

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/22/2015
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NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00171552 and IN00171753.</p> <p>Complaint IN00171552 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00171753 - Substantiated. Federal/state deficiencies related to the allegations are cited at F441.</p> <p>Survey dates: April 20, 21 and 22, 2015.</p> <p>Facility number: 004075 Provider number: 155734 AIM number: 200491220</p> <p>Census bed type: SNF: 14 SNF/NF: 31 Residential: 27 Total: 72</p> <p>Census payor type: Medicare: 20 Medicaid: 14 Other: 11 Total: 45</p>	F 000	<p>The submission of this Plan of Correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Thornton Terrace Health Campus. This facility recognized it's obligation to provide legally and medially 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. Attached you will find our Plan of Correction for Thornton Terrace Health Campus.</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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F 323 SS=G Bldg. 00	<p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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, record review and interview, the facility failed to prevent an avoidable fall and to identify and treat the resulting fractured femur (thigh bone) in a timely manner (Resident B). This deficient practice resulted in Resident B experiencing pain, which limited the resident's activities.</p> <p>Findings include:</p> <p>Resident B was observed on 4/20/2015 at 1:20 p.m. in her wheelchair with her right leg immobilized and elevated. The resident indicated she "broke her leg," but could not recall the incident.</p> <p>LPN (Licensed Practical Nurse) #2 was interviewed on 4/20/2015 at 2:05 p.m.</p>	F 323	<p>" We would like to provide more information and discuss the content in the 2567 as we do not believe the content is sufficient to support the cited deficiency".</p> <p>1. Resident # B is on a pain control regimen. Resident continues hydrocodone 5/525 po every 4 hours prn for pain and continues with splint to right leg at all times. Resident's activities have returned to previous level. Resident # B was re-assessed for pain control on 4/24/15 by the hospice nurse. Resident was seen by attending physician on 5/6/15. Resident was seen by orthopedic physician on 5/7/15. New orders received and care plan update to reflect current status. This was completed on 5/7/15. 2. All Nursing Staff and alert and oriented residents</p>	05/12/2015	

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	<p>LPN #2 indicated Resident B fell while being transported by a [college] student nurse on 4/2/2015. She indicated a mobile "tib-fib" [lower leg] x-ray was done. LPN #2 indicated the resident "had more swelling" and a right knee x-ray was obtained on 4/8/2015, which indicated a femur [thigh bone] fracture.</p> <p>Resident B's clinical record was reviewed on 4/20/2015 at 2:35 p.m. Diagnoses included, but were not limited to, dementia and osteoarthritis.</p> <p>Resident B's quarterly Minimum Data Set (MDS) assessment, dated 3/24/2015, indicated a Brief Interview for Mental Status (BIMS) score of 12 of 15; indicating she was cognitively intact. Resident B's functional status indicated that she required 2+ person physical assist for all activities of daily living (ADLs), including bed mobility, transfers, toilet use, and personal hygiene. The resident was dependent on staff for all locomotion, via wheelchair, in her room and throughout the facility.</p> <p>Resident B's care plan, updated 6/23/2014, indicated, "I am at risk for falls r/t [related to] decreased mobility and impaired cognition related to ALZ [Alzheimer's] DEMENTIA.... Please transfer me with a MEC [mechanical]</p>		<p>were interviewed by the DHS and ADHS on 5/6/15 to verify that any nursing student who assisted them to transfer had conducted it according to their plan of care. All residents stated no concerns with any nursing students. All residents had the potential to be affected. No other residents were identified as being affected by the practice. All residents care plans have been reviewed by MDS, DHS, ADHS to ensure that all areas are addressed and reflect current status. Completed on 5/7/15. 3. Orientation to the facility will be provided to all nursing instructors and all nursing students by the DHS or ADHS prior to the initiation of all clinical rotations in the facility. This will include but is not limited to location and use of residents plan of care, prior to any care being provided. Nursing instructor and all students will sign an acknowledgement and understanding of the material reviewed. The orientation manual will be located at the nurse's station for referencing, as needed. All nursing students were interviewed by the DHS and stated that they all knew where to access the plan of care. A meeting is scheduled for 5/12/15 between facility administration and nursing school administration to discuss responsibility/roles of nursing instructor and nursing students. Staff were re-educated by the DHS/ADHS</p>		

