

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F000000	<p>This visit was for the Investigation of Complaint IN00160392 and Complaint IN00161498.</p> <p>Complaint IN00160392 - Substantiated, Federal/State deficiencies are cited at F441.</p> <p>Complaint IN00161498 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: January 5 and 6, 2015</p> <p>Facility number: 000016 Provider number: 155042 AIM number: 100291500</p> <p>Survey team: Anne Marie Crays RN, TC Debra Holmes, RN</p> <p>Census bed type: SNF: 13 SNF/NF: 119 Total: 132</p> <p>Census payor type: Medicare: 17 Medicaid: 94 Other: 21</p>	F000000		

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=E	<p>Total: 132</p> <p>Sample: 9</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 8, 2015 by Jodi Meyer, RN</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p>				

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	<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 of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff washed their hands following</p>	F000441	<p>F441 It is the practice of Willow Manor for employees to assure to follow wash hands policy and maintain good infection control practices.</p>	01/27/2015

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	<p>resident care, for 2 of 4 staff observed providing care to 4 residents, in a sample of 9. Residents B, C, H, and J</p> <p>Findings include:</p> <p>1. On 1/5/15 at 2:50 A.M., CNA # 1 and CNA # 2 indicated they were going to provide care to Resident B. Neither CNA was observed to wash their hands prior to care. CNA # 1 and CNA # 2 removed the resident's brief, washed the resident's peri area, and changed her gown. Both staff members were wearing gloves. CNA # 1 left the room to obtain linen, wearing the same gloves, and returning holding the linen next to her clothing. When completed with Resident B, CNA # 1 was observed to remove her gloves, remove the resident's trash from the room, and obtain linen from the linen room. She was not observed to wash her hands. CNA # 2 was observed to use a hand sanitizer after leaving the room.</p> <p>CNA # 1 and CNA # 2 then immediately went to care for Resident C. Both staff members applied gloves, and transferred the resident to bed with a mechanical lift. CNA # 1 and CNA # 2 removed the resident's brief, provided peri care, and spread an ointment on the resident's buttocks. They changed the resident's brief, shirt and pants. They then</p>		<p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents B, C, H, J were assessed and have no infections at this time.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>Potentially any resident could be affected. Please refer to systems below to prevent reoccurrence.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>All staff will be in-serviced on the infection control and hand washing policy.</p> <p><i>The corrective action taken to monitor performance to assure compliance through quality assurance is:</i></p> <p>A Performance Improvement Tool has been initiated that will randomly review 5 residents during care to assure that infection control is being maintained. The DON, or designee, is responsible for complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as</p>	

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	<p>transferred the resident back into a wheelchair, removed their gloves, and proceeded to the next room without washing their hands. CNA # 2 used a hand sanitizer.</p> <p>CNA # 1 and CNA # 2 went into Resident H's room. CNA # 1 wiped the resident's mouth. CNA # 2 looked at the resident's brief to determine if the resident was incontinent. Neither staff member was wearing gloves. Neither staff member washed their hands.</p> <p>CNA # 1 went into Resident J's room, and gave her a blanket. At that time, CNA # 1 was interviewed. She indicated she could not think of anything that she would have done differently.</p> <p>2. On 1/6/15 at 1:45 P.M., the Director of Nursing provided the current facility policy on "Handwashing/Hand Hygiene," dated 1/1/14. The policy included: "The facility considers handwashing/hand hygiene as the primary means to prevent the spread of infections...Employees must wash their hands for 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...b. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; c. After handling items potentially contaminated with blood,</p>		<p>needed. Based on any recommendations changes will be made as necessary</p> <p><i>The date the systemic changes will be completed:</i> January 27th 2015</p>	

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	<p>body fluids, or secretions...If hands are not visibly soiled, use an alcohol-based hand rub...for all the following situations:</p> <p>a. Before direct contact with residents...g. After contact with a resident's intact skin; h. After handling used dressings, contaminated equipment, etc.; i. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; and j. After removing gloves. 4. The use of gloves does not replace handwashing/hand hygiene."</p> <p>This Federal tag relates to Complaint IN00160392.</p> <p>3.1-18(I)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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