

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2016
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NAME OF PROVIDER OR SUPPLIER  MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 8, 9, 10, 11, and 12, 2016</p> <p>Facility number: 000493 Provider number: 155728 AIM Number: 100291300</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 6 Medicaid: 35 Other: 12 Total: 53</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on February 17, 2016</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan related to urinary tract infection (UTI) for 1 of 10 residents who meet the criteria for urinary tract infection, in a total sample of 17 residents reviewed for care plans. (Resident #1)</p> <p>Findings include:</p> <p>During an interview on 02/10/2016 at 9:26 A.M., Physical Therapy Assistant (PTA) #3 indicated Resident #1 was receiving physical therapy (PT) before</p>	F 0279	<p>Deficiency ID: F-279 Completion Date: 02/29/2016 Plan of Correction Text: 1. In-service was held 02/25/2016 with all nurses regarding updating resident's plan of care on an as needed basis. See attached #1. 2. All resident's have the potential to be affected. 3. A) The Policy and procedure for care plans was reviewed and revised. See attached #2. B) An acute plan of care for Resident #1 was initiated on 2/15/16 using the attached form. C) An Acute/Short Term Plan of Care form has been put into place to be used when a resident has an</p>	02/29/2016	

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	<p>and after the fall on 01/12/2016. PTA #3 further indicated the root cause of the resident's fall was related to increased weakness from a urinary tract infection (UTI).</p> <p>During an interview on 02/11/2016 at 2:12 P.M., Licensed Practical Nurse (LPN) #4 indicated Resident #1 had fallen on 01/12/2016 from weakness related to a UTI. LPN #4 further indicated she could not find a care plan related to the resident's UTI.</p> <p>During an interview on 02/11/2016 at 2:21 P.M., Registered Nurse (RN) #5 indicated the nursing staff were to initiate an acute care plan for a UTI when a resident had signs and symptoms of a UTI. RN #5 indicated an acute care plan was not completed for Resident #1 related to the recent UTI.</p> <p>During an interview on 02/11/2016 at 2:30 P.M., the Director of Nursing (DON) indicated an acute care plan was to be initiated for a resident with a new onset of signs and symptoms of a UTI. The DON further indicated a care plan for a UTI should have been completed for Resident #1.</p> <p>During an interview on 02/12/2016 at 9:51 A.M., the Minimum Data Set</p>		<p>acute diagnosis. The form will be reviewed and if necessary updated quarterly. See attachment #4. 4. Director of Nursing and MDS nurses will ensure the resident's care plans has been initiated according to the Policy and Procedure. DON/or designee will monitor on going using the APOC book. See attachment #5. Director of Nursing/MDS will in service annually on proper care planning. 5. Completion Date February 29th, 2016.</p>		

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F 0323 SS=D Bldg. 00	<p>(MDS) officer indicated the nurse whom received the physician's order was responsible to ensure the application of the care plan.</p> <p>The most recent significant change MDS assessment, dated 01/16/2016, indicated Resident #1 had a BIMS (Brief Interview of Mental Status) of 06, which indicated the resident was cognitively impaired. The diagnoses included, but were not limited to, urinary tract infection, Diabetes Mellitus, cerebellar stroke syndrome, and unsteadiness on feet.</p> <p>The clinical record for Resident #1 was reviewed on 02/11/2016 at 2:13 P.M. There were no UTI care plans for the acute/short-term or long term plan of care related to the urinary tract infection for Resident #1.</p> <p>3.1-35(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure an environment free of hazards related to improperly disposed of sharps for 2 of 6</p>	F 0323	Deficiency ID: F-323 Completion Date: 2/25/2016 Plan of Correction Text: 1. In-service was held 02/25/2016 to all staff regarding proper disposal of	02/25/2016	

