

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131		
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F0000	<p>This visit was for Recertification and State Licensure Survey. This visit included the investigation of Complaint Numbers IN00116979 and IN00115653.</p> <p>Complaint number IN00115653- Unsubstantiated, Lack of sufficient evidence.</p> <p>Complaint number IN00116979- Unsubstantiated, Lack of sufficient evidence.</p> <p>Survey Dates: September 25, 26, 27, 28, 30 AND October 1, 2, 3, 4, 2012</p> <p>Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430</p> <p>Survey team: Patti Allen BSW TC Marcy Smith RN (September 26, 27, 28 AND October 1, 2, 3, 4, 2012) Leia Alley RN (September 26, 27, 28 AND October 1, 2, 3, 4, 2012) Dinah Jones RN</p> <p>Census Bed Type: Residential---109 SNF/NF--122 SNF--13</p>	F0000	<p>The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc. (the "Facility") that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 16/17 programs). To this end, this plan of corection shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of stature only.</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 244</p> <p>Census Payor Source: Medicaid--109 Medicare ---13 Other-----122 ----- Total 244</p> <p>Residential Sample: 08</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/10/12 Cathy Emswiller RN</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</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> <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 record review and interview, the facility failed to ensure comprehensive plans of care were in place for 1 of 1 residents in the facility who received outpatient hemodialysis (Resident #72) and 1 of 3 residents (Resident #168) of 8 who met the criteria for being at risk for falls in a sample of 47.</p> <p>Findings include:</p> <p>1. The record of Resident #72 was reviewed on 10/2/12 at 9:30 a.m.</p>	F0279	It shall be the policy of the Indiana Masonic Home, Inc. to develop comprehensive care plans to meet each resident's individual needs. I. The care plan for Resident #72 has been revised to specifically include a care plan dedicated to hemodialysis and care of the AV fistula/shunt. The nursing staff assess the dialysis access site for bruit, thrill, bleeding, and signs of infection every shift, and document completion of the assessment on the Treatment Administration Record. They are to report abnormal findings to the MD and document abnormal findings in	10/26/2012	

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	<p>Diagnoses for Resident #72 included, but were not limited to, renal failure.</p> <p>Resident #72 received hemodialysis 3 times per week at an outside facility. His current dialysis access site was an arteriovenous (AV) fistula/shunt in his left arm, placed surgically on 1/2/12. Prior to the AV fistula he had a intravenous catheter access for dialysis.</p> <p>A quarterly Minimum Data Set, MDS) dated 8/16/12, indicated Resident #72 received hemodialysis.</p> <p>A Significant Change MDS, dated 11/28/11, indicated Resident #72 received hemodialysis.</p> <p>A care plan for Resident #72 being a risk for changes in his nutritional status due to renal failure was created on 11/11/10 and documented as current through 10/29/12.</p> <p>A care plan for Resident #72 being at "Risk Infection at Catheter Site" was created 9/7/11 and documented as current through 11/6/12. Interventions included keeping the area around the catheter clean and checking the site every shift for signs of infection.</p>		<p>the Nurse's Notes of the resident's chart. The care plan for Resident #168 has been revised to specifically include a care plan for fall risk. II. There are no other residents in the facility receiving hemodialysis. A chart review has been conducted for every resident in the facility. Those residents identified as a high fall risk have a care plan specific to fall risk. III. In order to maintain compliance, the Interdisciplinary Team (IDT) will review the care plan for a resident that has a change in condition or who is a new admission/re-admission during a weekly risk management meeting. The purpose of the review is to ensure that the appropriate care plan is in place for meeting the resident's individual needs with respect to the change in condition, and/or to ensure that appropriate care plans are in place upon admission/re-admission. If the care plan is found to be lacking, the IDT will revise the care plan as appropriate during the weekly risk management meeting. IV. The IDT will monitor the number of care plans reviewed each week and document the number of care plans that were revised during the weekly risk management meeting. The purpose of this type of audit is to provide immediate feedback to the group so that staff education can be done quickly when a negative</p>		

