STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155631	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER LODGE	3710 KENNY SIMPSON LN BEDFORD, IN 47421

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey Dates: December 10, 11, 12, 13, 16, & 17, 2013 Facility number: 001153 Provider number: 155631 AIM number: 200155900 Survey team: Diana McDonald, RN-TC Melissa Gillis, RN Cheryl Mabry, RN Angela Patterson, RN Census bed type: SNF/NF: 46 Residential: 3 Total: 49 Census payor type: Medicare: 6 Medicaid: 35 Other: 8 Total: 49 Residential sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F000000	Preparation and execution of the plan of correction for the survey does not constitute admission of agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the Federal and State law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limits the providers' capacity to render adequate resident care. This plan of correction serves as the facility's credible allegation that it will be in substantial compliance on or before January 16th, 2014.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality review completed on December 23, 2013; by Kimberly Perigo, RN.			

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F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's privacy while receiving personal care by having left the window curtains open to the outside and by not having closed the room door for 1 of 1 randomly observed resident for privacy.	F000164	The facility does provide accommodations to ensure residents personal privacy and confidentiality of his or her personal and clinical records.LPN #3 was counseled regarding respecting the resident's rights by ensuring privacy during resident care.Education was provided 12/23/13 to all staff regarding	01/15/2014

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	(Resident #46, and LPN #3) Findings include: 1. On 12/12/13 at 11:58 a.m., LPN #3 was observed to not close the door nor close the exterior window blinds and curtains before giving an insulin injection to Resident #46. On 12/12/13 at 12:05 p.m., interview with LPN #3 when asked how could care for Resident #46 been done to provide privacy LPN#3 indicated, "Well I should have closed the door, and oh pull the curtains." 2. On 12/13/13 at 10:30 a.m., observed Resident #46's wound care being performed by LPN #3. exterior window blind and curtains were observed opened to the outside, during care. On 12/13/13 at 10:40 a.m., interview with LPN #3 when she was asked about how can privacy be provided for Resident #46 while doing wound care she indicated, "Pull shade down and keep [gender] covered more, close the curtains. Well she's got them blocked (meaning curtains blocked with candy cane lights hanging)." On 12/17/13 at 1:05 p.m., the DON		Resident's Rights to privacy. Those unable to attend are required to make up and have completed by 1/15/14. The facility Director of Nursing or designee will audit resident care area during routine normal care 5 random times per week over all 3 shifts, including weekends, for 4 weeks, then 2 random times per week over all 3 shifts, including weekends, for 4 weeks, then 1 random time per week over all 3 shifts, including weekends for 4 weeks, then 1 random time monthly over all 3 shifts including weekends for duration of 6 months monitoring. Audits will be continued based on QAPI review of any negative findings. Any negative findings from the audits will be reported to the facility Quality Assurance and Performance Improvement (QAPI) committee meeting monthly.	

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	(Director of Nursing) provided the Resident Rights under Federal Law dated January 2004, and indicated they have no policy for resident privacy and dignity. This was the one currently used by the facility. The DON indicated, " I don't believe we have anything specific." 3.1-3(o)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure a diagnosis for medications and failed to ensure a gradual dose reduction was completed as indicated by facility policy for 1 of 5 residents reviewed for unnecessary medications. (Resident #51) Findings include: On 12/12/2013 at 10:06 a.m., Resident #51's clinical record was	F000329	Facility does ensure resident's drug regimen is free from unnecessary drugs.Resident #51's clinical record was reviewed to ensure diagnosis for use of medications were present and updated the physician order summary on 12/12/13 to show diagnosis of Depression for Lexapro use and Acute CHF to support Lasix use. This residents' diagnosis for Lexapro was and is on residents' record as depression. Other resident records will be reviewed by 1-15-2014 to ensure compliance	01/15/2014

