

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2015
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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN 47031
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: December 16, 17, 18, 21, and 22, 2015</p> <p>Facility number: 000420 Provider number: 155730 AIM number: 100266230</p> <p>Census bed type: SNF/NF: 88 Residential: 21 Total: 109</p> <p>Census payor type: Medicare: 14 Medicaid: 63 Other: 11 Total: 88</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on December 28, 2015.</p>	F 0000		
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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 0441 SS=E Bldg. 00	<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 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</p>			
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	<p>of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper infection control practices were performed according to accepted professional standards, related to handwashing and glucometer sanitization for 3 of 5 residents observed during routine blood sugar checks. This had the potential to affect 18 out of 88 facility residents whom required the use of a glucometer to monitor blood sugar levels. (Resident #109, #107, and #18).</p> <p>Findings include:</p> <p>During an observation on 12/16/2015 at 11:38 A.M., LPN (Licensed Practical Nurse) #1 gathered supplies to check Resident # 109's blood sugar. LPN #1 entered the resident's room, did not perform handwashing or use hand sanitizer, donned gloves, swabbed the resident's finger with an alcohol swab, stuck the resident's finger with a lancet, gathered the sample of blood on the glucometer testing strip, cleaned the resident's finger, threw away trash, disposed of the lancet in a plastic cup, and removed her gloves. LPN #1 washed her hands for fifteen seconds. LPN #1 picked up the supplies, walked out of the resident's room and into the medication room behind the nurse's station. LPN #1</p>	F 0441	<p>It is the intent of Ripley Crossing to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infections</p> <p>Corrective Action taken for Residents #18, #107, #109, and #43</p> <p>Immediately after being made aware of the deficient practice, lancets that were contaminated were disposed of, and the policy for cleaning and disinfecting resident care equipment was revised</p> <p>All nurses present in the facility were made aware of the revision and we began inservicing all other nurses</p> <p>Glucose Monitoring Policy and Cleaning and Disinfecting Care Equipment Policy will be reviewed with all nurses and Hand Washing Policy will be reviewed with all nursing staff by January 21, 2016</p> <p>Proficiency Audits for hand washing and glucose monitoring will be performed at least 5 times a week for 4 weeks, then once per week for 4 weeks, then randomly thereafter to ensure compliance.</p> <p>DON/Designee will monitor.</p>	01/21/2016	

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	<p>immediately walked out of the medication room and walked over to the medication cart to document the resident's blood sugar level. LPN #1 was asked about the procedure for glucometer cleaning. LPN #1 walked back to the medication room and wiped off the glucometer with an alcohol pad then tossed the glucometer into the container of clean lancets without waiting for it to dry. LPN #1 picked up the plastic cup with the lancet and tossed the lancet into the sharps container.</p> <p>During an interview on 12/16/2015 at 11:44 A.M., LPN #1 indicated the glucometer was to be cleaned with alcohol pads between residents and sharps were to be placed into the sharps container after use. LPN #1 further indicated hands should be washed for 60 seconds, before and after resident contact.</p> <p>During an observation on 12/18/2015 at 11:07 A.M., LPN #3 gathered supplies to check Resident #107's blood sugar. LPN #3 washed her hands for 35 seconds. LPN #3 entered the resident's room, donned gloves, swabbed the resident's finger with an alcohol swab, stuck the resident's finger with a lancet, gathered the sample of blood on the glucometer testing strip, cleaned the resident's finger, threw away trash, disposed of the lancet</p>			

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	<p>in a sharps container, and placed the glucometer on top of the lancets without cleaning the glucometer. LPN #3 walked out of the resident's room and over to the medication cart and documented the resident's blood sugar level. LPN #3 picked up the tray containing the blood sugar testing supplies, walked into Resident #43's room, performed handwashing for 45 seconds and was preparing to test the resident's blood sugar with the unclean glucometer.</p> <p>During an interview on 12/18/2015 at 11:19 A.M., LPN #3 indicated she did not clean the glucometer prior to preparing to test Resident #43's blood sugar or after testing Resident #107's blood sugar. LPN #3 further indicated that the glucometer was not always cleaned when used on multiple residents.</p> <p>During an interview on 12/18/2015 at 2:00 P.M., the DON (Director of Nursing) indicated the glucometer should always be properly cleaned between residents. The DON further indicated the glucometer should have been cleaned properly following the facility's current policy.</p> <p>During an observation on 12/18/2015 at 11:05 A.M., LPN #2 gathered supplies to check Resident #18's blood sugar. Upon</p>			

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	<p>entering the resident's room, LPN #2 washed her hands for 10 seconds, donned gloves, prepared the glucometer, swabbed Resident #18's finger with an alcohol swab, and stuck the resident's finger with a lancet. When blood could not be obtained from that finger, the LPN swabbed a different finger with a new alcohol swab, stuck the resident's finger with a lancet, applied the blood to the blood sugar testing strip, and obtained the resident's blood sugar reading. LPN #2 then put the glucometer into a box of clean 1x1's (gauze pads), removed her gloves, washed her hands for 14 seconds, took the blood sugar testing supply basket to the medication cart, disposed of the used lancets with her bare hand, threw away the extra 1x1's and used two alcohol swabs to clean the glucometer before immediately putting it into the supply basket in the medication cart.</p> <p>During an interview on 12/18/2015 at 11:19 A.M., LPN #2 indicated she used the same glucometer for all residents who needed their blood sugar checked on her hall. She further indicated alcohol swabs were used to clean the glucometer between use and it should be left to air dry after it was cleaned.</p> <p>The current facility policy titled, "Glucose Monitoring Policy" and dated</p>			

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R 0000 Bldg. 00	<p>7/11/14, was provided by the DON on 12/18/2015 at 1:38 P.M. and reviewed at that time. The policy indicated, "1. Wash or disinfect hands and apply gloves...8. For machines used on multiple residents, disinfect machine after each use using disinfecting wipe..."</p> <p>The current facility policy titled, "Hand Washing" and dated 9/26/12, was provided by the Administrator on 12/18/2015 at 11:35 A.M. and reviewed at that time. The policy indicated, "...Hand washing will be done before and after direct resident care, before and after removal of gloves...before performing any invasive procedure on a resident..." and "...Wash hands well for at least 20 seconds to aid in the mechanical removal of bacteria..."</p> <p>3.1-18(a) 3.1-18(l)</p> <p>This visit was for a State Residential Licensure Survey.</p>	R 0000		

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	Residential Census: 21 Sample: 7 Ripley Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.				