 1/16/12, and 1/17/12.</p> <p>An interview with the Director of Nursing on 1/19/12 at 2:45 P.M., indicated a facility nurse may hold a resident's medication as a nursing measure and then notify the physician.</p> <p>This federal tag relates to Complaint IN00101614.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to assess a resident who was too lethargic to receive scheduled medications and failed to notify the physician of the resident's status, and</p>	F0309	<p><u>F 309 Provide Care/ Services For Highest Well Being.</u></p> <p>It is the policy of this facility to comply with regulatory requirement to provide care and services for highest well being.</p>	02/06/2012	

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	<p>report medications being held related to lethargic conditions, for 1 of 3 residents reviewed for medications, in the total sample of 6. (Resident #A).</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 1/18/12 at 1:47 P.M. Diagnoses included, but were not limited to, quadriplegia, C-5 and C-6 cervical spine injury, and chronic pain syndrome.</p> <p>Resident #A's physician recapitulation order for 1/1/12 through 1/31/12, included, but was not limited to, the following medication orders: 1.) 11/18/11 - Alprazolam 0.5 milligram (mg) tablet every 6 hours. (for anxiety) 2.) 10/14/11 -Baclofen 20 mg table every 6 hours. (relaxes muscles) 3.) Hydrocodone-APAP 10-325 mg table 4 times a day. (relieves pain) 4.) Morphine sulfate SA 30 mg tablet every 12 hours. (relieves pain) 5.) Zanaflex 4 mg tablet - 2 tablets every 6 hours. (reduces spasticity) 6.) Cymbalta 60 mg capsule every morning. (antidepressant) 7.) Lyrica 25 mg capsule 3 times a day. (anticonvulsant)</p> <p>Resident #A's admission Minimum Data Set assessment dated 10/27/11, indicated Resident #A had impaired movement of</p>		<p>1.) Resident A no longer resides in the facility.</p> <p>2.) The facility has conducted a review of medication administration records and no other residents have been affected.</p> <p>3.) Licensed staff re-educated on the facility policy and procedure related to physician notification and medication administration and change of condition assessment.</p> <p>During daily clinical meeting the DON or designee will review 24 hour report for residents with changes of condition and or medication being held to ensure proper physician notification and proper nursing assessment.</p> <p>DON or designee will QA monitor medication administration records for medication held, physician notification and change of condition assessment 3 times weekly x 1 month then weekly x 1 month then monthly.</p> <p>4. Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations.</p> <p>5.) Allegation of Compliance: Feb 6, 2012.</p>		

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	<p>his bilateral upper and lower extremities, required extensive assistance of 2 persons for transfer, personal hygiene, and toileting, extensive assistance of one person to dress, and did not walk.</p> <p>A local hospital note for Resident #A dated 6/25/11, indicated the following. "The patient who is known to our service with a prior hospitalization secondary to a similar presentation in the fall of 2010. At that time the patient was found to have an acute narcotic overdose. The patient is on chronic pain medications secondary to autonomic dysreflexia as a result of a C5-C6 spine injury in 2004."</p> <p>A physician's progress note for Resident #A dated 11/27/11, indicated the following: "The patient has quadriplegia secondary to C5-C6 spine injury involving his upper extremities well. He has good control over the upper extremities. He is wheelchair bound. He has chronic pain problems. He is on many medications. The patient is not happy and he wants stronger pain medications, which we are not going to give. Otherwise, the patient is also on many medications for his rigidity and other things."</p> <p>Nursing notes documented for resident #A, indicated the following:</p>			

