

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 18,19, 20, 21, and 22, 2015</p> <p>Facility Number: 011906 Provider Number: 155772 AIM Number: 201114960</p> <p>Census bed type: SNF/NF: 57 Residential: 37 Total: 94</p> <p>Census payor type: Medicare: 36 Medicaid: 9 Other: 12 Total: 57</p> <p>Residential sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 10 IAC 16.2-3.1</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.

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a urinary drainage bag was covered to enhance a resident's dignity for 1 of 2 residents (Resident #36) reviewed for dignity related to urinary catheters and failed to assist residents during dining in a dignified manner for 1 of 2 dining rooms. (Residents #45, #60, and #87).</p> <p>Findings include:</p> <p>1. On 5/18/15 at 10:45 a.m., Resident #36 was observed sitting in a wheelchair at the TV lounge area on the 100 hall. The drainage bag from the resident's indwelling urinary catheter was uncovered.</p> <p>On 5/19/15 at 10:20 a.m., Resident #36 was observed sitting in a wheelchair in the TV lounge area on the 100 hall. The drainage bag from the resident's indwelling urinary catheter was uncovered.</p> <p>On 5/20/15 at 10:13 a.m., Resident #36</p>	F 0241	<p>F 241</p> <p>Resident #36 has catheter drainage bag covered and staff that care for him have been inserviced on dignity as it relates to catheters.</p> <p>Res #45, #60, and #87 suffered no ill effects from findings of the 2567L and through corrective action will ensure that dignity is maintained throughout the meal service.</p> <p>All residents have the potential to be affected by the alleged deficient practice and will have the same dignified meal service and catheter bag coverage provided through corrective actions.</p> <p>In-service for all staff that assist with meal service to include table service process.</p>	06/21/2015

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	<p>was observed sitting in a wheelchair in the Physical Therapy room. The drainage bag from the resident's urinary catheter was uncovered.</p> <p>On 5/20/15 at 11:19 a.m., Resident #36 was observed sitting in a wheelchair in the TV lounge area on the 100 hall. The drainage bag from the resident's urinary catheter was uncovered.</p> <p>On 5/22/15 at 2:15 p.m., the Director of Nursing (DON) indicated Resident #36 had recently returned from the hospital with an indwelling urinary catheter and the facility should have concealed the drainage bag in a dignity cover.</p> <p>The clinical record was reviewed on 5/20/15 at 11:21 a.m., diagnoses included but not limited to, renal failure and urinary retention. The most recent Minimum Data Set (MDS) was completed on 4/22/15. The assessment identified the resident as moderately impaired in cognitive decision making skills.</p> <p>The care plan dated 5/21/15, indicated, "Problem-The resident requires an indwelling urinary catheter related to urinary retention. Goal-I will have catheter care managed appropriately as evidenced by: not exhibiting signs of</p>		<p>DHS/designee will monitor 2 random meals and 1 urinary drainage bag per day x2 weeks, 1 random meal and 1 urinary drainage bag per day x2 weeks, 2 random meals and 1 urinary drainage bag per week x 2 months, then 2 random meals and 1 urinary drainage bag per month thereafter.</p> <p>Results of audits will be reported to QA committee monthly x6 months and then quarterly.</p>	

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	<p>urinary tract infection or urethral trauma." Interventions included, but were not limited to: Store collection bag inside a protective dignity pouch.</p> <p>An undated policy, identified as a current, titled. "Guidelines for Preserving Dignity with Indwelling Catheter", provided by the Administrator on 5/22/15 at 11:30 a.m., included but not limited to, "... Purpose: To preserve resident dignity by concealing urinary drainage bags..."</p> <p>2. On 5/18/15 at 12:23 p.m., Certified Nurse Aide (CNA) #5 was observed in the assisted dining room standing to feed Residents #45, #60, and #87.</p> <p>On 5/21/15 at 2:49 p.m., DON (Director of Nursing) indicated staff should have sat next to a resident at the dining table when assisting with feeding in a dignified manner.</p> <p>On 5/21/15 at 1:00 p.m., clinical records reviewed indicated Residents #45, #60 and #87 all required extensive assist of one person for eating.</p> <p>A facility policy provided by the Administrator on 5/22/15 at 10:55 a.m., dated 12/05/2012 and identified as current, titled "Resident Rights," included but was not limited to, "Quality of Life:</p>			

