

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 23, 24, 25, 26, 30 and July 1,2014</p> <p>Facility number: 000439 Provider : 155716 AIM Number: 100275070</p> <p>Survey team: Diana Perry, RN, TC Barb Fowler, RN Denise Schwandner, RN Ann Villain , RN Diane Hancock, RN (June 23, 24, 25, 30 and July1, 2014)</p> <p>Census bed type: SNF: 19 NF: 41 SNF/NF: 114 Residential: 11 Total: 185</p> <p>Census payor type: Medicare: 13 Medicaid: 118</p>	F000000	Please accept the following Plan of Correction for the annual survey on June 23, 2014 through July 1, 2014 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth facts alleged or conclusion set forth in the statement of deficiencies This Plan of Correction is prepared and/or executed solely because it is required by the provision of the Federal and State laws This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for use in continuing to better the quality of care provided to the residents in our community We respectfully request desk review and paper compliance	

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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F000282 SS=D	<p>Private: 54 Total: 185</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 9, 2014 by Jodi Meyer, RN</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure services were provided in accordance with the plan of care for 1 of 3 sampled residents of 5 that met the criteria for urinary incontinence. (Resident #205)</p> <p>Findings include:</p> <p>The clinical record review of Resident #205 was reviewed on 6/25/14 at 3:21 p.m. The record indicated diagnoses including, but not limited to, glaucoma, osteoporosis, hypothyroidism, allergies,</p>	F000282	Beginning on June 28, 2014, a three-day (3) Bowel and Bladder Elimination Pattern Assessment was initiated for Resident #205 to ensure the Resident's current bowel and bladder needs were being met according to the Resident's functional abilities. Additionally, upon further review of the Resident's bowel and bladder toileting pattern documented on the Resident's ADL record that had been consistently completed on Resident #205 throughout the time frame identified in the Statement of Deficiency, the Resident had not had any	07/21/2014

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	<p>aproxatrial tachycardia, subarachnoid hemorrhage, hx of fall, trans cerebral ischemia, hx lymphoma, and constipation.</p> <p>The clinical record review on 6/26/14 at 8:45 a.m. indicated a Bladder Continence Assessment was done on 1/10/14 upon admission and indicated the resident was occasionally incontinent. The bladder assessment done on 4/18/14 also indicated the resident was occasionally incontinent.</p> <p>An initial care plan for urinary incontinence was provided by the DoN (Director of Nursing) on 6/26/14 at 1:22 p.m. The care plan, dated 1/10/14, indicated that an assessment for toileting pattern was to be done for 3 days. The bowel and bladder elimination pattern assessment for January 10, 11, and 12 was provided on 6/26/14 at 2:02 p.m. by the DoN. The assessment was incomplete, in that the resident's urination pattern had been documented 2 times in the 3 day period.</p> <p>An interview with the ADoN (Assistant Director of Nursing) on 6/26/14 at 9:35 a.m. indicated the resident is checked every 2 hours to see if she needs to toilet and that she lets them know if she needs help.</p>		<p>episodes of incontinence Residents who have episodes of urinary incontinence have the potential to be affected by the alleged deficient practice On June 28, 2014, an audit was completed for residents who have episodes of urinary incontinence to ensure a Bowel and Bladder Elimination Pattern Assessment had been completed and assessments and care plans were updated as indicated In-servicing was initiated on July 14, 2014 and completed on July 21, 2014 with Licensed Nursing staff by Nursing Administration with regard to ensuring that services are provided in accordance to the residents' Plan of Care and to ensure a three-day (3_ Bowel and Bladder Elimination Pattern Assessment is completed upon admission, quarterly, and as indicated The Director of Nursing or designee will randomly audit five (5) medical records on each unit weekly for four (4) weeks and continue monthly for no less than two (2) additional months to ensure the appropriate Bowel and Bladder Assessments are being completed and services provided according to the resident's care plan, as indicated The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee The Committee will re-evaluate the continued need of audits; facility</p>		

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F000371 SS=D	<p>The policy entitled "Care Plans-Comprehensive", dated 2008, was provided by the DoN on 6/26/14 at 3:35 p.m. The policy included, but was not limited to, the following: "Aid in preventing or reducing declines in the resident's functional status and/or functional levels; and enhance the optimal functioning of the resident by focusing on a rehabilitative program."</p> <p>The policy entitled "Incontinence Care", undated, was provided by the DoN on 6/26/14 at 3:35 p.m. The policy included, but was not limited to, the following: "Key components of a bowel and/or bladder management program include the following: determining level of incontinence or patterns."</p> <p>3.1-35(g)(2)</p> <p>483.35(i) FOOD PROCURE,</p>		will achieve 95% compliance threshold prior to discontinuing audits Plan to updated as indicated		