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	reviewed. Diagnosis included but were not limited to, adenoid mass, anemia, dementia with behaviors, diabetes mellitus stage 2, gastroenteritis/colitis, hypertension hypothyroidism, chronic kidney disease, and transient cerebral ischemia. The MDS (Minimum data set) assessment dated 9/24/2013 indicated, Resident #51's BIMS (Brief Interview of Mental Status) indicated, a score of 4 out of a scale of 0-15. This score indicated, Resident #51's cognitive ability was severely impaired. Medications included but were not limited to: furosemide 40 mg by mouth two times a day. (diuretic medication to treat congestive heart failure) Lexapro 10 mg by mouth daily for depression. (anti-depressant used to treat depression) Medication start date was 8/20/2013. Physicians order dated 12/09/13 indicated, Resident #51 had change in Lexapro from 10 mg daily to 15 mg daily. risperidone 0.5 mg 1 tablet by mouth at bedtime, for dementia with		of documented diagnosis and gradual dose reductions. Facility has reviewed attending physician response regarding gradual dose reduction (GDR) with facility medical director. Medical director will discuss with attending physicians the need to document reason why declining any requested GDR. If physician fails to document a reason declining a recommendation, they will be contacted again by the Director of Nursing. If they do not respond then she will contact Medical Director for clarification and confirmation in regards to recommendation.The facility Director of Nursing or designee will review physician order summaries and resident medical records monthly for 3 months to ensure diagnoses to support medication usage are documented.The facility Director of Nursing or designee will audit all pharmacist requests to physicians for GDR monthly for 6 months to ensure documentation and/or orders are received. Continued audits will be based on QAPI review of any negative findingsNegative findings from the audits above will be reported to the facility Quality Assurance and Performance Improvement (QAPI) committee meeting monthly.	

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	behaviors. (anti-psychotic used to treat anxiety) Medication start date was 12/06/2012. A physicians progress noted dated 11/22/13, indicated Resident #51 was being treated for congestive heart failure (CHF). The clinical record lacked documentation for diagnosis of CHF (congestive heart failure), and depression. On 12/12/2013 at 10:37 a.m., an interview with the DON (Director of nursing) indicated, Resident #51's clinical record lacked documentation of diagnosis of CHF and depression. The DON indicated, she would fax the physician for diagnosis to be added. On 12/12/2013 the facility faxed the physician a request for additional diagnosis of depression for use of Lexapro, and the diagnosis of congestive heart failure for use of furosemide. The facilities "Psychoactive Medication Behavior Monitoring Record,"for Resident #51 indicated the resident had taken Risperdal and the targeted behaviors were anxiety and agitation, possible side effects			

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	were listed. The record indicated: October, November, and December of 2013 Resident #51 had no side effects for use of Risperdal. Resident #51 had increased anxiety on December 4, 5, 6, 7, 8, 9, and 10th. Resident #51 had increased agitation on December 4, 5, 7, 8, 9, and 10th. On 12/12/13 at 10:37 a.m., an interview with the DON (Director of Nursing) indicated, she keeps a file of all GDR's (gradual dose reduction) in her office and she tracks the use of psychoactive medication with "Psychoactive and Sedative/Hypnotic Utilization Trends." She provided a copy of this tool and all GDR's for the facility at that time. Review of the GDR indicated, an evaluation of the Antipsychotic medication was sent on 6/2013, 7/2013, and 12/03/13. On 7/2013 a GDR was denied for Resident #51 by her physician, no indication for denial. On 12/11/2013 her physician denied GDR request sent by facility, no indication for denial. No GDR was sent in March of 2013 three months after risperidone began. On 12/13/13 at 10:45 a.m., the facility policy "Medication Monitoring and			

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	Management", dated 8/2010, was provided by the DON. The policy indicated, "9)...a. Antipsychotics. If a resident is admitted on an antipsychotics medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated...." 3.1-48(b)(2)			

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F000371 SS=F	483.35(i) FOOD PROCURE, 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 1.) Based on observation, interview, and record review, the facility failed to maintain a clean dry storage area and failed to ensure proper handwashing in the kitchen. This had the potential to impact 46 out of 46 residents that are served from the kitchen. (Cook #1) 2.) Based on observation, interview, and record review, the facility failed to ensure staff used proper handwashing in the main dining room, in that the staff was observed not to wash their hands as indicated by facility property. This deficient practice had the potential to affect 22 out of 22 residents being served in the main dining room. (LPN #1) Findings include: 1A) On 12/10/2013 at 11:30 a.m., an observation of the dry storage in the kitchen indicated, five containers storing dried goods were covered with	F000371	The facility does procure food from approved sources based on Federal, State and Local authorities and does store, prepare and distribute food under sanitary conditions. 1A.The outside of the container identified in dry storage area was cleaned of koolaid dust immediately when noted 12/11/13.1B. Cook #1 was counseled regarding washing of hands as indicated by facility policy. 2. LPN#1 was counseled regarding washing of hands as indicated by facility policy. The cleaning schedules for storage areas were reviewed by Dietary Manager and she will review with all dietary staff by 1/8/14.Education including return demonstration if indicated will be provided to all staff on or before 1/15/14 regarding the facility policy and procedure for proper hand washing. The facility will continue to orient new staff to facility hand washing policies and continue to include return demonstration to ensure skill competency.Dietary Manager will audit Food Storage and kitchen & dining room hand sanitation 5 times a week ,at random meals	01/15/2014

