

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155370	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/18/2013
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NAME OF PROVIDER OR SUPPLIER NEW HARMONIE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 251 HWY 66 NEW HARMONY, IN 47631
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 9/30, 10/1,2,3,7,8,18/2013</p> <p>Facility Number: 000555 Provider Number: 155370 AIM Number: 100267530</p> <p>Survey Team: Denise Schwandner, RN TC 9/30,10/1, 10/2, 10/3, 10/7, 10/8/2013 Barbara Fowler, RN Amy Wininger, RN 9/30,10/1, 10/2, 10/3, 10/7, 10/8/2013 Diane Hancock, RN 9/30/13 - 10/1/13 Diana Perry, RN 9/30,10/1, 10/2, 10/3, 10/7, 10/8/2013 Anna Villain, RN 9/30,10/1, 10/2, 10/3, 10/7, 10/8/2013 Sylvia Martin, RN 9/30, 10/1, 10/3/2013</p> <p>Census Bed Type: SNF/NF: 70 Total: 70</p> <p>Census Payor Type: Medicare: 5 Medicaid: 45 Other: 20</p>	F000000		
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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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	<p>Total: 70</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on October 21, 2013, by Jodi Meyer, RN</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review the facility failed to ensure the care plan was revised for 1 of 3 residents reviewed for falls in the stage 2 sample of 28 residents. (Resident #77)</p> <p>Findings include:</p> <p>Resident #77 was observed on 10/1/13 at 8:34 a.m., working a puzzle in her room.</p> <p>Resident #77 was observed on 10/2/13 at 10:10 a.m., sitting in the lounge on the Alzheimer's unit.</p>	F000280	Please accept this POC as our Allegation of Compliance. Likewise, due to low Scope and Severity we are requesting a desk review. Fall Prevention Care Plan was reviewed and revised for resident #77 by IDT to ensure appropriate interventions are in place 10-2-13. Residents with Fall Prevention Care Plans will be reviewed and revised by IDT to ensure accurate update, intervention and documentation 11-15-13 IDT and Licensed Staff will be re-educated by Director of Nursing on accurate updating and documentation of Falls Prevention Care Plan 11-15-13 24 hour report will be reviewed in Daily Operations meeting by the	11/15/2013			

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	<p>The clinical record of Resident #77 was reviewed on 10/2/13 at 1:09 p.m. Resident #77 was admitted with diagnoses including, but not limited to, depressive disorder, chronic kidney disorder, and fatigue.</p> <p>The MDS (Minimum Data Set) assessment, dated 7/17/13, indicated the BIMS (Brief Interview for Mental Status) assessment to be a 9 (nine), which indicated Resident #77 had cognitive impairment.</p> <p>During the record review of Resident #77 on 10/2/13 at 1:09 p.m., the clinical record indicated the resident had falls on 9/13/13, 8/30/13, 7/18/13, and 6/8/13.</p> <p>A physician's order, dated 9/3/13, indicated Resident #77 was to have a mobility alarm to her chair at night due to the risk of falls. The order indicated Resident #77 slept in a recliner and refused to sleep in a bed.</p> <p>A "Falls Prevention Care Plan," which began on 4/11/13, indicated the goal for Resident #77 was to have no falls for a 90 day period. The Fall Prevention Care Plan" indicated Resident #77 was to have a bed alarm at night.</p>		<p>IDT daily 5 times a week. Care plans will be reviewed at this time to reflect needed intervention/documentation. Direct or of Nursing and or Assistant Director of Nursing will review Fall Care Plans weekly times 12 weeks and then 1 time monthly for 9 months to ensure accuracy and revise as needed with tracking and trending being noted. Tracking and trending will be brought to Risk Managment/Quality Improvement Committee montly for 12 months for further review and further recomendations as warranted.</p>	

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	<p>The care plan lacked any documentation which indicated Resident #77 had a mobility alarm to her chair at night.</p> <p>During an interview with LPN #1 on 10/2/13 at 1:34 p.m., indicated Resident #77 would sleep in a recliner in the room when the resident entered the facility. RN #1 indicated Resident #77 had the chair alarm ordered after the fall on 8/30/13.</p> <p>During an interview on 10/2/13 at 2:50 p.m., the DoN (Director of Nursing) indicated Resident #77 indicated the care plan should be updated after each fall and the nursing staff should be dating and initialing the care plan with each revision.</p> <p>A policy titled, "Care Plan" and obtained from the MDS Coordinator on 10/7/13 at 3:09 p.m., indicated a plan of care will be updated on an as needed basis.</p> <p>3.1-35(d)(2)(B)</p>			

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F000441 SS=D	<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> <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</p>	F000441	Resident #3 was assessed by assigned licensed nurse for any	11/15/2013			

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	<p>record review, the facility failed to ensure proper hand washing and/or hand hygiene was performed for 1 of 3 residents observed for receiving treatments, in that, hand washing and/or hand hygiene was not performed after contact with body fluids and/or after the removal of gloves. (Resident #3)</p> <p>Findings include:</p> <p>The clinical record of Resident #3 was reviewed on 10/02/13 at 09:14 a.m. The record indicated Resident #3 had a colostomy.</p> <p>During an interview on 10/02/13 at 9:30 a.m., RN #1 indicated she was going to perform colostomy care for Resident #3 and needed to gather the supplies. RN #1 was observed, at that time, to exit the room of Resident #3.</p> <p>RN #1 was observed on 10/02/13 at 9:36 a.m., to return to the room of Resident #3 and prepare the colostomy supplies. RN #1 was observed, at that time, to apply gloves without performing hand washing and/or hand hygiene, and clean the skin around the stoma. RN #1 was then observed to remove the gloves and apply new gloves without</p>		<p>symptoms related to infections with no negative outcomes noted 10-3-13. Residents have been monitors by licensed staff for any symptoms related to infections with no negative outcomes noted 10-26-13. All direct care and non direct care staff will be re-educated on Policy and Procedure regarding Proper Handwashing by Director of Nursing and or Assistant Director of Nursing -11-15-13. Nurse performing care during observation has been re-educated on proper handwashing procedure by Director of Nursing -10-25-13. Director of Nursing and or Assistant Director of Nursing will observe 25% of all direct care staff weekly times 12 weeks, then 1 time monthly for 9 months to ensure proper handwashing technique. Findings will be brought to Risk Management/Quality Improvement Committee monthly for 12 months for further review and recommendations as warranted.</p>		

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	<p>performing hand washing and/or hand hygiene. RN #1 was further observed to apply powder and a new wafer with colostomy bag to the stoma and remove her gloves. RN #1 was then observed to apply new gloves without performing hand washing and/or hand hygiene.</p> <p>The policy and procedure for Hand washing provided by the ADoN (Assistant Director of Nursing) on 10/02/13 at 4:00 p.m. indicated, "Policy...All personnel will wash hands to remove dirt, organic material, and transient microorganisms to prevent the spread of infections. Hands must be washed: After contact with blood/body fluids...after removal of gloves..."</p> <p>During an interview with the ADoN on 10/03/13 at 9:47 a.m., indicated staff should wash hands between glove applications.</p> <p>3.1-18(l)</p>			