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F 0315 SS=D Bldg. 00	<p>35. Dignity/Self Determination and Participation: You have the right to receive care from the facility in a manner that is a safe environment and that promotes, maintains, or enhances your dignity and respect in full recognition of your individuality...."</p> <p>3.1-3(t)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure services were provided to prevent possible urinary tract infections for 2 of 2 residents reviewed with a urinary catheter. (Resident #36 and # 57)</p> <p>Findings include:</p> <p>1. On 5/18/15 at 10:45 a.m., Resident #36 was observed sitting in a wheelchair in the TV lounge area on the 100 hall.</p>	F 0315	<p>Resident #36 suffered no ill effects from the findings on the 2567 and staff that care for her have been inserviced on her catheter care needs.</p> <p>Completion Date 6-21-15</p> <p>Resident #57 suffered no ill effects from the findings on the 2567 and staff that care for her have been inserviced on her catheter care needs.</p>	06/21/2015

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	<p>The drainage tube from the resident's indwelling urinary catheter was on the floor under her wheelchair.</p> <p>The clinical record was reviewed on 5/20/15 at 11:21 a.m., diagnoses included but not limited to, renal failure and urinary retention. The most recent Minimum Data Set (MDS) was completed on 4/22/15. The assessment identified the resident as moderately impaired in cognitive decision making skills.</p> <p>The care plan, dated 5/21/15, indicated a "Problem-The resident requires an indwelling urinary catheter related to urinary retention. Goal-I will have catheter care managed appropriately as evidenced by: not exhibiting signs of urinary tract infection or urethral trauma." Interventions included, but were not limited to, do not allow tubing or any part of the drainage system to touch the floor.</p> <p>2. On 5/22/15 at 9:19 a.m., Resident #57 was observed sitting in a wheelchair in his room. The drainage tubing from the resident's indwelling urinary catheter was lying on the floor under his wheelchair.</p> <p>On 5/22/15 at 11:13 a.m., Resident #57 was observed sitting in a wheelchair in</p>		<p>Completion Date 6-21-15</p> <p>Nursing staff will be inserviced on catheter policy.</p> <p>Completion Date 6-21-15</p> <p>DHS and/or designee will monitor compliance with rounds daily to ensure catheter tubing is kept off floor.</p> <p>Completion Date 6-21-15</p> <p>Results of daily rounding audits will be forwarded to QA committee monthly x3months and quarterly thereafter.</p>	

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	<p>the TV lounge area. The drainage tube from the resident's indwelling urinary catheter was lying on the floor under his wheelchair.</p> <p>On 5/22/15 at 1:54 a.m., Resident #57 was observed sitting in a wheelchair in the TV lounge area. The drainage tubing from the resident's indwelling urinary catheter was lying on the floor under his wheelchair.</p> <p>During an interview on 5/22/15 at 2:07 p.m., CNA # 6 indicated the indwelling urinary catheter tubing shouldn't be touching the floor at anytime due to contamination.</p> <p>The clinical record was reviewed on 5/22/15 at 10:00 a.m., diagnoses included, but were not limited to, history of prostate cancer, BPH (Benign prostatic hyperplasia), and history of frequent urinary tract infections. The most recent Minimum Data Set (MDS) was completed on 4/7/15. The assessment identified the resident as severely impaired in cognitive decision making skills.</p> <p>The care plan, dated 4/7/15, indicated a "Problem- The resident requires use of a Foley Catheter due to: renal insufficiency and is at risk for infection. Goal-The</p>			

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F 0371 SS=E Bldg. 00	<p>resident will not have signs and or symptoms UTI (urinary tract infection)."</p> <p>An undated policy, identified as a current, titled. "Guidelines for Urinary Catheter Care", provided by the Administrator on 5/22/15 at 10:55 a.m., included but was not limited to. "...11. Be sure the catheter tubing and drainage bag are kept off the floor...."</p> <p>3.1-41(a)(2)</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 local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to ensure staff distributed and served food and drinks to residents under sanitary conditions for 1 of 1 dining observation. This deficient practice had the potential to affect 30 of 30 residents served in the dining room.</p> <p>Findings include:</p>	F 0371	<p>There were no residents affected by the alleged deficient practice and through inservicing and corrective actions will ensure staff distribute and serve food and drinks to residents under sanitary conditions.</p> <p>Completion Date 6-21-15</p>	06/21/2015