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	<p>STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to distribute food under sanitary conditions for 3 of 11 randomly observed residents during an observation for 1 of 5 dining rooms observed.</p> <p>Findings include:</p> <p>During a dining observation in the Pavilion 1 (one) dining room on 6/23/2014 at 12:20 p.m., CNA #3 was observed to be rubbing her neck and back by raising the back of her shirt with her hands, and putting her hair behind her ears, prior to serving plates of food to three residents. No hand hygiene was performed.</p> <p>During an interview on 6/26/14 at 1:20 p.m., LPN #1 indicated hand gel was to be used between serving each resident.</p> <p>A policy titled, "Handwashing/Hand Hygiene," dated May,2013 and obtained from the DoN (Director of Nursing) on 6/26/14 at 11:30 a.m., indicated employees must wash their hands for</p>	F000371	Nursing and Dietary staffs ensure proper hand sanitation occurs during the serving of meals. At this time we have not been able to provide re-education to CNA#3 who was allegedly witnessed to engage in the deficient practice r/t the CNA not an employee of The Home and is employed through a supplemental staffing agency. However, CNA#3 will receive re-education r/t proper hand hygiene during the serving of meals prior to being allowed to work in the facility again after our alleged date of compliance of 7/21/2014. Residents being served meals at the time of alleged deficient practice are at risk to be affected In-servicing with return demonstration was initiated on July 14, 2014 and completed on July 21, 2014 with staff by Nursing Administration regarding proper hand sanitation when serving meals to residents The Director of Nursing or designee will complete random hand sanitation observations of the staff during the serving of resident meals at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months The results of these audits will be	07/21/2014			

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F000431 SS=E	<p>twenty seconds using a antimicrobial or non-antimicrobial soap and water under the following conditions before and after direct contact with residents. The policy further indicated the preferred method of hand hygiene is with an alcohol-based hand rub.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt</p>		presented to the monthly Performance Improvement Committee The Performance Improvement Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits Plan to be updated as indicated	

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	<p>and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure timely disposal of expired medications, sanitary conditions of medication rooms, and dated medications with shortened expiration dates for 3 of 6 medication carts and 2 of 3 medication rooms reviewed.</p>	F000431	<p>Upon review of the alleged incident as cited in the Statement of Deficiencies, no harm was incurred by any of the residents related to the alleged deficient practice. The expired medication in the carts on West and Pathways II units were discarded, and a new supply of the medications was obtained. The open date was added to the label.</p>	07/21/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> On 6/26/14 at 9:05 a.m., the West Hall medication cart was observed. A bottle of Humalog (a medication used for the treatment of high blood sugar) was observed with an open date of 4/30. At that time, QMA (Qualified Medication Aide) #2 indicated insulin was good for 30 days. On 6/26/14 at 9:16 a.m., the West Hall medication room was observed. The cove base was observed to be detached from the wall and dirt and debris was built up in the corners and along the edges of the floor. On 6/26/14 at 9:26 a.m., the Pathways II medication cart was observed. A bottle of Latanoprost (a medication used for the treatment of glaucoma) eye drops was observed with an open date of 3/27 and an expiration date of 6/5. On 6/26/14 at 9:40 a.m., the Pathways I medication cart was observed. An Advair Diskus (a medication used for the treatment of asthma) was observed to be without an open date. On 6/26/14 at 9:51 a.m., the Pavilion medication room was observed. The refrigerator was observed with ice built 		<p>of the Advair Diskus identified according to the remaining number of doses available in the diskus. The cove base along the wall in the medication room was repaired by the maintenance staff. The refrigerator with ice build-up in the freezer has been defrosted and cleaned. Residents residing in the facility have the ability to be affected by the alleged deficient practice. On June 27, 2014, Nursing Administration ensured that the medication carts on the other units were free of expired medications, and medications were appropriately labeled as indicated. The cove base in the medication rooms were evaluated to ensure that it was secured appropriately to the walls. Additionally, the freezers in the refrigerators were evaluated for ice build-up. Corrections were made as indicated. In-servicing was initiated on July 14, 2014 and completed on July 21, 2014 for Licensed Nursing Staff by Nursing Administration on the importance of ensuring that medications are not expired and appropriately labeled as indicated. Additionally, the Director of Facility Operations developed and initiated Daily Cleaning and Deep Cleaning Checklists. The Maintenance Checklist will allow the staff when completing cleaning tasks to be able to evaluate the resident rooms for maintenance needs.</p>				