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	<p>LIFT because I have arthritis to my knees and I can no longer safely bare [sic] my own weight.... I require 2 [person] assist for bed mobility, max [maximum] for transfers, max for ambulating, 2 for bathing...and 2 for toileting."</p> <p>Resident B's care plan, updated 4/3/2015, indicated, "I was with a nursing student and she was getting me up and I was too close to the edge of the bed.... I c/o [complained of] pain in my right leg...."</p> <p>Resident B's most recent quarterly Resident Lift Assessment Profile, completed 3/24/2015, indicated she required a standing (Sara) lift for all transfers.</p> <p>A Change in Condition form, dated 4/2/2015 at 9:30 a.m., indicated "...Signature/title of nurse: [LPN #2]. Condition change that prompted request for physician order: [blank].... Describe signs and symptoms of condition change: Resident getting up slid to floor...c/o [complaint of] right knee & [down arrow] leg pain. Can we get an x-ray. Resident being transferred with [school nursing] student [without] lift. Physician order/response to communication: Radiology: x-ray right knee & [down arrow] leg.... Follow up Date/time: 4/2/15 2 [p.m.] - 10 [p.m.] c/o [complaint of]</p>		<p>on guidelines for fall circumstance form, change in condition forms, physicians' orders, pain assessment, and physician notification with emphasis placed on thorough completion and follow through of the documented assessments. LPN #2 was re-educated by DHS 4/23/15 on change in condition, fall circumstance form, pain assessment and follow through on physician orders. Any nursing staff on leave will be indentified and re-educated upon return to facility prior to beginning their assigned shift by the DHS/ADHS.</p> <p>4. A review of all circumstances forms, change in condition forms, including assessment of any injuries, will be completed by the DHS/ADHS and reviewed by the IDT 5 times a week in daily clinical meeting. This will be ongoing. All new physician orders will be reviewed in the daily clinical care meeting to verify appropriate interventions and follow up. During weekends and off hours the licensed staff will notify the on call nursing administrator of all incidents that occur for review and follow up. These incidents will also be included for daily review in clinical meeting. Findings and results of completed audits will be reviewed in the monthly quality assessment and assurance committee meeting and further recommendations will be made if indicated by the committee. This</p>	

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	<p>knee pain. X-ray negative. Refuses to get up.... Follow up Date/time: 4/3/15 1st [first shift] PRN [as needed] pain meds given.... 4/3/2015 2 [p.m.] - 10 [p.m.] Continues to c/o knee & leg pain...."</p> <p>Physician's Order, dated 4/2/2015 at 9:30 a.m., indicated, "X-ray of [right] tibia and fibia. Indication - Dx [diagnosis]: [up arrow] pain. T/O [telephone order] Dr. [name] / [LPN #2 signature]."</p> <p>Mobile x-ray Radiology Report, dated 4/2/2015, indicated a right tibia/fibula AP & LAT was done with no fracture or dislocation observed.</p> <p>Fall Circumstance, Assessment and Intervention form, dated 4/2/2015, indicated, "Time of fall: 09 [no minutes noted].... Injury location: Right knee & [down arrow] leg.... C/O pain (1-10): 9 [severe pain]...Location: Right knee & [down arrow] leg.... Care Plan: I had a recent fall because: [blank]. My goal is to: not fall [check mark]. Please help me do this by using/doing the following things: Other: Make sure Resident positioned in center of bed when getting up. IDT [Interdisciplinary Team] Review Date: 4/2/15. Root cause: too close to edge of bed, students involved. Intervention update appropriate: [blank]. Change to: Educate student nurses re:</p>		<p>will be ongoing. If concerns are identified re-education and or counseling will be provided. Action plans will be developed for any non-compliance during the QA process. A peer review process is conducted twice a year with and IDT from other trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home office support follows up on these action plans for correction during routine visits.</p>	