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	<p>observations of sharps disposal.</p> <p>Findings include:</p> <p>1. During an observation on 02/10/2016 at 10:54 A.M., RN (Registered Nurse) #5 completed a blood sugar check on Resident #9. After completing the check, RN #5 disposed of the used lancet in the resident's trash can. A second used lancet was observed already in the trash can.</p> <p>During an interview on 02/10/2016 at 11:07 A.M., RN #5 indicated she was taught in school that lancets could be thrown away in the trash can because the needle retracted.</p> <p>During an interview on 02/10/2016 at 12:39 P.M., the Administrator indicated the lancets are supposed to be disposed of in the sharps container.</p> <p>During an interview on 02/11/2016 at 10:28 A.M., the DON (Director of Nursing) indicated lancets were considered sharps and should go in a sharps container.</p> <p>The (name brand) lancet box indicated, "...Dispose of the lancet in a suitable sharps container..."</p> <p>The current facility policy, titled "Blood</p>		<p>sharps, to ensure that the resident environment remains as free of accident hazards as is possible. See attached #1. 2. All residents and nursing staff have potential to be affected. 3. A) Policy and Procedure was revised. See attached #2. B) All staff will dispose sharps in a designated disposable sharp container. All full sharps containers will be sealed and be disposed of in proper container. 4. Director of Nursing will monitor and ensure staff disposes sharps properly and empties when needed ongoing. 5. Completion date: 02/25/2016</p>		

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	<p>Glucose Monitoring Procedure" and dated 9/05, was provided by the MDS (Minimum Data Set) Coordinator on 02/11/2016 at 10:16 A.M., and was reviewed at that time. The policy indicated, "...Discard the lancet and test strip in the sharps container..."</p> <p>2. During an observation on 02/11/2016 at 7:59 A.M., RN #9 administered two insulin injections to Resident #9. After completing the injections, the RN returned to the medication cart. RN #9 then put the used insulin needles into the sharps container by pulling down the protective cover that indicated the container was full, dropping the needles into the container, and letting the protective cover move back into the full position.</p> <p>During an observation on 02/11/2016 at 8:12 A.M., RN #9 administered medication, including an insulin injection, to Resident #4. Following the administration, the RN disposed of the insulin needle in the sharps container that had the protective cover up indicating the container was full.</p> <p>During an interview on 02/11/2016 at 10:28 A.M., the DON indicated sharps containers are supposed to be replaced when they were full and that more sharps</p>				

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F 0441 SS=E Bldg. 00	<p>should not be added to full container.</p> <p>During an interview on 02/11/2016 at 10:45 A.M., RN #6 indicated you should not put anything in a sharps container once the protective cover indicated the container is full.</p> <p>The current facility policy, titled "Sharps, Disposal of" and dated 7/2013, was provided by the Administrator on 02/10/2016 at 12:38 P.M. and was reviewed at that time. The policy indicated, "...Needles/sharps disposable containers will be sealed properly as indicated and disposed of in a biohazard box...Seal the needles/sharps disposable container when 3/4 full to full, according to directions on container..."</p> <p>3.1-45(a)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>				

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	<p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to 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 ensure proper infection control procedures were followed related to hand washing for 6 of 13 (Resident #'s 2, 4, 9, 28, 50, and 57) observations of hand washing during resident care and sanitization of glucometers for 1 of 3 observations of blood sugar checks. (Resident #18)</p> <p>Findings include:</p>	F 0441	Deficiency ID: F-441 Completion Date: 02/25/2016 Plan of Correction Text: 1. In service was held on 02/11/2016 and 02/25/2016 with all staff regarding infection control policy and procedures regarding hand washing/hand hygiene, personal protective equipment and cleaning glucometers. See attached #1. 2. All staff and residents have the potential to be affected. 3. A) The Policy and Procedures for hand washing, use of gloves, and equipment	02/25/2016

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	<p>1. During an observation on 02/08/2016 at 4:22 P.M., RN (Registered Nurse) #6 administered medication to Resident #28 and returned to the medication cart. Without washing her hands, RN #6 checked off Resident #28's medications in the computer and pulled the medications for Resident #2. The RN administered Resident #2's medications, returned the resident's inhaler to the medication cart, checked the medications off on the computer, and without washing or sanitizing her hands, prepared medications for Resident #50. RN #6 administered the medications to Resident #50, returned to the medication cart, checked the resident's medications off in the computer and left to retrieve a resident for medication pass. The RN did not wash or sanitize her hands between each medication pass.</p> <p>During an observation on 02/09/2016 at 9:54 A.M., CNA #7 sneezed into his cupped hands. The CNA then used hand sanitizer, retrieved a pillow from the linen room, and placed it behind Resident #57.</p> <p>During an observation on 02/10/2016 at 10:54 A.M., RN #5 checked Resident #9's blood sugar. After removing her gloves and without washing or sanitizing her hands, the RN returned to the</p>		<p>cleaning were reviewed and revised. See attached. B) All staff will follow the guidelines related to prevention of the spread of contagious, infectious or communicable diseases. Facility will do yearly infection control in service and will monitor staff performance, on going. 4. Director of Nursing/designee will monitor staff performance of infection control policy, daily ongoing. 5. Completion Date February 25th, 2016.</p>	