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	dried particles. A purplish dried substance was on one of the containers. On 12/11/2013 at 11:10 a.m., an observation of dry storage area in the kitchen indicated five containers storing dried goods were covered with dried particles. A purplish substance was on one of the containers. 1B) On 12/11/2013 at 11:35 a.m., an observation of Cook #1 handwashing in the kitchen indicated, she washed her hands for 15 seconds. At that time an interview with the Cook #1 indicated, she didn't know the time for handwashing. She indicated, she sings the happy birthday song. Cook #1 was standing in the kitchen waiting to serve the residents lunch. On 12/16/2013 at 9:53 a.m., the facility policy "HAND HYGIENE: WHY, HOW, & WHEN?", was provided by the DON. The policy indicated, "What is the right way to wash your hands?...Continue rubbing your hands for at least twenty seconds. Need a timer? Hum the 'Happy Birthday' song from beginning to end twice..." 2.) Observation of the main dining		and on weekends for 4 weeks, then 2 times a week at random meals, including weekends for 4 weeks then 1 time a week at random meals, including weekend for 4 weeks then 1 time every other week for 12 weeks to ensure continued compliance. Continued audits will be based on QAPI review of any negative findings Negative findings from audits will be reported to the facility Quality Assurance and Performance Improvement (QAPI) committee monthly meeting.	

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	room on 12/10/2013 at 12:20 p.m., indicated Resident #46 was being assisted with his meal by LPN #1. LPN # 1 assisted Resident #46 several times by using a utensil and then scratched the back of her neck. LPN #1 was not observed to wash her hands. She assisted Resident #46 again and then assisted Resident #54 with turning his lunch plate. LPN #1 assisted Resident #46 again and helped him with the rest of his meal. LPN#1 was observed not to wash her hands during the meal, nor did she use hand gel. Interview on 12/10/2013 at 1:00 p.m., when asked when she should wash hands, LPN #1 indicated, "You are suppose to wash your hands for 20 seconds and between each resident." Interview on 12/12/2013 at 10:00 a.m., with DON indicated she has self study sheets that she puts up in all the staff bathrooms and in the break room. The DON indicated, "We have yearly inservices, but the Hand Hygiene paper is something they can look at on their breaks and in the bathrooms all the time." On 12/12/2013 at 10:17 a.m., the DON provided Hand Hygiene: Why, How & When, undated, and indicated			

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	it was the one currently being used by the facility. The policy indicated "... 1. Before touching a patient...When? Clean your hands before touching a patient when approaching him/her... 4. After touching a patient... 5. After touching patient surroundings... a) After an activity involving physical contact with the patients immediate environment... b) After a care activity..." 3.1-21(i)(3)			

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F000431 SS=E	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 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. 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. 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. 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. Based on observation, interview, and record review, the facility failed to ensure that medications being used had a label with documented resident	F000431	The facility does obtain services of a licensed pharmacist. Drugs and biological used in the facility are labeled in accordance with currently accepted professional	01/15/2014

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	names and a documented open date for multi use vials for 3 of 4 medication carts observed. (Medication Cart 300 rear hall, Cart 300 front hall, & Cart 200 hall) Findings include: During observation of medication carts on 12/11/13 at 1:30 p.m., LPN #2 indicated the following medication bottle/tubes did not have a documented resident name/open date affixed to them. LPN #2 also indicated, "We don't have to label bottles, because the box has a label on it." When asked how can you identify whom the medication belongs to without a resident's name, LPN #2 indicated "I can't, but that won't never happen." 1). Medication cart 300 hall rear: Resident #2's Lantus (used to treat diabetes) was observed to be open, without a documented open date. The Lantus was filled on 11/4/13. There was no documented resident name on the label. Novolog (use to treat diabetes) was observed to be open, without a documented open dated. The Novolog was filled on 11/4/13.		principles'… … and the expiration date when applicable.Resident #2's Lantus and Novolog were discarded and replaced during survey process.Resident # 34's Calcitonin, secondary label indicating resident name affixed during survey process after discussing with facility pharmacistResident # 64's Combivent respimat inhaler, secondary label indicating resident name affixed during survey process after discussing with facility pharmacistResident #9's Lantus and Novolin R. Lantus was delivered 11/27/13 therefore open date of delivery date as indicated affixed during survey process. Novolin R was dated 11/26/13, this was added to bottle during survey process after discussing with facility pharmacist.Resident #53's Lantus did have open date on box, added open date to bottle during survey process after discussing with facility pharmacist.Resident #51's artificial tears ophthalmic drops had secondary label affixed indicating her name during survey process after discussing with facility pharmacist.Resident #46's Lantus and Novolog did have open dates on boxes, added open date to bottles during survey process after discussing with facility pharmacistResident #30's Apidra insulin was discarded and replaced during survey	