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	<p>following res [resident] transfer CP [care plan]. Other comments: Students attempting to get res up [without] lift."</p> <p>Physician's Order, dated 4/8/2015 at 9:45 a.m., indicated, "Obtain A & P [anterior and posterior] X-ray of [right] knee. Indication - Dx [diagnosis]: edema. T/O [telephone order] Dr. [name] / [LPN #2 signature]."</p> <p>Mobile X-ray Radiology Report, dated 4/8/2015, indicated, "Examination: KNEE...Right. Conclusion: Right distal femur [thigh] comminuted [splintered, crushed, or broken into pieces] fracture [broken bone]."</p> <p>Physician's Order, dated 4/9/2015 at 10:18 a.m., indicated, "Send to [hospital] - ER [emergency room]. Indication - Dx [diagnosis]: Fx [fracture] to femur."</p> <p>Hospital Medical Imaging Report, dated 4/9/2015, indicated, "Study: femur 2 views. Clinical history: pain. Description: There is a severely comminuted displaced fracture through the supracondylar femur.... Impression: Severely comminuted distal femur fracture.</p> <p>Emergency Room Report, dated 4/9/2015 at 11:32 a.m., indicated, "...Patient</p>			

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	<p>apparently has been having some pain over the past week.... Patient tells me she is not ambulatory at baseline. She's not sure how her fever [sic] was broken.... Physical Exam: ...Musculoskeletal: There is swelling and tenderness over the right distal femur."</p> <p>Emergency Room Progress Notes, dated 4/9/2015 at 12:30 p.m., indicated, "...the patient [Resident B] is non-weight bearing even prior to this fracture...."</p> <p>Pain Circumstance, Assessment, Data Collection and Intervention, dated 4/9/2015 at 7:00 p.m. indicated, "Location of pain: Rt [right] knee. R/T [related to]: Rt [right] femur fracture. Type: Acute [check mark]...Continuous [check mark]...Intensity of the worst pain over the last 5 days?: Moderate pain (4-5) [checked]. How much of the time has the resident experienced pain or hurting over the last 5 days? Almost constantly [circled]. During the last 5 days, has the resident: Been on a scheduled pain regimen: No [circled]. Received PRN [as needed] pain medication? Yes [circled].... Have activities been limited because of pain: Yes [circled].... Diagnosis contributing to pain: Rt [right] femur fracture...."</p> <p>There was no evidence in Resident B's</p>			

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	<p>clinical record that a physician saw Resident B after the fall on 4/2/2015 or prior to being sent to the Emergency Department on 4/9/2015. There was no evidence that staff contacted the physician regarding Resident B's condition after the negative x-ray on 4/2/2015 and prior to obtaining the right knee x-ray order on 4/8/2015.</p> <p>Resident B's Orthopedic Physician's Progress Notes, dated 4/15/015, indicated, "[Resident B] stood up and fell in spite of the fact that she is non-ambulatory and she fell [illegible] a comminuted supracondylar [right] femur fracture. Was put in knee immobilizer which does not help. Pt [patient] complains of pain..."</p> <p>On 4/20/2015 at 3:40 p.m., the Director of Health Services (DHS), indicated Resident B fell on 4/2/2015 when a student nurse went into Resident B's room "without prior knowledge" of Resident B's care requirements attempted to assist the resident to a standing position from bed.</p> <p>On 4/22/2015 at 10:29 a.m., LPN #2 indicated she faxed the Change in Condition form to the physician and the physician called with orders to obtain an x-ray of Resident B's tibia-fibia (shin</p>			

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	<p>bones).</p> <p>The current Change in Condition Form Guidelines Policy and Procedure, was provided by the DHS on 4/22/2015 at 10:27 p.m. The procedure included, but was not limited to, "2. The nursing assessment will be entered onto the first section of the Condition Change Form labeled 'Change That Prompted Physician Request for Order.' Information should be completed in it's entirety.... Physician Telephone Orders Section: ...2. The nurse who receives the physician order is responsible to complete the 'Physician's Responses' section of the form that shall include the order, date and time the order is received from the attending physician.... Care Plan Update Section: 1. The care plan update section will be completed in it's entirety. 2. If the problem area is a new area include measurable and time-specific goal(s), and realistic, individualized approaches, and the disciplines who will be involved in the care of the resident."</p> <p>The current Falls Management Program Guidelines Policy and Procedure was provided by the DHS on 4/20/2015 at 4:45 p.m. The procedure included, but was not limited to, "...3. Should the resident experience a fall the attending nurse shall complete the 'Fall</p>			