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	<p>10/16/11 at 10:00 A.M. - The resident was very upset with the doctor when the doctor stated, instead of giving him more medication, he would refer him to a pain clinic.</p> <p>10/22/11 at 1:00 P.M. - The resident was too lethargic to wake up and eat. His lunch was still in his room.</p> <p>10/22/11 at 1:30 P.M. - The resident was clearly sleeping well. The resident had aroused slightly by calling his name 3 times. The resident's lunch was still sitting in front of him untouched. 12:00 Noon routine medications were held.</p> <p>10/22/11 at 3:30 P.M. - The resident was still sleeping well. The writer would continue to monitor the resident.</p> <p>11/16/11 at 5:00 A.M. - The resident had reported to the CNA that yesterday while visiting family he was accused by his grandmother of stealing 15 of her pain pills. The resident had been falling asleep very easily. The writer and CNA had attempted to wake the resident up last night for a shower. The resident was very lethargic. The resident had went outside. The writer had let the resident back in and he had fallen asleep at the door within a matter of seconds. The resident was assisted to bed. The Director of Nursing was notified.</p> <p>1/7/12 at 9:00 A.M. - The resident was slumped over the left side of his wheelchair sleeping. The resident was too</p>			

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	<p>lethargic to eat breakfast. The resident was too lethargic to take his medications. 9:00 A.M., medications were held.</p> <p>1/7/12 at 12:00 P.M. - The resident was still laying over in his wheelchair sleeping. The resident did not arouse when staff were calling his name.</p> <p>1/12/12 at 6:00 P.M. - The resident's mother had brought the resident belongings into the facility, then she had brought the resident in. The resident's eyes were glossy and droopy, and his speech was slurred.</p> <p>1/12/12 at 6:06 P.M. - The resident's medications were taken to his room. The resident seemed to be under the influence of "something" to the writer. 6:00 P.M., medications were given at the request of the resident and the resident's mother. The writer would monitor the resident.</p> <p>1/12/12 at 7:00 P.M. - The resident was passed out in his wheelchair and could not hold his eyes open. The resident was like that every time he went on a leave of absence with his mother.</p> <p>1/16/12 at 12:00 A.M. - The resident was sleeping in his wheelchair. The writer called the resident's name 4 times for his 12:00 A.M., medications. The resident continued to sleep. 12:00 A.M., medications were held.</p> <p>1/17/12 at 9:00 A.M. - Staff attempted 3 times to awaken the resident. He was snoring loudly. 9:00 A.M., medications</p>			

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	<p>were held.</p> <p>1/17/12 at 10:00 A.M. - The resident continued to be in his wheelchair snoring. Staff were unable to awaken the resident. 9:00 A.M., medications were held as a nursing judgement.</p> <p>The facility was unable to provide assessment documentation for Resident #A when staff suspected him to be under the influence of "something" on 1/12/12. The facility was unable to provide assessment documentation for Resident #A when he was too lethargic to take his medications on 10/22/11, 1/7/12, 1/16/12, and 1/17/12. The facility was unable to provide physician's notification for Resident #A when he was suspected to be under the influence of "something" on 1/12/12 and when he was too lethargic to take his medications, resulting in his medications being held, on 10/22/11, 1/7/12, 1/16/12, and 1/17/12.</p> <p>An interview with the Director of Nursing on 1/19/12 at 2:45 P.M., indicated a facility nurse may hold a resident's medication as a nursing measure and then notify the physician.</p> <p>This federal tag relates to Complaint IN00101614.</p> <p>3.1-37(a)</p>				

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F0323 SS=D	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to properly assess a resident for independent smoking safety, to prevent potential injury, for 1 of 3 residents reviewed for smoking safety, in the total sample of 6. (Resident A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 1/18/12 at 1:47 P.M. Diagnoses included, but were not limited to, quadriplegia, C5 and C6 cervical spine injury, and chronic pain syndrome.</p> <p>Resident #A's admission Minimum Data Set assessment dated 10/27/11, indicated Resident #A was a current tobacco user and he had impaired movement of his bilateral upper and lower extremities.</p> <p>A physician's progress note dated 11/27/11, indicated the following: "The patient has quadriplegia secondary to C5-C6 spine injury involving his upper extremities well. He has good control</p>	F0323	<p><u>F 323 Free of Accident/ Hazards/ Supervision.</u></p> <p>It is the policy of this facility to comply with regulatory requirement accidents and hazards.</p> <p>1.) Res #A no longer resides at the facility</p> <p>2.) Facility has completed a review of residents who smoke and a reassessment has been completed and care plans revised and updated to reflect supervised smoking.</p> <p>3. Staff have been re-educated on facility policy related to supervised smoking.</p> <p>Facility has revised smoking policy to reflect supervised smoking that provides assistance or supervision for all residents that smoke.</p> <p>Administrator or designee will randomly observe supervised smoking 5 x weeks to ensure residents are assisted and supervised per policy.</p>	02/06/2012