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	<p>During an interview with Unit Manager #4 on 10/2/12 at 10:25 a.m. she indicated Resident #72 did not have a care plan specific to caring for a resident with an AV fistula/shunt for dialysis. On 10/2/12 at 10:40 a.m. RN #5 went to the computer and printed off the facility's care plan, titled "Dialysis Shunt," which indicated "Problem/Need...At risk for complications related to use of AV Shunt for dialysis..."</p> <p>A facility policy, dated 9/20/04, received from the Director of Nursing on 9/25/12 at 3:30 p.m., titled "Nursing Dialysis Access Site Assessment and Care," indicated "Fistula - A fistula surgically connects the artery and vein...Assess for signs of infection (tenderness, swelling, redness, warmth). If symptoms are present, notify MD...The fistula...will be assessed every shift and will be documented on the Treatment Administration Record.</p> <p>On 10/3/12 at 12:17 p.m. the Director of Nursing provided a revised "Physician's Order Sheet" which indicated "3-Oct-12 Treatment Procedure **Treatment/Procedure**Nursing Order- Assess dialysis access site for bruit, thrill, bleeding, and signs of</p>		<p>trend is identified. The IDT will report audit findings and actions taken to correct negative trends to the Quality Improvement Committee. Monitoring will stop when the IDT determines that care plans reviewed each week are complete and do not require the IDT to revise or complete the care plans as written. V. Staff responsible: Director of Nursing Unit Managers Other Interdisciplinary Team members</p>				

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	<p>infection. Report abnormal findings to MD and document abnormal findings in nurses notes dx [diagnosis] Hemodialysis..." to be done every shift. She indicated at this time "We've added this to the care plan."</p> <p>2. The record for Resident # 168 was reviewed on 10/2/12 at 2:00 p.m.</p> <p>Diagnoses Included, but were not limited to, colorectal cancer (cancer in the colon), malnutrition and confusion.</p> <p>The record indicated Resident #168 had a fall on 9/20/12. The nurses notes dated 9/20/12 indicated Resident #168 stood from her chair in the dining room, her feet slipped from under her and she fell onto her buttocks.</p> <p>A fall risk assessment dated 8/18/12 indicated Resident #168's fall risk was "High". The assessment indicated any score above a 10 was "High" risk for falls and Resident #168 scored a 12 on her assessment.</p> <p>A Minimum Data Set (MDS) assessment dated 8/25/12 indicated that Resident #168 was severely cognitively impaired and was not steady on her feet and was "only able</p>			

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	<p>to stabilize with Human assistance".</p> <p>A facility care plan for "Injury" dated 8/18/12 indicated Resident #168 was "at risk for injury related to health conditions such as... Cognitive Deficit, Safety Awareness and New Environment". The care plan did not indicate if Resident #168 was at risk for injury related to falls.</p> <p>Further information was requested of the DON (Director of Nursing) on 10/2/12 at 4:00 p.m. in regards to a care plan for fall related injury. No care plan was provided by the facility.</p> <p>3.1-35(b)(1)</p>			

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure a nutrition care plan was updated with new interventions for 1 of 22 of residents reviewed for care plan updates in a sample of 24 residents. (Resident #164)</p> <p>Findings include:</p> <p>The record of Resident #164 was reviewed on 10/1/12 at 1:56 p.m.</p> <p>Diagnoses for Resident #164 included, but were not limited to, aspiration pneumonia.</p>	F0280	<p>It shall be the policy of the Indiana Masonic Home, Inc. to develop a care plan that is specific to the resident's individual needs, and make revisions to the care plan as the resident's needs change.</p> <p>I. Resident #164 was deceased prior to the Annual Survey. No action can be taken to correct the care plan. II. A chart review has been conducted for every resident in the facility. Those residents identified as aspiration precautions have a care plan specific to aspiration precautions. III. In order to maintain compliance, the Interdisciplinary Team (IDT) will review the care plan for a resident that has a change in condition or who is a</p>	10/26/2012			