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	<p>Circumstance and Reassessment Form.' The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by IDT to evaluate thoroughness of the investigation and appropriateness of the interventions. 4. An 'Accident and Incident Report' should be completed at the time of the incident."</p> <p>On 4/21/2015 at 2:43 p.m., the DHS provided a typed document which indicated, "[Resident Name] 4/20/2015 Summary of investigation. On 4/2/15 [CNA (Certified Nurse Aide) #1] was approached by an [college] student asking her to come into [Resident B's] room. [CNA #1] stated she saw [Resident B] on her buttocks in front of her bed with her right leg out slightly bent at the knee. The student stated to her 'she told me she could stand' and the student began hysterically crying.... The student stated that she was helping her stand and [Resident B's] knees gave out.... LPN #2 stated she then went to retrieve the instructor who was off of the floor and found in the private dining room...."</p> <p>The DHS, Corporate Clinical RN, and</p>			

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F 441 SS=E Bldg. 00	<p>Executive Director were interviewed on 4/21/2015 at 4:10 p.m. The DHS indicated it was the responsibility of the college's clinical instructor to ensure that student nurses were made aware of resident conditions and care needs and that instructors were expected to be present for all direct resident care. The DHS indicated that facility staff was available for student nurses to utilize as a "resource." The Corporate Clinical RN indicated student nurses have access to resident functional status and/or transfer requirements via care plans located in a binder at the nurses' station or in resident charts. The DHS indicated the "Accident and Incident Report" referred to in the Falls Management Program Guidelines was an "internal document" and the facility declined to provide the document.</p> <p>This Federal tag relates to the Investigation of Complaint IN00171552.</p> <p>3.1-45(a)(2)</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</p>			

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	<p>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, record review and interview, the facility failed to implement appropriate infection control precautions, provide readily available personal protective equipment (PPE), and provide appropriate resident and/or family education for 1 resident with</p>	F 441	<p>1. Resident #C was provided education regarding their infection utilizing an easy to read FAQ sheet and modes of possible transmission. This was conducted by the DHS on 4/24/15. Resident #D was discharged to home on 4/22/15. Signage was placed at the entrance</p>	05/12/2015

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	<p>Clostridium Difficile infection (Resident C) and 1 resident with Methicillin Resistant Staphylococcus Aureus (MRSA) in the sputum (Resident D), and to provide proper hand washing for 1 resident during toileting (Resident B).</p> <p>Findings include:</p> <p>1. Resident C was interviewed on 4/20/2015 at 1:32 p.m. The resident's room was located at the end of 100-hall and the furthest from the nurses' station. She indicated she had C-diff (an infectious toxin that causes watery diarrhea) and continued to have diarrhea. Resident C indicated she did not receive any special instruction regarding infection control and/or precautions to take with family, whom she indicated visited frequently. There was no signage posted on the resident's door or anywhere in the room instructing visitors to see the nurse before entering. There was no personal protective equipment (PPE) readily available near the entrance or anywhere in the room or bathroom. There were no biohazard boxes and/or bags visible in the resident's room or bathroom.</p> <p>LPN (Licensed Practical Nurse) #3 was interviewed on 4/20/2015 at 1:42 p.m.</p>		<p>of each of their doors stating "Stop. See nurse before entering the room," by the DHS on 4/22/15. PPE equipment (gowns, gloves, masks as needed) were provided in each of their rooms to be readily available for staff and visitors on 4/20/15 by the DHS. Resident # B has been assessed by a licensed nurse and shows no signs or symptoms of infection 5/6/15.</p> <p>2. All residents have the potential to be affected. All residents with infectious disease that require contact or droplet precautions will be provided education regarding their disease and ways of possible transmission. Two residents were identified and signage was placed at the entrance of each of the 2 resident's doors stating "Stop. See nurse before entering the room." PPE equipment (gowns, gloves, masks as needed) were provided in the two identified residents rooms to be readily available for staff and visitors. Education was discussed and reviewed with the two residents and/or their responsible party by the DHS on 4/24/15. Residents and responsible party member stated understanding of information provided. FAQ sheets were given to the two residents for their reference.</p>	

