

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155596	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/11/2014
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NAME OF PROVIDER OR SUPPLIER  LAKELAND SKILLED NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 500 N WILLIAMS ST ANGOLA, IN 46703
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 7, 8, 9, 10, and 11, 2014</p> <p>Facility number: 000474 Provider number: 155596 AIM number: 100290510</p> <p>Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 69 Total: 72</p> <p>Census payor type: Medicare: 15 Medicaid: 40 Other: 17 Total: 72</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 -3.1.</p> <p>Quality review completed on July 14,</p>	F000000	<p><b>This Plan of Correction is the centers credible allegation of compliance.</b></p> <p><b>Preparation and /or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts al- leged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</b></p> <p><b>We respectfully request that this Plan of Correction be</b></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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F000441 SS=D	<p>2014 by Randy Fry RN.</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 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>		given a desk review.		

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	<p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure 2 staff members followed infection control procedures in regard to proper hand washing technique and glove use prior to leaving a resident's room and disinfecting a glucometer, and placing a used Asepto syringe on the staff member's personal papers in a resident's room. This deficiency affected 2 of 2 residents observed during blood glucose testing (Residents # 105 and #126) and 1 of 1 resident who was observed during gastrostomy medication administration (Resident # 77)</p> <p>Findings include:</p> <p>1. On 7/7/14 at 1:10 p.m., LPN # 1 was observed during blood glucose testing with Resident #105. LPN # 1 donned gloves in the resident's room, obtained and tested the drop of blood with a glucometer, and then gathered her supplies. LPN # 1 touched Resident #105's wheel chair handles with gloved hands and pushed the resident in his wheelchair out of the resident's room to the 400 hall dining room. With the gloves still on LPN #1 opened the</p>	F000441	<p>F441 It is the policy of this facility to 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>On July 10,2014, LPN #1 and RN #2 were both re-educated on infection control procedures specifically glove use and proper infection control during medication administration through a gastrostomy tube.</p> <p>Nursing staff were re-educated on those same topics on July 10 through 20th. (Exhibit A) Nursing staff will also be re-educated during a nursing meeting on July 22 and 23, 2014, on the facility policy and procedure on Infection Control which will include glove use, hand washing and procedure for infection control during medication administration through a gastrostomy tube.</p> <p>(Exhibit B)</p>	08/10/2014

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	<p>bottom drawer of the medication cart and removed a Clorox bleach wipe and proceeded to clean the glucometer machine for 60 seconds. LPN #1 then removed her gloves and washed her hands for 25 seconds.</p> <p>On 7/10/14 at 7:45 a.m. LPN #1 was observed during blood glucose testing on resident #126. She donned gloves, then obtained and tested a drop of blood with the glucometer machine. LPN #1 removed the gloves and left the resident's room without washing her hands and at the medication cart LPN #1 regloved without washing hands and cleaned the glucometer machine for 60 seconds with a Clorox bleach wipe. LPN #1 removed gloves and sanitized hands with gel sanitizer.</p> <p>An interview with LPN #1 indicated she likes to come out of the residents room and wash her hands in the utility room.</p> <p>On 7/10/14 at 11:00 a.m. an interview with the DNS (Director of Nursing Service) indicated LPN #1 should have removed the gloves and washed her hands prior to leaving the resident's rooms and especially before cleaning the glucometer machine.</p> <p>The policy for "Glove Use" dated 2012 received from the Director Nursing</p>		<p>LPN#1 and RN #2, along with two other randomly selected nurses, on different shifts, will be audited on a weekly basis for their performance of infection control procedures for the next month. (Exhibit C) If there are not any further issues, then LPN#1 and RN #2 along with three other randomly selected nurses, on different shifts, will be audited on a monthly basis concerning their infection control procedures for the next 5 months.</p> <p>The Director of Staff Development or her designee will conduct the performance audits and will present the results of those audits to the Business Leadership Team, on a weekly/monthly basis for review. The Business Leadership Team will present the results monthly/quarterly to the Quality Assurance Committee. The Quality Assurance Committee responsible to the Administrator will monitor the results for continued compliance.</p>				

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	<p>Service (DNS) on 7/10/14 at 2:15 p.m., indicated</p> <p>"...B. Used gloves should be discarded into the nearest waste receptacle inside the room."</p> <p>"E. Perform hand hygiene after removing gloves."</p> <p>2. On 7/10/14 at 8:30 a.m., RN #2 was observed during medication administration through a gastrostomy tube (g-tube) with Resident # 77. RN #2 listened with a stethoscope and injected 10 cubic centimeters (cc) of air with an Asepto syringe into the resident's g-tube to check for placement of the g-tube in the resident's stomach. RN #2 then removed the Asepto syringe from the g-tube and laid it on her personal papers on the clip board RN #2 had brought into the resident's room. RN #2 then reinserted the Asepto syringe in the resident's g-tube and checked for residual of the resident's stomach contents. With the Asepto syringe RN #2 had obtained 80 cc of formula from the resident's g-tube and then RN #2 poured the formula back into the resident's g-tube and then proceeded to give the resident her medications.</p> <p>On 7/10/14 at 11:00 a.m. an interview with the DNS indicated RN #2 should not put the Asepto syringe on her personal</p>						

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