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	<p>up in the freezer area.</p> <p>6. On 6/30/14 at 2:15 p.m., the NUM (Nurse Unit Manager) #1 provided the "Storage and Expiration of Medications, Biologicals, Syringes and Needles" policy. The policy indicated, "Facility should ensure that medications and biologicals have not been retained longer than recommended by manufacturer or supplier guidelines...." The policy further indicated, "Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened". The "Medications with Shortened Expiration Dates" section of the policy indicated: Advair: use within 30 days of removing from protective wrap. Humalog: may be kept at room temperature for up to 28 days. Latanoprost: may be used for 42 days after opening.</p> <p>3.1-25(m) 3.1-25(o)</p>		<p>The checklists will be submitted to the Director of Facility Operations and/or his assistant on a daily basis as they are completed. If a maintenance repair is needed, the Director of Facility Operations and/or his assistant will then create a work order, and assign the task to an individual to make the repair(s) The Director of Facility Operations and/or his assistant will follow up on the work order to ensure the repair has been appropriately completed On July 14, 2014, maintenance and housekeeping employees were in-serviced on the two (2) cleaning checklists, the Maintenance checklist, as well as the processes to follow, and the expectations thereof Lastly, in conjunction with dietary and housekeeping services, staff were re-educated on the process of completing a work order when identifying areas or items in the facility that require cleaning and/or repairs The Director of Nursing or designee will audit medication carts for expired medications and inappropriately labeled medications weekly for four (4) weeks and continue weekly for no less than two (2) additional months to ensure that medications are not expired and/or appropriately labeled as indicated The Director of Facility Operations will audit refrigerators and completed work orders</p>				

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F000441 SS=D	<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</p>		<p>weekly for four (4) weeks and continue weekly for no less than two (2) additional months to ensure all work orders have been followed-up on and areas identified have been cleaned and/or repaired, as indicated The results of these audits will be presented to the monthly Performance Improvement Committee The Performance Improvement Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits Plan to be updated as indicated</p>	

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	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 maintain an infection control procedure for 3 of 5 residents observed for care, in that handwashing and glove changes were not completed for a resident who received pericare, a glucometer was not adequately cleaned, and pericare was not performed properly for a resident. (Resident # 52, 190, 143)</p> <p>Findings include:</p> <p>1. On 6/25/14 at 11:25 a.m., QMA (Qualified Medication Aide) #1 was observed administering accuchecks (a test which measures blood sugar levels) for Resident #190. QMA #1 was observed to hand wash and apply gloves. QMA #1 then performed the accucheck.</p>	F000441	<p>Upon review of the alleged incident as cited in the Summary Statement of Deficiencies, no harm was incurred by the resident related to the alleged deficient practice. Licensed Nursing staff and QMAs ensure glucometers are cleaned and sanitized according to facility policy and procedure. On June 24, 2014, QMA #1 was re-educated on the appropriate cleaning procedures in accordance to the facility's policy and procedure. Additionally, on June 26, 2014, CNA #1, #2, and #4 received re-education on appropriate hand washing, donning and removal of gloves and perineal care, according to the facility's policy and procedure. Residents receiving accu-check readings via a glucometer at the time of the alleged deficient practice are at risk to be affected. Additionally, other residents residing in the</p>	07/21/2014