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NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243		
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	<p>She indicated the facility did not post signage instructing visitors to see the nurse before entering outside the rooms of residents requiring special infection control precautions. LPN #3 indicated PPE and biohazard bags were available in the supply closet (indicating the closet behind the nurses' station, at the opposite end of the hall from Resident C's room). LPN #3 indicated Resident D, also on 100-hall, had a MRSA (Methicillin Resistant Staphylococcus Aureus) infection.</p> <p>Environmental Services Aide #1 was interviewed on 4/20/2015 at 1:55 p.m. She indicated she was not aware of any residents with infectious diseases on the unit requiring additional precautions or cleaning measures.</p> <p>CNA (Certified Nurse Aide) #2 was interviewed on 4/20/2015 at 2:10 p.m. She indicated, "When we see the special [biohazard] boxes [in resident rooms], then we know [they have an infection requiring special PPE or waste disposal]."</p> <p>Resident C's brother, who visits weekly, was interviewed on 4/20/2015 at 2:55 p.m. He indicated staff does not always wear gowns or gloves when caring for Resident C. He recalled an incident</p>		<p>3. All environmental staff were re-educated regarding identifying residents who have infectious diseases requiring additional precautions or cleaning measures. This was conducted by environmental services director on 4/23/15. CNA #1 and CNA #2 were reeducated on infection control with emphasis on proper hand washing by the DHS or ADHS on 4/27/15 and 4/28/15. All direct care staff have been re- in serviced by the DHS and ADHS regarding the infection control guidelines (contact precautions, standard precautions, proper disposal of soiled linens, and hand washing), this was conducted by the DHS/ADHS on 4/27/15 and 4/28/15. LPN # 3 was educated on 4/28/15 and environmental services aids were re-educated by the DHS and ADHS on 4/27/15 regarding policy and procedure on infectious diseases including c-diff, MRSA and door signage. A pre and post test was completed by all direct care staff.</p> <p>4. The DHS or ADHS will monitor for proper infection control measures during care of residents with infectious diseases 5 times a week for 8 weeks then 3 times a</p>		

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	<p>when Resident C was incontinent of stool while family was visiting and staff "had to change her entire bed clothes." He indicated, "They threw the [soiled] bed clothes on the bathroom floor. That shocked us." Resident C's brother indicated the family did not receive any education requiring C-diff or special precautions, nor was PPE made available to them.</p> <p>A current copy of Guidelines for Management of Residents with Clostridium Difficile Policy and Procedure was provided by the DHS on 4/20/2015 at 3:00 p.m. Procedure included, but was not limited to, "...2. Contact Precautions should be initiated at onset of diarrhea...and continue until disease is ruled out or resolved. Staff should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment (2007 CDC isolation guidelines). Donning gown and gloves upon room entry and discarding before exiting the patient room is done to contain pathogens.... 5. Staff caring for residents on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's</p>		<p>week for 4 weeks and 1 time a week for 2 weeks, then monthly x 3 months. Unannounced observations of hand washing and proper donning of PPE and proper disposal of soiled linen will continue to be performed by the ADHS or DHS on random shifts 3 times a week for 8 weeks, then 2 times a week for 4 weeks, then once a week for 2 week, then monthly x 3 months Audit results will be presented to the QA committee for review and further recommendations as indicated based on results. If concerns are identified, re-education and or counseling will be provided. In addition action plans will be developed for any identified non-compliances and through home office peer review process. The peer review process is conducted twice a year with an IDT from other trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home office support follows up on these action plans for corrections during routine visits.</p> <p>Results of the observations will be reviewed in the QA meeting along with any further recommendations if indicated for 6 months.</p>	