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	<p>Resident #164 was readmitted to the facility 5/17/12 after being hospitalized for aspiration pneumonia. He was again admitted to the hospital on 6/3/12 after choking on food in the facility's dining room and returned to the facility on 6/8/12, with Hospice Care. Resident #164 died on 6/10/12 in the facility.</p> <p>A care plan dated 5/17/12 and current through 6/17/12 indicated a problem of "At risk for declines...in ADL's [Activities of Daily Living] due to: Asp[iration] pneu[monia]. Interventions included "Refer to therapy for screening evals PT OT ST... set up meals and assist as needed..."</p> <p>A care plan dated 5/17/12 and current through 6/17/12 indicated a problem of "Resident is at risk for changes in nutritional status D/T [due to] Asp pneu..." Interventions included "...Monitor for chewing and swallowing problems..."</p> <p>A Speech Therapy Progress Report dated 5/21/12, indicated the Speech Therapist had evaluated Resident #164's chewing and swallowing skills on this date. It indicated therapy would continue due to "Decreased</p>		<p>new admission/re-admission during a weekly risk management meeting. The purpose of the review is to ensure that the appropriate care plan is in place for meeting the resident's individual needs with respect to the change in condition, and/or to ensure that appropriate care plans are in place upon admission/re-admission. If the care plan is found to be lacking, the IDT will revise the care plan as appropriate during the weekly risk management meeting.</p> <p>IV. The IDT will monitor the number of care plans reviewed each week and document the number of care plans that were revised during the weekly risk management meeting. The purpose of this type of audit is to provide immediate feedback to the group so that staff education can be done quickly when a negative trend is identified. The IDT will report audit findings and actions taken to correct negative trends to the Quality Improvement Committee. Monitoring will stop when the IDT determines that care plans reviewed each week are complete and do not require the IDT to revise or complete the care plan as written. V. Staff responsible: Director of Nursing Unit Managers Other Interdisciplinary Team members</p>		

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	<p>swallow skills continue to negatively impact his ability to safely consume food and/or liquids..." It indicated "Educated Res[ident] and caregivers in regards to Res[ident's] current status, recommendations, and changes. Modified Res' diet to mech-soft. Instructed Res in use of various compensatory strategies to attempt to reduce risk of aspiration. Made referral for a Modified Barium Swallow study..."communicated with caregivers [staff] on a daily basis regarding Res' current status...SLP (Speech Language Pathologist) attempted to identify various safe swallow strategies to reduce his risk of choking...Caregivers are working with SLP to implement any safe swallow strategies that work...Currently no safe swallow precautions are in place...Target Goal...Caregivers and Res implement safe swallow precautions 90% of the time..."</p> <p>There was no documentation to indicate the above Nutrition and ADL care plans were updated with any of the SLP interventions or precautions prior to Resident #164's rehospitalization on 6/3/12 after choking in the dining room.</p> <p>A care plan, dated 6/8/12, when</p>			

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	<p>Resident #164 returned to the facility on Hospice Care , indicated he was at risk for a decline in ADL's due to aspiration. Interventions did not include any aspiration precautions. Another care plan started 6/8/12 indicated he was at risk for changes in nutritional status. An intervention was to "Monitor for chewing and swallowing problems. It did not mention he was a risk for aspiration. Interventions did not include aspiration precautions or safe swallow strategies.</p> <p>3.1-35(d)(2)(B)</p>			

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F0334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>				

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview, the facility failed to ensure residents received the pneumococcal immunization for 2 of 5 residents reviewed for immunizations. (Residents #69 and 126)</p> <p>Findings include:</p> <p>1. The record of Resident #69 was reviewed on 10/1/12 at 3:06 p.m.</p> <p>Diagnoses for Resident #69 included, but were not limited to, anemia, dementia with agitation, high blood</p>	F0334	It is the policy of the Indiana Masonic Home, Inc. to offer influenza and pneumococcal vaccinations to every resident in accordance with CDC recommendations. CDC MMWR dated 9/3/2010 recommends: * PPSV23 should be administered to adults aged 19-64 years with chronic or immunosuppressing medical conditions, including those who have asthma. * Adults aged 19-64 years who smoke cigarettes should receive PPSV23. * All persons should be vaccinated with PPSV23 at age 65 years. Those who received PPSV23 before age 65 years for any indication should receive	10/26/2012