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	<p>1. On 5/18/15 at 12:04 p.m., Activity Director #1 was observed in the dining room holding a resident's drinking glass in her left hand, while brushing her hair away from her face with her right hand. She then proceeded with her right hand to grab the ice scoop and tea pitcher and serve the resident the drink. Activity Director #1 scratched her head and pulled her hair behind her ear and then served a resident a tray of food.</p> <p>On 5/18/15 at 12:10 p.m., Certified Nurse Aide (CNA) #2 wiped her hands on her pants after serving a drink to a resident and then picked up another resident's glass and filled a pitcher of orange juice.</p> <p>On 5/21/15 at 2:49 p.m., Director of Nursing (DON) indicated staff should have washed and sanitized their hands before and after serving drinks, meals and after contact with non-clean surfaces.</p> <p>2. On 5/18/15 at 12:30 p.m., Guest Relations Staff #3 tucked her hair behind her ears and did not sanitize her hands before serving resident's their lunchtime meal.</p> <p>On 5/18/15 at 12:35 p.m., the Activity Director was observed, during meal service. She tucked her hair behind her</p>		<p>Activity Director #1, CNA #2, Guest Relations staff #3, and other employees that serve meals have been inserviced on sanitary distribution and serving of food and drinks.</p> <p>Completion Date 6-21-15</p> <p>Executive Director/designee will monitor 1 random meal service daily x2 weeks and then 2 random meals per week thereafter for sanitary food and drink distribution.</p> <p>Results of audits will be forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further recommendations.</p>	

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F 0441 SS=D Bldg. 00	<p>ears, scratched her face, pulled up her pants, and put her hands in her pockets. She was in between serving resident's their lunchtime meal.</p> <p>The facility policy dated 8/20/14, provided by the Administrator on 5/22/15 at 10:55 a.m., titled, "Guideline for Handwashing/Hand Hygiene," included but was not limited to, "Procedure":...a. On reporting to work; before/after eating, after smoking, toileting, blowing nose, coughing, sneezing, etc. b. Before/after preparing/serving meals, drinks, tube feedings, etc. c. Before/after having direct physical contact with residents...."</p> <p>3.1-21(i)(3)</p> <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</p>			

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	<p>resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</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 ensure hand hygiene was maintained for 2 of 2 residents observed for blood glucose monitoring and insulin injections. (Residents #128 and #85)</p> <p>Findings include:</p> <p>1. On 5/21/15 at 8:27 a.m., LPN #4 was observed to perform a blood glucose check on Resident #128. LPN #4 wore gloves during the procedure, but failed to wash or sanitize hands before or after the procedure.</p>	F 0441	<p>Res #128 and #85 suffered no ill effects from the findings on the 2567L and staff have been inserviced on glove usage/changing and handwashing or sanitizing.</p> <p>Completion Date 6-21-15 All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensure corrective actions to prevent spread of infection are followed. Completion Date 6-21-15 LPN #4 will have directed inservice and return demonstration of skills performing hand hygiene during and after accuchecks and insulin</p>	06/21/2015

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	<p>On 5/21/15 at 8:30 a.m., LPN #4 was observed giving an insulin injection to Resident #128 but failed to wear gloves or wash hands before the procedure.</p> <p>On 5/21/15 at 10:15 a.m., the Director of Nursing (DON) indicated staff should have washed hands before and after donning gloves for resident care, blood glucose checks, insulin injections and direct physical contact with a resident.</p> <p>Resident #128's clinical record was reviewed on 5/21/15 at 9:45 a.m. A diagnosis was noted of, but not limited to, Diabetes Mellitus. A physician's order, dated 4/1/15, indicated the resident was to receive blood sugar checks twice daily and an insulin injection every morning.</p> <p>2. On 5/21/15 at 8:58 a.m., LPN #4 was observed to perform a blood glucose check on Resident #85. LPN #4 wore gloves during the procedure, but failed to wash or sanitize hands before or after the procedure.</p> <p>On 5/21/15 at 9:05 a.m., LPN #4 was observed giving an insulin injection to Resident #85, but failed to wear gloves or wash hands for the procedure.</p>		<p>administration. Completion Date 6-21-15 Nursing staff will be inserviced on proper handwashing and glove usage procedures to prevent spreading of infection. Completion Date 6-21-15 DHS/Designee will monitor resident care that includes handwashing/glove usage after care and techniques provided daily x5days, 3xweek for 2 weeks, then weekly. Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.</p>	