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	<p>environment."</p> <p>The DHS provided the facility's Infection Control Log for 1/20/2015 through 4/20/2015 on 4/20/2015 at 3:10 p.m. The list did not include Resident C, or any residents with infectious diseases requiring special precautions. The DHS indicated residents in the facility with C-diff and/or MRSA were not included in the document, nor tracked, because those residents were admitted with the infections and the facility did not monitor "socomial" (sic) infections. The DHS clarified that "socomial" [sic] infections were those which did not occur in the facility.</p> <p>The Director of Health Services (DHS) was interviewed on 4/20/2015 at 3:40 p.m. She indicated nursing staff was responsible for signage and/or notifying staff of special precautions.</p> <p>A current copy of Guidelines for Contact Precautions Policy and Procedure was provided by the DHS on 4/20/2015 at 4:45 p.m. Procedures included, but were not limited to, "...2. Contact Precautions are indicated to prevent and control...transmission and infection with any of the following: ...b. Clostridium difficile. c. Staphylococcus aureus resistant to Methicillin/oxacillin</p>			

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	<p>(MRSA).... 5. Personal Protective Equipment: a. Wear gloves 6. Precaution Sign: a. Post a sign at the resident's door to advise the visitors to report to nurses station before entering the room.... 8. Resident Bathrooms/Hygiene: ...b. If one bathroom serves two resident rooms, and any resident...utilizes the facilities, all residents in both rooms must be cohorted as one.... 9. Visitors: a. Visitors must be taught how to properly gown and glove by facility staff...."</p> <p>A typed document indicating, "List of residents with MRSA, CDiff [sic] or socomial [sic] infections." was provided by the DHS on 4/20/2015 at 6:15 p.m. The list indicated, "[Resident H]: C-diff. [Resident G]: MRSA. [Resident F]: MRSA - wound. [Resident C]: C-diff. [Resident D]: MRSA - resp [respiratory]."</p> <p>The Corporate Clinical RN was interviewed on 4/21/2015 at 11:36 a.m. She indicated residents with C-diff and/or MRSA should have signage posted on the door and appropriate PPE should be available at the entrance of the room.</p> <p>A copy of the current Guidelines for Handling Linen Policy and Procedure was provided by the DHS on 4/21/2015 at 1:54 p.m. The procedure included, but</p>			

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	<p>was not limited to, "...Dirty Linen: ...4. Do not place soiled linen on furniture or floor."</p> <p>A copy of the current Infection Control Committee Responsibilities Policy and Procedure was provided by the DHS on 4/21/2015 at 3:35 p.m. Procedure included, but was not limited to, "...5. The Infection Control Committee: ...b. ...surveillance activities to identify, investigate, control, and prevent the spread of infection.... e. Monitors compliance with infection control practices and procedures...."</p> <p>2. Resident D was interviewed in her room on 4/20/2015 at 1:48 p.m. She indicated, "They say I have MRSA...I don't know where." There was no signage posted on the resident's door or anywhere in the room instructing visitors to see the nurse before entering. There was no personal protective equipment (PPE) readily available near the entrance or anywhere in the room or bathroom. There were no biozard boxes and/or bags visible in the resident's room or bathroom.</p> <p>Resident D's clinical record was reviewed on 4/21/2015 at 11:10 a.m. Diagnoses included, but were not limited to, MRSA in sputum and "congested cough."</p>			

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	<p>Resident D's current care plan indicated, "I have an infection MRSA in the sputum.... Please follow standard precautions and other contact precautions as needed."</p> <p>3. Resident B, who was non-ambulatory and required 2+ physical assist for toileting, was observed during toileting on 4/20/2015 at 4:05 p.m. CNA #1 entered Resident B's room and performed handwashing for 5 seconds. CNA #2 entered Resident B's room and performed handwashing for 9 seconds. Each CNA donned gloves, assisted Resident B with the bed pan, removed the gloves, and exited the room without washing their hands or utilizing hand sanitizer. Both CNAs exited Resident B's room and walked into the chart/ice machine room behind the nurses' station.</p> <p>A copy of the current Guideline for Handwashing/ Hand Hygeine Policy and Procedure was provided by the DHS on 4/21/2015 at 1:54 p.m. The procedure included, but was not limited to, "...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.... 8. Wash well for 20 seconds...."</p>			

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	This Federal tag related to the Investigation of Complaint IN00171753. 3.1-18(a) 3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(l)				