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	<p>medication cart, prepared the resident's insulin, donned gloves, administered the insulin, removed her gloves, and washed her hands appropriately.</p> <p>During an observation on 02/11/2016 at 7:59 A.M., RN #9 prepared insulin for Resident #9 in two needles, answered a phone call at the nurse's station, entered the resident's room, donned gloves, administered the first dose of insulin in the resident's stomach, removed her gloves, donned new gloves, administered the second dose of insulin in the opposite side of the resident's stomach, removed her gloves, wheeled Resident #9 into the main living area by the nurse's station, disposed of the two used insulin needles, rolled up her sleeves, and touched the medication cart computer. The RN then prepared medications for Resident #4, administered the medications to the resident using a spoon, washed her hands for 15 seconds, donned gloves, administered insulin to the resident, removed her gloves, used hand sanitizer, and disposed of the insulin needle in the sharps container.</p> <p>During an interview on 02/11/2016 at 10:28 A.M., the DON indicated hands were supposed to be washed or sanitized between each residents' medication administration. She further indicated</p>			

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	<p>hands should be washed if you sneeze into them.</p> <p>During an interview on 02/11/2016 at 10:45 A.M., RN #6 indicated hand sanitizer should be used between each resident during medication pass. Hands should be washed after administering insulin and if gloves were worn. RN #6 further indicated hands should be washed after coughing or sneezing and hands should be washed for at least 20 seconds.</p> <p>The current facility policy, titled "Personal Protective Equipment - Gloves" and dated 5/2012, was provided by the MDS (Minimum Data Set) Coordinator on 02/11/2016 at 10:16 A.M. and was reviewed at that time. The policy indicated, "...Gloves must be worn when handling blood...Wash your hands after removing gloves..."</p> <p>The current facility policy, titled "Handwashing/Hand Hygiene" and dated 5/2014, was provided by the MDS Coordinator on 02/11/2016 at 10:16 A.M. and was reviewed at that time. The policy indicated, "...7. Hand hygiene is always the final step after removing and disposing of personal protective equipment... 8. The use of gloves does not replace handwashing/hand hygiene..."</p> <p>The current facility policy, titled "How to</p>				

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	<p>Handwash?" and dated 5/2009, was provided by the MDS Coordinator on 02/11/2016 at 10:16 A.M. and was reviewed at that time. The policy indicated, "...Duration of the entire procedure: 40-60 seconds..."</p> <p>2. During an observation on 02/10/2016 at 10:43 A.M., QMA (Qualified Medication Aide) #10 gathered supplies to check a Resident's blood sugar. After checking the resident's blood sugar, the QMA set the glucometer on the medication cart, washed her hands appropriately, pulled testing supplies from the medication cart, picked up the used glucometer, and walked into Resident #18's room. The QMA set the glucometer on the resident's bedside dresser, sanitized her hands, donned gloves, and picked up the glucometer. The process was interrupted prior to QMA #10 checking Resident #18's blood sugar.</p> <p>During an interview on 02/10/2016 at 10:46 A.M., QMA #10 indicated she had not sanitized the glucometer between resident use, but she should have. She further indicated she was supposed to use a sanitizing wipe and allow the glucometer to air dry until it was no longer wet.</p>			