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	Resident #34's calcitonin salmon nasal solution (used for treatment of osteoporosis in women) was observed to have no resident label on it. Resident #64's combivent respimat inhaler (used for treatment of COPD (Chronic Obstructive Pulmonary Disease) was observed to have no resident label on it. 2). Medication Cart 200 hall: During an observation on 12/11/13 at 2:00 p.m., LPN #3 indicated, the following medication bottle/tubes did not have a documented resident name/open date affixed to them. LPN #3 when asked if the medications were out of the box how would you identify whom it belonged to she indicated, "I couldn't tell who it belonged to or when open." Resident #9's Lantus (used to treat diabetes) was observed to be open, without a documented open dated. The Lantus was filled on 11/27/13. Novolin R (use to treat diabetes) was observed to be open, without a documented open dated. The Lantus was filled on 11/6/13. Resident # #53's Lantus (used to		process.An audit of all medications concluded there were no other concerns identified.The facility licensed nurses will have completed by 1/10/13 reeducation in regards to label/date on any bottle/tube of medication when item is first used/opened.The facility's primary pharmacy has been contacted and will be attaching a label to the bottle/tube prior to delivery to facility.The facility Director of Nursing or designee will audit all carts for bottle/tubes of medications for label documenting resident name being affixed to medication bottle/tube and for date opened 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly x 4 weeks and then monthly for 3 months to ensure compliance. Continued audits will be based on QAPI reviews of negative findings.Negative findings will be reported to the facility QAPI committee monthly meeting.	

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	treat diabetes) was observed to be open, without a documented open dated. The Lantus was filled on 11/06/13. Resident #51's artificial tears (used to moisten eyes) was observed to have no resident label on it. 3). Medication Cart 300 front During observation on 12/11/13 at 2:30 p.m., LPN #3 indicated, the following medication bottle/tubes did not have a documented resident name/open date affixed to them. LPN #3 when asked if the medications were out of the box how would you identify whom it belonged to indicated, "That won't happen, I wouldn't know." Resident #46's Lantus (use to treat diabetes) was observed to be open, without a documented open dated. The Lantus was filled on 11/4/13. Novolog (insulin) was observed to be open without a documented open dated. The Novolog was filled on 10/8/13. Resident #30's apidra (insulin) was observed to be open, without a documented open dated. It was filled on 11/5/13.			

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	On 12/16/13 at 2:45 p.m., interview with ADM (Administrator) indicated, " Nurses are not allowed to put labels on medications, they never have. The pharmacist put the labels on the boxes and bottles, except for Lantus and calcitonin. Those boxes come unopened. We don't label those, because the box is labeled." When asked who documents the open dates, the ADM indicated, "Well the nurses are suppose to mark when they open the medicine." On 12/16/13 at 3:20 p.m., the ADM provided General Guidelines for Insulin Administration undated but copyright 2001 and indicated, the guideline was the one currently used by the facility. Review of the guideline indicated, "... Insulin may be kept at room temperature for 30 days from the date opened. Always time and date a vial when it is first opened." 3.1-25(j) 3.1-25(k)(1)			

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F000441 SS=D	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F000441	The facility does have an Infection Control Program	01/15/2014

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	Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed related to hand washing during patient care as indicated by the facility policy. This deficient practice had to potential to affect 1 out of 1 residents observed. (Resident #46) (CNA #3) Findings include: During observation on 12/13/2013 at 10:30 a.m., CNA # 3 entered the room after knocking and then donned gloves. CNA #3 was not observed to wash her hands before putting on her gloves. She proceeded to assist with the care of Resident #46. changed his soiled brief and repositioned him. CNA # 3 was observed to grab the top pillow from a stack of three pillows on a chair to put in between the resident's knees. LPN #3 instructed CNA #3 that she would have to change the pillow and pillow case, because it was now soiled. CNA #3 pulled the pillow case off the pillow, without changing her gloves and put the pillow on top of a pile of pillows with pillow cases. CNA #3 went to bathroom and retrieved a trash bag. Interview with LPN #3, at that time, indicated when asked what is wrong		designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. C.N.A. #3 was counseled regarding washing hands as indicated by facility policy.Education with return demonstration will be provided to the nursing department regarding the facility policy and procedure for proper hand-washing on 1/8/14 with completion of all nursing staff by 1/15/14.Hand washing education will continue to be reviewed with new staff and validation of skill competency will be completed during orientation process.Facility Director of Nursing or designee will observe proper hand washing during direct care , 10 times per week at random times across all 3 shifts and weekends for 4 weeks, then 5 times per week at random times across all 3 shifts and weekends for 4 weeks, then 1 time weekly across all 3 shifts and on weekends for a duration of 6 months of monitorring to ensure compliance. Continued audit will be based on QAPI review of any negative findings.Negative findings will be reported to facility QAPI committee monthly meeting.	