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	<p>QMA #1 removed gloves and sanitized the glucometer (the machine used to measure blood sugar levels) with a "Super Sani-Cloth" for 14 seconds. QMA #1 removed the trash and the "Super Sani-Cloth" and placed it in the trash. QMA #1 indicated she cleansed the entire glucometer with the "Super Sani-Cloth" a few times and then allows it to dry. QMA #1 indicated no specific time frame was required for cleansing the glucometer. At that time, QMA #1 provided the "Super Sani-Cloth" packaging. The packaging indicated, "Treated surface must remain visibly wet for a full two minutes".</p> <p>On 6/25/14 at 2:33 p.m., the DoN (Director of Nursing) provided the "Blood Glucose Meter Cleaning and Disinfecting" policy. The policy indicated, "Allow surface of the meter to remain wet at room temperature for at least two minutes" and "Between every resident use clean meter with a facility-approved hospital cleaner disinfectant or germicidal disposable wipe (PDI Super Sani-Cloth Germicidal Disposable Wipe). Be sure to read the correct use for cleaning products guidelines".</p> <p>2. During an observation on 6/26/14 at 9:10 a.m., CNA (certified nursing assistant) #1 and CNA #2 were observed</p>		<p>facility who require assistance with perineal care have the potential to be affected by the alleged deficient practice In-servicing with return demonstration was initiated on July 14, 2014 and completed on July 21, 2014 with Licensed Nursing, QMA, and CNA staffs by Nursing Administration on the correct method of cleaning glucometers, hand washing, donning and removal of gloves, and pericare, in accordance with the facility's policy and procedure</p> <p>The Director of Nursing or designee will audit nursing staff obtaining accu-check readings at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months to ensure that glucometers are being cleaned according to company policy. Additionally, hand washing, donning and removal of gloves and pericare audits will be completed at least five (5) times per week for four (4) weeks and continue weekly for no less than two (2) additional months to ensure care is being provided appropriately and in a manner that promotes good hand hygiene and perineal care. The results of these audits will be presented to the monthly Quality Assurance Committee The Quality Assurance Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to</p>	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>to perform pericare on Resident #52. CNA #1 and CNA #2 initially performed hand sanitization and applied gloves. After removing a wet brief from Resident #52, CNA #1 washed the right groin area, the periarea, and the left groin area with the same washcloth. CNA #1 rinsed and dried the groin area and periarea using the same wash cloth to rinse and the same towel to dry the areas. Resident #52 was turned to the right side and CNA #1 proceeded to wash and dry Resident #52's buttocks and left hip area with a clean wash cloth and towel. The resident's left hip was not cleaned. No hand sanitization or glove change was observed.</p> <p>During an interview on 6/26/14 at 9:35 a.m., CNA #2 indicated hands should be washed and gloves changed before beginning a procedure, when going from dirty area to the clean area of a resident, and after completion of the procedure.</p> <p>A policy titled, 'Handwashing/Hand Hygiene,' dated May 2013 and obtained from the DoN (Director of Nursing) on 6/26/14 at 11:30 a.m., indicated hand hygiene is to be performed before moving from a contaminated body site to a clean body site during resident care.</p> <p>3. CNAs #4 and #5 were observed to take Resident #143 to the bathroom. The</p>		discontinuing audits Plan to be updated as indicated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
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	<p>resident was transferred from the wheelchair to the commode with the assistance of both CNAs. The resident's incontinence brief was soiled with urine and feces. After transferring the resident and removing the soiled brief, the CNAs removed their gloves and washed their hands. They then donned clean gloves. CNA #4 used multiple wash cloths and wet towels to remove the feces from the resident. She would initially move the wash cloth from the front periarea to the back, but then move it back to the front with visible brown substance on the wash cloth. No soap or periwash was used initially. After exhausting the supply of towels and wash cloths, CNA #4 removed her gloves, rinsed her hands in plain water, and left the bathroom. She returned to the bathroom with clean towels and wash cloths and a bottle of periwash. She continued to wash the resident back to front and front to back several times. Brown stool was visible on the wash cloths.</p> <p>A policy and procedure for Perineal Care, dated May, 2014, was provided by the Director of Nurses on 6/30/14 at 3:15 p.m. The policy statement indicated the facility strived to "provide cleanliness, prevent infections, skin irritation...to the residents we serve." The procedure included, but was not limited to, the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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F000465 SS=E	<p>following: "For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back. (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side and using downward strokes. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (4) Gently dry perineum.... e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia..."</p> <p>3.1-18(b)(1) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based observation, interview, and record review, the facility failed to ensure a safe and sanitary environment, in that, dirt and debris was present on the floors, drywall and paint was cracked and peeling, walls</p>	F000465	Alleged deficient areas identified during the survey were cleaned and/or repaired. Additionally, residents' personal items (i.e., bedpans, urinals and denture cups) were covered, labeled, and stored appropriately. The can of	07/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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	<p>were marred, chemicals were stored in a resident's room, and urinals and bedpans were stored uncovered and unlabeled for 21 of 38 rooms observed during Stage 1. (Room #659, 408, 420, 110, 208, 582, 668, 586, 658, 428, 425, 590, 548, 584, 426, 417, 583, 418, 415, 544, 547)</p> <p>1. On 6/23/14 at 1:59 p.m., Room #659 was observed. The bathroom was observed with a strong urine odor and an unlabeled and uncovered bed pan. On 6/30/14 at 8:08 a.m., the same was observed.</p> <p>2. On 6/23/14 at 2:57 p.m., Room #408 was observed. The cable outlet was observed to not be secured to the wall and the walls were observed to be marred. In the bathroom, visible dust was observed accumulated on the tile walls. On 6/26/14 at 1:38 p.m., the same was observed, in addition to, an unlabeled urinal and loose cove base in the bathroom.