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	<p>On 5/21/15 at 10:15 a.m., the DON indicated staff should have washed hands before and after donning gloves for resident care, blood glucose checks, insulin injections and direct physical contact with a resident.</p> <p>Resident #85's clinical record was reviewed on 5/21/15 at 9:50 a.m. A diagnosis was noted of, but not limited to, Diabetes Mellitus. A physician's order was noted, dated 4/16/15, indicated the resident was to receive blood sugar checks before meals and at bedtime and an insulin injection before breakfast.</p> <p>On 5/21/15 at 10:15 a.m., the DON provided documentation, dated 8/2014, titled, "Guideline for Handwashing/Hand Hygiene," included but was not limited to, "Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [Long Term Care Facilities]. Implementation of PROPER handwashing practices has interrupted outbreaks in many settings.</p> <p>Procedure:...3. Health Care Workers shall wash hands at times such as: c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions</p>			

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(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
R 0000 Bldg. 00	<p>for direct contact with excretions or secretions...."</p> <p>A facility policy titled, "Specific Medication Administration Procedures IIB16: Subcutaneous Medication Administration," dated 2/1/10, included, but was not limited to: "Procedures...B. Apply gloves and select an appropriate site for injection...P. Wash hands...."</p> <p>3.1-18(a)</p>	R 0000		
R 0273 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 37 Sample: 5</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and</p>	R 0273	R 273	06/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2015
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	<p>record review, the facility failed to ensure dishes were handled in a manner to prevent contamination for 1 of 2 residential meal services observed. This had the potential to affect 10 residents seated at the dining tables on the secured unit.</p> <p>Finding includes:</p> <p>On 5/21/15 at 11:50 a.m., noon meal service was observed in the secure residential unit. Ten residents were seated in the dining area, and tables were set for the family style dining. Residential LPN #1 and Residential CNA #1 were observed setting the tables. The eating surface of the plates were touched with staffs' bare hands when they were placed on tables. Residential LPN #1 went to the nurses' desk and answered the telephone. She returned to the dining area, and continued with setting the tables without sanitizing her hands. The Residential LPN touched the exteriors of cabinets, the food delivery cart, the refrigerator, and patted residents' arms. One resident was assisted with the meal. Hands were not washed at any point of the meal service.</p> <p>On 5/21/15 at 2:49 p.m. the Director of Nursing (DON) was interviewed. She indicated staff should have washed or</p>		<p>The 10 residents on the residential unit suffered no ill effects from the findings on the 2567L and through inservicing will ensure staff practice handwashing during table setting procedures. LPN #1 and CNA #1 have been inserviced on handwashing as it relates to handling dishes.</p> <p>LPN #1 and CNA #1 have received directed inservice on handwashing policy and infection control procedures during setting.</p> <p>Residential nursing staff will be inserviced on proper handwashing and table setting procedures to prevent contamination.</p> <p>DHS/Designee will monitor mealtime preparation that includes handwashing and handling of dishes daily x5days, 3xweek for 2 weeks, weekly for 4 weeks and monthly thereafter.</p> <p>Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter</p>	

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	<p>sanitized their hands before and after serving drinks, meals, and after contact with non-clean surfaces.</p> <p>A facility policy titled "Guidelines for Handwashing", dated 3/2013, provided as current by the Administrator on, 5/22/15 at 11:30 a.m., included but was not limited to, ...#3. Health Care Workers shall wash hands at times such as: ...B. Before/after preparing/serving meals, drinks, tube feedings, etc. c. Before/after having direct physical contact with residents...."</p>		for review and further suggestions/comments.	