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	<p>pressure, dysphagia and malabsorption syndrome.</p> <p>The resident's record indicated she had received the pneumonia vaccine in 10/2004. Documentation was provided which indicated Resident #69 signed a "Pneumonia and Influenza Vaccine Consent Form" on 1/24/06 that she did not want to participate in the pneumonia vaccination program.</p> <p>On 10/4/12, Unit Manager #3 indicated Resident #126 was moved to the Alzheimer's unit on 2/8/06. She indicated the resident or the resident's representative had not been offered the opportunity to receive the pneumonia vaccine since 1/24/06.</p> <p>2. The record of Resident #126 was reviewed on 10/2/12 at 3:07 p.m.</p> <p>Diagnoses for Resident #126 included, but were not limited to, Parkinson's disease, chronic dementia with behaviors and senile delusions. She was admitted to the facility on 12/1/10.</p> <p>A "Pneumonia and Influenza Vaccine Consent Form," dated 12/1/10,</p>		<p>another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose. Those who receive PPSV23 at or after age 65 years should receive only a single dose. * ACIP does not recommend routine revaccination for most persons for whom PPSV23 is indicated. A second dose of PPSV23 is recommended 5 years after the first doese for persons aged 19-64 years with functional or anatomic asplenia and for persons with immunocompromising conditions. ACIP does not recommend multiple revaccinations because of uncertainty regarding clinical benefit and safety. * ACIP does not recommend routine revaccination for most persons for whom PPSV23 is indicated. A second dose of PPSV23 is recommended 5 years after the first dose for persons aged 19-64 years with functional or anatomic asplenia and for persons with immunocompromising conditions. ACIP does not recommend multiple revaccinations because of uncertainty regarding clinical benefit and safety I. The chart was reviewed for Resident #69. The chart indicates that this resident did receive a pneumococcal vaccine in October, 2004. This resident was 82 years of age at time of</p>				

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	<p>indicated Resident #126 wanted to receive the pneumococcal vaccination. There was no documentation in the resident's record to indicate she received this vaccination.</p> <p>Further information was requested from Unit Manager #4 on 10/3/12 at 10:00 a.m. regarding whether Resident #126 had received the pneumococcal vaccination.</p> <p>On 10/3/12 at 10:25 a.m. Unit Manager #4 indicated another nursing facility had the information regarding whether/when Resident #126 had received the vaccination. She indicated the other facility was going to fax the information to her. No further information was received by the time of exit on 10/4/12 at</p> <p>A facility policy, dated 7/27/06, titled "Nursing & Infection Control Influenza Vaccination & Pneumovax," received from the Director of Nursing on 9/25/12 at 3:30 p.m., indicated "...The pneumovax will be offered to...any resident who has not been or does not recall being vaccinated in the past 5 years..."</p> <p>3.1-13(a)</p>		<p>vaccination. Her vaccine was given in accordance with CDC recommendations and no further vaccination is warranted. The chart was reviewed for Resident #126. The chart indicates that she hasnot been offered the pneumococcal vaccine. Resident #126 has now been offered the pneumococcal vaccine. II. A chart review has been conducted for every resident in the facility. Each resident's pneumococcal vaccination status has been reviewed. Any resident who has previously refused vaccination, or whose vaccination status cannot be determined will be offered a pneumococcal vaccination. The resident's acceptance or refusal of the vaccine will be documented in the resident's chart.. III. In order to maintain compliance, the Interdisciplinary Team (IDT) will review the vaccination status for each new admission during a weekly risk management meeting. Pneumococcal vaccination will be offered to each resident in accordance with the CDC recommendations. IV. The Director of Nursing will monitor the status of those residents who decline the offer of pneumococcal vaccination, and report findings to the Quality Improvement Committee. The facility will offer to vaccinate residents each year, if they continue to decline the previous year's offer of vaccination. Monitoring will be ongoing for each resident that</p>		

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			<p>does not meet pneumococcal vaccination recommendations. For those residents who have met pneumococcal vaccination recommendations, no further monitoring is required. V. Staff Responsible: Director of Nursing</p> <p>Interdisciplinary Team</p>	

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review the facility failed to ensure</p>	F0441	It is the policy of the Indiana Masonic Home, Inc. to establish	10/26/2012			