</p> <p>3. On 6/23/14 at 3:05 p.m., Room #420 was observed. The bedroom and bathroom walls were observed to be marred. An unlabeled denture cup was observed to be sitting by the sink. In the bathroom, four urinals and a bed pan were observed to be unlabeled and uncovered. The tiles beside the</p>		<p>Powerhouse Disinfectant Spray that was allegedly identified by the surveyor in Room# 583, was not provided by the facility and had apparently been supplied, brought in and stored by a resident's family member. However, the disinfectant spray has since been removed by facility administration and will be provided back to the resident's family member who brought the can of disinfectant spray in.</p> <p>Residents residing in the facility at the time of survey have the potential to be affected by the alleged deficient practice. On July 16, 2014, an audit was completed by Nursing Administration to ensure residents did not have other cans of disinfectant spray or potentially harmful chemicals stored in their rooms and that resident personal items (i.e., bedpans, urinals, and denture cups) were covered, labeled with the resident name, room and bed number, and that they were stored appropriately. Between the dates of July 2, 2014 through July 21, 2014, an audit was completed by the Director of Facility Operations of resident rooms/bathrooms to evaluate for other areas that may potentially need repairs and/or additional cleaning.</p> <p>The Director of Facility Operations created/revised two different cleaning lists. One list will be used to guide/instruct housekeeping employees on what areas are to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>commode were observed to be cracked. On 6/26/14 at 1:31 p.m., the bedroom and bathroom walls were observed to be marred and an unlabeled denture cup was sitting by the sink. In the bathroom, four urinals and a bedpan were observed to be unlabeled. The tiles beside the commode were observed to be cracked.</p> <p>4. On 6/23/14 at 3:21 p.m., Room #110 was observed. A large water stain was observed on the ceiling tile. On 6/26/14 at 1:48 p.m., the same was observed.</p> <p>5. On 6/23/14 at 3:37 p.m., Room #208 was observed. A brown substance was observed at the base of the toilet. On 6/26/14 at 1:50 p.m., the same was observed.</p> <p>6. On 6/23/14 at 4:15 p.m., Room #582 was observed. The bathroom was observed with dirt and debris built up in the corners and along the edges of the floor. On 6/30/14 at 8:14 a.m., the same was observed, in addition to, two areas of cracked porcelain at the base of the commode.</p> <p>7. On 6/24/14 at 8:57 a.m., Room #668 was observed. The doorframe to the bathroom was observed to be scuffed with peeling paint and a section of paint was observed to be missing to the left of</p>		<p>becleaned on a daily basis as scheduled. The other list will be used toguide/instruct housekeeping employees on the expectations of what tasks mustbe completed when deep cleaning a resident's room, according to the routine deepcleaning schedule, and after a resident is discharged. Additionally, on the backof the Daily Cleaning and Deep Cleaning Checklists, a Maintenance Checklist wasadded, thereby allowing the staff to evaluate the resident rooms for maintenance needs while completing cleaning tasks.. The checklistswill be submitted to the Director of Facility Operations and/or his assistanton a daily basis as they are completed. If a maintenance repair is needed, theDirector of Facility Operations and/or his assistant will then create a workorder, and assign the task to an individual to make the repair(s). The Director ofFacility Operations and/or his assistant will follow-up on the work order toensure the repair has been appropriately completed. On July 14, 2014, maintenanceand housekeeping employees were in-serviced on the two (2) cleaning lists andthe expectations thereof, as well as the processes to follow. In-servicing wasinitiated on July 14, 2014 and completed on July 21t,2014 with Licensed Nursing, QMA and C.N.A staffs by Nursing Administration on theimportance of ensuring that resident personal items (i.e., bedpans, urinalsand denture cups) are covered, labeled with</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the bathroom door. A bed pan was observed stored in the bathroom uncovered and unlabeled. On 6/30/14 at 8:49 a.m., the same was observed, in addition to, a trash bag of paper towels soiled with a brown substance.</p> <p>8. On 6/24/14 at 8:59 a.m., Room #586 was observed. The walls were observed to be chipped and marred. The bathroom was observed with dirt and debris built up in the corners and along the edges of the floor. On 6/30/14 at 8:30 a.m., the same was observed.</p> <p>9. On 6/24/14 at 9:06 a.m., Room #658 was observed. The bathroom was observed with an unlabeled and uncovered urinal and a soiled brief and a soiled towel on the floor. On 6/30/14 at 8:10 a.m., an uncovered and unlabeled urinal was observed in the bathroom.</p> <p>10. On 6/24/14 at 9:12 a.m., Room #428 was observed. The walls were observed to be chipped and marred. The bathroom was observed with dirt and debris was built up in the corners and around the edges of the floor.</p> <p>11. On 6/24/14 at 9:31 a.m., Room #425 was observed. The walls were marred, chipped, and cracked and the door frame drywall was observed missing. In the</p>		<p>resident name, room and bednumber, and that they remain stored appropriately.</p> <p>The Director of Facility Operations or designee will audit resident rooms for cleanliness and potential maintenance needs according to the following schedule; one (1) room per unit daily three (3) times per week for four (4) weeks, one (1) room per unit daily two (2) times per week for four (4) weeks, and then one(1) room per unit weekly for four (4) weeks. The Director of Nursing or designee will audit resident rooms to ensure personal items (i.e., bedpans, urinals and denture cups are covered, labeled with resident name, room and bed number, and stored appropriately according to the following schedule; four (4) rooms per unit daily three (3) times per week for four (4) weeks, three (3) rooms per unit daily two (2) times per week for four (4) weeks, and then two (2) rooms per unit weekly for four (4) weeks. The results of these audits will be presented to the monthly Quality Assurance Committee. The Quality Assurance Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits. Plan to be updated as indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>bathroom, dirt and debris was observed to be built up in the corners and along the edges of the floor. On 6/26/14 at 1:28 p.m., the same was observed.</p> <p>12. On 6/24/14 at 10:44 a.m., Room #590 was observed. Dust was observed to be accumulated on the bathroom vent and cobwebs were observed on the bathroom light fixtures. The bathroom was observed with dirt and debris built up in the corners and along the edges of the bathroom floor. A sponge was observed lying on the bathroom floor. On 6/30/14 at 8:19 a.m., the same was observed.</p> <p>13. On 6/24/14 at 10:49 a.m., Room #548 was observed. The bathroom was observed with dirt and debris built up in the corners and along the edges of the floor. On 6/30/14 at 9:00 a.m., the same was observed, in addition to, an uncovered and unlabeled bedpan.