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	<p>over the upper extremities. He is wheelchair bound. He has chronic pain problems. He is on many medications."</p> <p>A smoking safety screen for Resident #A dated 10/14/11, indicated the following: The resident is on medications with side effects of sedation. Assistance with smoking is required.</p> <p>A smoking care plan for Resident #A, initiated 10/27/11, indicated the following: Problem - Potential for injury related to smoking. Goal - Will be free of injury related to smoking within 3 months. Approaches - All smoking materials to be kept at the nurses station. The resident will be supervised during smoking. A smoking assessment will be completed according to policy and as needed. The resident will be educated on the smoking policy.</p> <p>Nursing notes documented for resident #A indicated the following: 11/15/11 at 10:30 P.M. - The resident was outside with another resident and visitor. The resident had his wheelchair on a sloped area and tipped the wheelchair over on its side. 11/26/11 at 5:00 A.M. - The resident had knocked on the door to be let back in the facility. The writer had got up and let the resident back in. The resident was asleep at the door within a matter of</p>		<p>4.) Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations.</p> <p>5.) Allegation of Compliance: Feb 6, 2012.</p>		

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	<p>seconds. 1/17/12 at 2:00 A.M. - The resident had gone outside approximately an hour earlier, stating he needed "fresh air". The writer had not given the resident cigarettes prior to going outside. The resident was lethargic since he came back in. He was noted to have ashes on his sweat pants. The resident had made it from the front door to just a few feet past the nurses station when he had fallen asleep. The writer called his name several times before he opened his eyes. The resident's speech was slurred. The resident had woke up, wheeled his chair approximately 5 feet and had fallen asleep again. 1/17/12 at 2:15 A.M. - The resident had fallen asleep again in his chair at the nurses station in a matter of minutes.</p> <p>On 1/18/12 at 10:28 A.M., Resident #A was observed asleep, seated in his wheelchair in his bedroom. Resident #A was observed to have some mild upper body involuntary movements. Resident #A indicated the facility staff wanted him to be supervised when he went out and smoked but he had went out and smoked by himself. Resident #A indicated the staff wanted him to be supervised when he went out and smoked because they had seen some old burn holes on his pants.</p> <p>An interview with LPN #1 on 1/18/12 at</p>				

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	<p>12:53 P.M., indicated Resident #A was supervised when he smoked. LPN #1 indicated Resident #A was not safe to smoke unsupervised because he sometimes fell asleep while he was smoking.</p> <p>An interview with Resident B on 1/18/12 at 12:07 P.M., indicated Resident #A was supervised by the staff when he smoked because Resident #A would close his eyes when he smoked. Resident #B indicated "he will be falling asleep."</p> <p>An interview with CNA #2 on 1/19/12 at 9:23 A.M., indicated she felt when Resident #A was alert, he was safe to smoke unsupervised, but he was not alert approximately 85% of the time. CNA #2 indicated Resident #A would fall asleep with a cigarette in his hand and staff would have to take the cigarette from him. CNA #2 indicated she believed the last time she observed Resident #A fall asleep with a cigarette in his hand was when she supervised him on 1/16/12. CNA #2 indicated she removed the cigarette from him at that time.</p> <p>A smoking safety screen for Resident #A dated 1/18/12, indicated the following: The resident is able to smoke independently. The smoking safety screen for Resident #A was signed by</p>				