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	<p>During an interview on 02/10/2016 at 10:54 A.M. RN #5 indicated glucose monitors were supposed to be sanitized between each resident and that the monitor should be left to air dry for two minutes.</p> <p>The current facility policy, titled "Cleaning and Disinfection of Resident-Care Items and Equipment" and dated 7/2013, was provided by the Administrator on 02/10/2016 at 12:38 P.M. and was reviewed at that time. The policy indicated, "...Reusable resident care equipment will be decontaminated and/or sterilized between residents according to the disinfectant manufacturer instructions. (e.g. glucometers.)..."</p> <p>The manufacturers instructions for the (name brand) blood glucose meter was provided by the DON on 02/10/2016 1:01 P.M. and was reviewed at that time. The policy indicated, "...Disinfecting can be accomplished with an EPA-registered disinfectant detergent or germicide that is approved for healthcare settings...blood glucose meters need to be cleaned and disinfected after each use for individual resident care..."</p> <p>3.1-18(l)</p>				

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F 9999  Bldg. 00	<p>3.1-14 PERSONNEL</p> <p>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>(u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>Based on record review and interview the</p>	F 9999	<p>Deficiency ID:F-9999 Completion Date: 03/04/2016 Plan of Correction Text: 1. Staff responsible for new hire employees was oriented on the screening of prospective employees and scheduling of Dementia in-service for new hires. 2. Policy and procedure on background screening has been revised to reflect utilization of check off form attached #1. 3. Administrator and/or Director of Nursing will monitor that all background screenings are done per policy, see attached #1, with each new hire. 4. All potential new employees have the potential to be affected. 5. Completion Date 2/25/16</p>	02/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2016
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NAME OF PROVIDER OR SUPPLIER  MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
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	<p>facility failed to provide background checks in a timely manner for 4 of 12 employee records reviewed and failed to ensure appropriate Dementia training was provided within the required six month time frame following initial employment for 2 of 12 employee records reviewed. (Dietary Aides #1 and #2, and CNA (Certified Nurse Aide) #12, Housekeeper #13, Driver #14, and Dietary Aide #15)</p> <p>Findings include:</p> <p>1. Employee records were reviewed on 02/12/2016 at 10:30 A.M. CNA #12 was hired on 02/03/2016, Housekeeper #13 was hired on 02/03/2016, Driver #14 was hired on 12/30/2015, and Dietary Aide #15 was hired on 01/20/2016, did not have the required background checks completed.</p> <p>During an interview on 02/12/2016 at 12:39 P.M., Receptionist #16 indicated she thought the back ground checks had been submitted to the state for employees CNA (Certified Nurse Aide) #12, Housekeeper #13, Driver #14, and Dietary Aide #15 upon hire and was waiting to receive them from the state.</p> <p>Receptionist #16 contacted the state on 02/12/2016 and discovered the state had never received the back ground check</p>			

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	<p>applications. Receptionist #16 indicated she was informed by the state the background checks generally were sent to the facility within a week after filing the applications.</p> <p>During an interview on 02/12/2016 at 1:30 p.m., Receptionist #16 indicated she failed to follow up on the back ground checks.</p> <p>During an interview on 02/12/2016 at 2:32 P.M., the DON indicated she was not aware that staff did not have background checks completed.</p> <p>2. Employee records were reviewed on 02/12/2016 at 10:30 A.M. Dietary Aides #1, hired on 07/20/2015, and #2, hired on 07/27/2015, did not have the required Dementia Training completed.</p> <p>During an interview on 02/12/2016 at 2:00 P.M., the DON (Director of Nursing) indicated the 6 hour dementia training was last done on July 16, 2015. She further indicated staff should have had their 6 hour dementia training done within 6 months of hire.</p> <p>The current "Abuse Prohibition, Reporting and Investigation Policy and Procedure" with a revised date of 1/10, was provided by Human Resources on</p>			

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NAME OF PROVIDER OR SUPPLIER  MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037		
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	<p>02/12/2016 at 1:27 P.M. The policy indicated, "All the employees of Manderley Health Care Center will be screened during the hiring process by the use of 2 reference checks from previous places of employment and utilization of the Criminal Background Check procedure outlined in the Facility Policy and Procedure Manual."</p> <p>The current "Criminal History of Nurse Aides and Other Unlicensed Employees IC 16-28-13", from the Facility Policy and Procedure Manual was provided by Human Resources on 02/12/2016 at 1:27 P.M. The policy indicated, "Facilities must apply for a limited criminal history within 3 business days of employing a nurse aide or other unlicensed employee."</p> <p>The current policy on Dementia training was provided by Receptionist #16 on 02/12/2016 at 11:10 A.M. The policy indicated, "...staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment..."</p>				