</p> <p>14. On 6/24/14 at 10:58 a.m., Room #584 was observed. The drywall outside of the bathroom door was observed to be cracked. The paint on the bathroom door frame was chipped. The sink was cracked. Dirt and debris was observed built up in the corners and along the edges of the bathroom wall. On 6/30/14 at 8:17 a.m., the same was observed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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	<p>15. On 6/24/14 at 11:24 a.m., Room #426 was observed. The walls were observed to be marred. The drywall surrounding the bathroom doorframe was chipped. Dirt and debris was observed built up in the corners and along the edges of the bathroom floor. On 6/26/14 at 1:27 p.m., the same was observed.</p> <p>16. On 6/24/14 at 11:30 a.m., Room #417 was observed. The walls were observed to be marred. The bathroom wall tiles were broken. The drywall surrounding the bathroom doorframe was observed to be chipped. On 6/26/14 at 1:33 p.m., the same was observed.</p> <p>17. On 6/24/14 at 11:32 a.m., Room #583 was observed. A can of Powerhouse Disinfectant Spray was stored on the bathroom shelf. On 6/26/14 at 1:56 p.m., the same was observed. The warning label included; avoid contact with eyes and skin and avoid breathing spray.</p> <p>18. On 6/24/14 at 11:37 a.m., Room #418 was observed. The drywall surrounding the bathroom door frame was cracked. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom floor. On 6/26/14 at 1:31 p.m., the same was observed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>19. On 6/24/14 at 1:35 p.m., Room #415 was observed. The paneling around the sink was loose. Dirt and debris was built up in the corners and along the edges of the bathroom floor. On 6/26/14 at 1:35 p.m., the paneling around the sink was loose. Dirt and debris was observed to be built up in the corners and along the edges of the bathroom floor. A piece of drywall was observed to be missing outside of the closet.</p> <p>20. On 6/24/14 at 2:07 p.m., Room #544 was observed. The bathroom was observed with built up dirt and debris in the corners and along the edges of the floor. On 6/26/14 at 2:00 p.m., the same was observed, in addition to, an unlabeled and uncovered urine hat and bed pan.</p> <p>21. On 6/24/14 at 2:24 p.m., Room #547 was observed. The bathroom was observed with built up dirt and debris in the corners and along the edges of the floor. On 6/30/14 at 8:04 a.m., the same was observed, in addition to, two unlabeled and uncovered urinals.</p> <p>22. On 6/30/14 at 9:32 a.m., Housekeeper #1 was interviewed. Housekeeper #1 indicated on a daily basis bathrooms are cleaned and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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R000000	<p>floors are were swept and mopped on a daily basis</p> <p>On 6/30/14 at 1:55 p.m., the DoN (Director of Nursing) provided the "Environmental Checklist". The checklist indicated, floors were swept and mopped on a daily basis.</p> <p>On 7/1/14 at 9:49 a.m., the DoN provided the "Cleaning & Labeling of Equipment & Supplies" policy. The policy indicated, "Staff should ensure that resident's personal equipment/supplies (e.g. bedpans, urinals, wash basins, denture cups ect.) have been properly cleaned after each use, labeled with the resident's name and room/bed #, and appropriately stored away (i.e. a bag, cabinet or drawer)".</p> <p>3.1-19(f)</p> <p>This visit included a State Residential Licensure Survey.</p> <p>These deficiencies reflect state finding cited in accordance with 410 IAC 16.2-5.</p>	R000000	Please accept the following Plan of Correction for the annual survey on June 23, 2014 through July 1, 2014 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth facts alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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R000035	<p>410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. (3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication.</p>		<p>or conclusion set forth in the statement of deficiencies This Plan of Correction is prepared and/or executed solely because it is required by the provision of the Federal and State laws This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for use in continuing to better the quality of care provided to the residents in our community We respectfully request desk review and paper compliance</p>	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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	<p>(5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility.</p> <p>(6) Be afforded confidentiality of treatment.</p> <p>(7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.</p> <p>Based on record review and interview, the facility failed to ensure service plans were developed for 1 of 7 residents reviewed for service plans in that the resident did not have a service plan. (Resident #241)</p> <p>Findings include:</p> <p>The closed record of Resident #241 was reviewed on 6/26/14 at 1:14 p.m. The clinical record lacked any documentation of a service agreement plan or updates.</p> <p>During an interview on 6/16/14 at 2:00 p.m., with MRC (Medical Records Clerk) #1 indicated she was unable to locate the service plan for Resident #241.</p> <p>During an interview on 6/26/14 at 2:30 p.m., DSS (Director of Social Services) #1 indicated she had the service plan signed by the resident but was unable to located the actual service plan.</p>	R000035	<p>Due to Resident #241 no long residing in the Residential Unit, a Resident Service Plan is no longer applicable, and therefore, could not be initiated</p> <p>Residents residing on the Residential Unit have the potential to be affected by the alleged deficient practice On June 27, 2014, an audit was completed by the Social Services Director to ensure the other residents residing on the Residential Unit had a Resident Service Plan present and in their medical record</p> <p>On July 14, 2014, employees of the Social Services Department were re-educated by the Director of Nursing on the importance of completing a Resident Service Plan with each resident admitted to the Residential Unit and to ensure the Service Plans are completed upon admission, reviewed and/or revised semi-annually, and on as "as needed" basis</p> <p>The Social Services Director or designee will randomly audit two (2) medical records on the</p>	07/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIA	STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711
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R000216	<p>During an interview on 6/30/14 at 1:54 p.m., the DoN (Director of Nursing) indicated the facility was unable to locate a service plan for Resident #241.</p> <p>A policy titled, "Residential Service Plan" obtained from the DoN on 6/30/14 at 2:46 p.m., indicated the service plan should be developed and initiated upon admission and is reviewed and revised semi-annually and on an as needed basis.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in</p>		Residential Unit weekly for four (4) weeks and continue monthly for no less than two (2) additional months to ensure that residents residing on the Residential Unit have a Resident Service Plan completed and in place The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee The Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits Plan to be updated as indicated	