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	with those other pillows, "I guess they are all soiled now." CNA #3 came back beside the bed and LPN #3 instructed her to get a bigger bag because all the pillows were soiled. CNA #3 was observed not to change her gloves. She retrieved a large bag and proceeded to put all pillows and pillow cases in a large bag. She tied the bag up and took off her gloves. She walked out of the room. When returning to the room, CNA #3 knocked, entered the room, donned on gloves and finished with the care of the resident. CNA #3 was not observed to wash her hands during the care of the resident. Interview on 12/17/2013 at 10:00 a.m., with CNA #3 indicated when asked when she should wash hands in regard to patient care, "When you enter a room and before you leave a room. You are suppose to wash hands for 20 seconds." Interview on 12/12/2013 at 10:00 a.m., with the DON indicated she has self study sheets, Hand Hygiene form, that she puts up in all the staff bathrooms and in the break room. DON indicated, "We have yearly			

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	inservices, but the Hand Hygiene paper is something they can look at on their breaks and in the bathrooms all the time." On 12/12/2013 at 10:17 a.m., the DON provided Hand Hygiene: Why, How & When, undated, and indicated it was the one currently being used by the facility. The policy indicated "... 1. Before touching a patient...When? Clean your hands before touching a patient when approaching him/her... 3. After body fluid exposure risk...When? Clean your hands as soon as the task involving an exposure risk to body fluids has ended (and after glove removal)*... d) After removing any form of material offering protection... 4. After touching a patient... 5. After touching patient surroundings... a) After an activity involving physical contact with the patients immediate environment... b) After a care activity... * NOTE: Hand hygiene must be performed in all indications described regardless of whether gloves are used or not." 3.1-18(l)			

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to maintain a clean dry storage area, and failed to ensure proper handwashing in the kitchen. This had the potential to impact 3 out of 3 residents served from the kitchen. (Cook #1) Findings include: 1) On 12/10/2013 at 11:30 a.m., an observation of the dry storage in the kitchen indicated, five containers storing dried goods were covered with dried particles. A purplish dried substance was on one of the containers. On 12/11/2013 at 11:10 a.m., an observation of dry storage area in the kitchen indicated, five containers storing dried goods were covered with dried particles. A purplish substance was on one of the containers. 2) On 12/11/2013 at 11:35 a.m., an observation of Cook #1 handwashing in the kitchen indicated, she washed	R000273	The facility does procure food from approved sources based on Federal, State and Local authorities and does store, prepare and distribute food under sanitary conditions. 1. The top of the container identified in dry storage area was cleaned of koolaid dust immediately when noted 12/11/13.2. Cook #1 was counseled regarding washing of hands as indicated by facility policy. The cleaning schedules for storage areas were reviewed by Dietary Manager and she will review with all dietary staff by 1/8/14. Education with return demonstration will be provided to all staff on or before 1/15/14 regarding the facility policy and procedure for proper hand-washing. Hand washing education will continue to be reviewed with new staff and validation of skill competency will be completed during orientation process.Dietary Manager will audit Food Storage and kitchen & dining room hand sanitation 5 times a week ,at random meals and on weekends for 4 weeks, then 2 times a week at random meals, including weekends for 4 weeks then 1 time a week at random meals, including	01/15/2014

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	her hands for 15 seconds. At that time an interview with the Cook indicated, she didn't know the time for handwashing, she indicated, she sings the happy birthday song. Cook #1 was standing in kitchen, waiting to serve residents lunch. On 12/16/2013 at 9:53 a.m., the facility policy "HAND HYGIENE: WHY, HOW, & WHEN?", was provided by the DON. The policy indicated, "What is the right way to wash your hands?...Continue rubbing your hands for at least twenty seconds. Need a timer? Hum the 'Happy Birthday' song from beginning to end twice..."		weekend for 4 weeks then 1 time every other week for 12 weeks to ensure continued compliance. Continued audits will be based on QAPI review of any negative findingsNegative findings from audits will be reported to the facility Quality Assurance and Performance Improvement (QAPI) committee monthly meeting.	