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	<p>residents were protected from possible spread of infections in that two Licensed Practical Nurses [LPNs], did not practice proper hand washing during medication passes on Murat Manor and Royal Arch Halls. This had the potential to affect 13 of 13 residents residing on Murat Manor Hall and 16 of 16 residents residing on Royal Arch Hall.</p> <p>1. During an observation on Residential Hall, Murat Manor, of a medication pass on 9/28/12 at 11:48 AM, LPN #1 failed to wash her hands or don gloves before administering insulin to resident #5. Without washing her hands, LPN #1 removed the vial of insulin from the refrigerator, rolled the vial in the palms of her hands, pulled up the dose of insulin and returned the vial to the refrigerator. LPN #1 proceeded to Resident #5's room. Without washing her hands or donning gloves the LPN proceeded to administer the medication with proper technique. LPN #1 returned to the Nurses Station, turned on the water in the sink located at the Nurses Station, placed soap in the palm of her hand, washed her hands for 6 seconds, shook the water from her hands into the sink then briefly dried her hands on a paper towel. Her hands</p>		<p>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. I. LPN #1 has received additional training on proper hand washing and glove use during medication administration. LPN #2 has received additional training on proper hand washing and glove use during medication administration. II. Additional education on proper hand washing and glove use during medication administration has been completed with all Licensed Nurses and Qualified Medication Aides. III. Hand washing and glove use during medication administration will be monitored randomly each week for a minimum of 4 weeks. Additional education will be provided as needed during that time. All Licensed Nurses and Qualified Medication Aides will be evaluated no less than annually for proper hand washing and glove use during medication administration. Any newly hired Licensed Nurse or Qualified Medication Aide will receive education on proper hand washing and glove use during medication administration upon hire and annually thereafter. Documentation of that evaluation/education will be placed in the employees' file. IV. Results of the weekly</p>		

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	<p>remained wet when she threw the paper towel in the trash receptacle.</p> <p>2. During an observation on Residential Hall, Royal Arch, on 10/02/12 at 3:33 PM, LPN #2 failed to wash her hands before dispensing eye drops to Resident #39. LPN #2 donned gloves at the medication cart located in the hall directly across from Resident #39's room, picked up the blood glucose monitoring machine, entered the resident's room and without taking off her gloves and washing her hands and donning clean gloves, performed a blood glucose test on the resident. LPN #2 then, without removing her gloves, went back out to the cart located in the hallway to get a medication requested by the resident, reentered the resident's room, doffed her left glove and proceeded to administer eye drops in both of Resident #39's eyes. The LPN then doffed her right gloved and exited the resident's room without washing her hands.</p> <p>A review on 10/04/12 at 11:00 AM of the infection control policy entitled, "Infection Control Administrative Policies" indicated the Facility Guidelines included but not limited to, "provide a sanitary, safe and comfortable environment for resident,</p>		<p>proper hand washing and glove use during medication administration observation will be reviewed by the Quality Improvement Committee and reviewed for any additional education needs. Once all staff demonstrate mastery of proper hand washing and glove using during medication administration, weekly monitoring will cease. V. Staff Responsible: Director of Nursing Management N</p>				

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	<p>staff members and visitors; requires the implementation of standard precautions to protect all entities including residents, staff and visitors; and ensure compliance to Federal, State and local regulations."</p> <p>3.1-18(l)</p>			

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R0215	<p>410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility.</p> <p>Based on record review and interview, the facility failed to ensure a preadmission evaluation was done for 1 of 8 residents reviewed for preadmission evaluations in a sample of 8. (Resident #135)</p> <p>Findings include:</p> <p>The record of Resident #135 was reviewed on 10/3/12 at 3:40 p.m.</p> <p>Diagnoses for Resident #135 included, but were not limited to, congestive heart failure, insulin dependent diabetes mellitus and high blood pressure.</p> <p>Resident #135 was admitted to the facility on 9/26/12. Documentation of a preadmission evaluation being performed was not found in his</p>	R0215	<p>It is the policy of the Indiana Masonic Home to conduct Nursing evaluation of Medical needs for any resident who is admitted to a Residential Licensed bed. I-II. Resident #135 was identified as not having a current nursing evaluation prior to admission. Since Resident has already been admitted, a nursing evaluation prior to admission cannot now be completed. No further action can be taken for this or similar resident(s). III. All approved applications that have yet to move in, will have file jackets marked with the expiration dates of the medical evaluation and Physician Certificates. Prior to admission, all prospective residents will be required to have an appointment 1 - 3 days prior to actual move-in to verify all required evaluations, Physician's Certificates and chest x-rays are in compliance. A checklist will be used and placed in each admission file. IV. A monthly review will take place and any expired applications will be placed in an expired file. The</p>	11/01/2012	

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	<p>record.</p> <p>During an interview with the Director of Nursing on 10/3/12 at 4:15 p.m. she indicated a preadmission evaluation had not been done on Resident #135. She indicated one should have been done prior to his being admitted to the facility on 9/26/12.</p>		<p>applicants with expired documents will be send a notice by U.S. Mail requesting updated information. A summary of the monthly review will be submitted to the Quality Improvement Committee to evaluate for negative trends and identify future opportunities for improvement.</p> <p>V. Staff Responsible: Director of Marketing</p>		