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	<p>writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to ensure an evaluation of the resident's ability to self-administer medications was completed, for 1 of 2 residents reviewed who self-administered medications in the total sample of 7. (Resident #236)</p> <p>Findings include:</p> <p>1. The record for Resident #236 was reviewed on 6/26/14 at 2:00 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, hypertension, hypothyroidism, and hyperlipidemia.</p> <p>The record indicated that the resident self-administered her medications, but failed to have an evaluation for self-administration of medications.</p> <p>The resident self administers the following medications:</p> <p>Acyclovir [used for the treatment of Herpes] Aspirin [used for mild pain, fever and/or blood thinner] Calcium [supplement of calcium] Celebrex [used as anti-inflammatory, pain] Certa-vite [vitamin supplement] Lasix [used for reduction of fluid and high blood pressure]</p>	R000216	<p>On June 30, 2014, the Unit Manager completed a Self-Administration Medication Evaluation for Resident #236 Residents residing on the Residential Unit have the potential to be affected by the alleged deficient practice On June 30, 2014, an audit was completed by the Nurse Manager providing oversight for the Residential Unit to ensure the other residents who reside on the Residential Unit and who potentially have the ability to safely self-administer their medications have a completed Self-Administration Medication Evaluation completed In-servicing was completed on July 15, 2014 wherein staff who provide care services to residents residing on the Residential Unit were re-educated by the Nursing Administration on the importance of completing a Self-Administration Medication Evaluation with each resident admitted to the Residential Unit, as well as to ensure the Evaluation is completed upon admission, are reviewed and/or revised annually, and/or with a significant change in the resident's condition</p> <p>The Director of Nursing or designee will randomly audit two (2) medical records on the Residential Unit weekly for four (4) weeks and continue monthly for no less than two (2) additional</p>	07/21/2014			