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	<p>QMA #3.</p> <p>An interview with QMA #3 on 1/19/12 at 11:00 A.M., indicated she determined a resident's safety for smoking by talking with the resident and watching the resident smoke at times. QMA #3 indicated " a lot of times I will look through their chart to see what kind of medicines they're on and look at nursing notes to see if they are awake and coherent." QMA #3 indicated she felt Resident #A was safe to smoke independently. QMA #3 indicated "I think by talking to him, I feel like he knows what he is doing."</p> <p>A physician's progress note dated 1/19/12 at 6:30 P.M., indicated the following: "Resident is lethargic at times- resulting in medications being held by nursing. Missed doses are not life threatening. As resident becomes alert - nursing is to resume medication regimen. Nursing to monitor for safe smoking."</p> <p>The most recent smoking policy and procedure provided by the Director of Nursing on 1/19/12 at 9:00 A.M., indicated the following: "Residents/patients who smoke will be evaluated for smoking safety, utilizing the Smoking Safety Screen for (FSE2-4). Residents that are not safe to smoke alone</p>				

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	<p>will be supervised at routine times...."</p> <p>This federal tag relates to Complaint IN00101614.</p> <p>3.1-45(a)(2)</p>				

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility failed to handle linens in a manner to prevent the potential spread of infection, in that linens were piled on a dirty, bare cement floor, and staff took</p>	F0441	<p><u>441 Infection Control, Prevent Spread, Linen.</u></p> <p>It is the policies of this facility to comply with regulatory requirement infection control</p>	02/06/2012

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	<p>linens to their own personal home to dry. This practice had the potential to affect all 118 residents who resided in the facility and received linens from the laundry.</p> <p>Findings include:</p> <p>On 1/19/12 at 11:10 A.M., the facility laundry room was observed with linens piled on the dirty, bare cement floor, in the soiled section of the laundry room. The barrels available for soiled laundry were all full. An interview with Laundry Assistant Manager/Floor Technician at that time indicated the linens were piled on the floor because the staff were struggling to keep the laundry caught up. The Laundry Assistant Manager/Floor Technician indicated the facility laundry had only one dryer in working condition. The Laundry Assistant Manager/Floor Technician indicated there had only been one functioning dryer in the facility for approximately two weeks.</p> <p>An interview with the Housekeeping and Laundry Manager on 1/19/12 at 11:20 A.M., indicated there had only been one functioning dryer in the facility for approximately two weeks. The Housekeeping and Laundry Manager indicated he was not sure of the facility's policy when their equipment was broken and they could not keep up with the</p>		<p>prevent the spread.</p> <p>1.) Linen has been removed from the bare cement floor. Laundry personnel have been instructed to extend hours of laundry operation as needed. Laundry supervisor has been instructed to notify Administrator in the event of equipment failure.</p> <p>2.) Facility has conducted a review of laundry services and no other linen on floor has been identified. Equipment is currently functioning.</p> <p>3.) Facility laundry service staff have been re-educated on facility policy related to infection control and equipment failure.</p> <p>Facility administrator has secured an outside agreement related to laundry services in the event of equipment failure.</p> <p>Administrator or designee will conduct random QA observation of laundry services 3 x week x 1 month then weekly x one month then monthly to ensure linen is handled appropriately.</p> <p>4.) Results of QA reviews will be forwarded to the Facility Risk Management Quality Initiative, (RMQI), for further evaluation and recommendations.</p> <p>5.) Allegation of Compliance: Feb</p>		

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	<p>laundry. The Housekeeping and Laundry Manager indicated Laundry Staff #4 had taken the facility's linens home one time and dried them. The Housekeeping and Laundry Manager indicated Laundry Staff were also working at night to try and keep up.</p> <p>An interview with Laundry Staff #4 on 1/19/12 at 2:00 P.M., indicated she had taken washed wet linens home one time and dried them in her personal home dryer. Laundry Staff #4 indicated the linens consisted of blankets, sheets, towels, washrags, and pillow cases. Laundry Staff #4 indicated she took home approximately 4 to 5 bags of washed wet linens to dry.</p> <p>An interview with the Housekeeping and Laundry Manager on 1/19/12 at 3:28 P.M., indicated his District Manager informed him the procedure to follow if the laundry equipment was broken was to take it to the laundromat or come in extra hours and get it done.</p> <p>3.1-19(g)(1)</p>		6, 2012.		