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R000410	<p>Synthroid [thyroid supplement] Losartan [used for high blood pressure] Metoprolol [used for high blood pressure and heart failure] Tobramycin [used for eye infections] Vitamin D3 [vitamin supplement] Acetaminophen [used for pain and fever] Artificial tears [used for dry eyes] Milk of magnesia [used for bowel regularity]</p> <p>2. An interview with the DoN (Director of Nursing) on 6/30/14 at 1:54 p.m., indicated that there was no evaluation for self-administration of medications found for this resident. He also indicated that an evaluation had been done on this date and is now on the chart.</p> <p>3. The policy entitled "Medication Self-Administration", March 2014, was provided by the DoN on 7/1/14 at 9:25 a.m. The policy included, but was not limited to the following: "An assessment will be done upon admission, yearly or with a change in the resident's condition."</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to</p>		<p>months to ensure the other residents who reside on the Residential Unit and who potentially have the ability to safely self-administer their medications have a completed Self-Administration Medication Evaluation completed The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee The Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits Plan to be updated as indicated</p>	

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	<p>admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure a Tuberculin Skin Test was completed annually for 1 of 7 residents reviewed. (Resident #239)</p> <p>Findings include:</p> <p>On 6/30/14 at 10:55 a.m., Resident #239's clinical record was reviewed. Resident #239 was admitted on 6/1/13. The "Immunization Record and TB Screening/Risk Assessment" indicated the last Tuberculin Skin Test was administered on 6/18/13.</p> <p>On 6/30/14 at 2:03 p.m., the DoN (Director of Nursing) indicated the Tuberculin Skin Test had not been</p>	R000410	Upon further review of the finding noted in the Statement of Deficiencies, Resident #239's annual TST (Tuberculin Skin Test) had been scheduled for June 18, 2014. For unknown reasons, the test had been omitted on that date but was given on June 30, 2014. Therefore, the Resident has received his annual TST. Residents residing in the facility have the ability to be affected by the alleged deficient practice. Additionally, on June 30, 2014, an audit was completed by the Unit Manager of residents residing on the Residential Unit to ensure that resident with orders to receive an annual TST had received their annual TST or were scheduled to do so.	07/21/2014			

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	<p>completed since 6/18/13.</p> <p>On 7/1/14 at 12:15 p.m., the DoN provided the "Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Tests" policy. The policy indicated, "A one-step TST (Tuberculin Skin Test) is to be repeated annually".</p>		<p>In-servicing was initiated on July 14, 2014 and completed on July 21, 2014 with West Unit staff by Nursing Administration on the importance of ensuring each resident with orders to receive an annual TST receives the test as scheduled unless otherwise contraindicated</p> <p>The Director of Nursing or designee will randomly audit two (2) medical records on the Residential Unit weekly for four (4) weeks and continue monthly for no less than two (2) additional months to ensure that residents with orders to receive an annual TST has received the test as scheduled The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee The Committee will re-evaluate the continued need of audits; facility will achieve 95% compliance threshold prior to discontinuing audits Plan to be updated as indicated</p>		