

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 24, 25, 29, 30, July 1, 7, 8 2015</p> <p>Facility number: 012448 Provider number: 155785 AIM number: 201039500</p> <p>Census bed type: SNF: 13 SNF/NF: 42 Residential: 69 Total: 124</p> <p>Census payor type: Medicare: 17 Medicaid: 8 Private: 30 Total: 55</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on July 8, 2015. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before August 7, 2015. We respectfully request a desk review to substantiate 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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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, record review, and interview, the facility failed to ensure 1 of 3 residents, in a sample of 9 residents who met the criteria for accidents, was provided care in accordance with the care plan, in that, a care plan for falls indicated a resident was to have a fall mat at the bedside and a clip alarm attached to the resident while up in the chair. (Resident #5)</p> <p>Findings include:</p> <p>During an observation on 6/30/15 at 9:45 a.m., Resident #5 was observed to be lying in bed. An alarming floor mat was lying next to the bed but no fall mat was observed.</p> <p>During an observation on 6/30/15 at 11:48 a.m., Resident #5 was observed sitting in a wheelchair. A clip alarm was on the wheelchair but was not attached to the resident.</p> <p>The clinical record for Resident #5 was reviewed on 6/30/15 at 10:05 a.m.</p>	F 0282	<p>Resident #5 suffered no ill effects from the alleged deficiency. Resident's #5 clip alarm and fall mat were put in place and staff were in serviced on residents plan of care. All residents have the potential to be affected by the deficient practice and through alterations in processes and in servicing we will ensure development and implementation of all residents plan of care. An audit was completed of all residents with safety plans of care to ensure interventions were implemented accordingly. All Nursing staff were in serviced on following the resident plan of care in accordance with the CNA assignment sheet. Systemic change is that all resident records requiring plan of care updates for safety interventions will be brought daily to Morning Clinical Meeting. At that time, the resident profile and CNA assignment sheet will be updated and rerouted to the direct care staff. All nurse managers were in serviced on process of updating the plan of care regarding the circumstance prevention update, the resident profile and the CNA assignment sheet. Nurse</p>	08/07/2015

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	<p>Resident #5 had clinical diagnoses including, but not limited to, dementia, diabetes mellitus type 2 (two), renal insufficiency, frequent falls, aortic stenosis, congestive heart failure, hypertension, hypertrophied, right shoulder dislocation, and overactive bladder.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 4/22/15, indicated Resident #5 had a score of 5 out of 15, which indicated severe cognitive impairment.</p> <p>Resident #5 had a care plan for falls, dated 4/15/15 and reviewed on 5/4/15, which indicated the resident was to have a clip alarm on when up in the chair. The care plan, dated 6/20/15, further indicated the resident was to have a blue fall mat at the bedside.</p> <p>During an interview on 7/1/15 at 12:05 p.m., the DON (Director of Nursing) indicated the clip alarm was to be attached to the resident when up in the chair and a fall mat should have been next to the bed with the alarming floor mat on top of it.</p> <p>3.1-35(g)(2)</p>		<p>managers will perform random audits of residents with fall prevention plans to ensure that the resident profile and CNA assignment sheets coincide and that fall interventions are implemented as per plan of care.</p> <p>This will be conducted on 3 random fall risk residents 5x/week x one month, 3x/week x one month, 1x/weekly x one month then monthly x 3 months with results forwarded to QA committee monthly x 6 months and then quarterly thereafter for review and further suggestions/comments</p>	

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F 0441 SS=D Bldg. 00	<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 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread</p>			

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	<p>of infection.</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an Infection Control program to prevent the development and transmission of disease and infection in 2 (two) of 5 (five) residents observed receiving personal care, in that, handwashing and/or sanitization was not completed during care. (Resident #96, Resident #5)</p> <p>Findings include:</p> <p>1. During an observation on 7/1/15 at 9:18 a.m., CNA#1 (certified nursing assistant) and RN #1 were observed to be toileting Resident #96. After assisting the resident onto the commode, CNA #1 was observed to remove a wet brief from the resident. CNA #1 was observed to apply a clean brief on the resident. CNA #1 removed her gloves with no hand sanitization observed. CNA #1 was observed to wash Resident #96's buttocks and periarea and dry the resident. After providing pericare, CNA #1 was observed to assist RN #1 with standing the resident and pulling up the clean briefs and slacks prior to transferring the resident to the wheelchair. No hand sanitization was observed after providing</p>	F 0441	<p>Resident #96 and resident #95 suffered no ill effects from the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. Systemic change is an alteration in our processes and inservicing will ensure corrective actions to prevent the spread of infection are followed. CNA #1, CNA #2 and RN#1 have received directed inservicing on glove use, handwashing policy and infection control procedures when providing direct care. Nursing staff will be inserviced on proper handwashing and glove usage procedures to prevent the spread of infection. Nursing staff will have return demonstration of skills to prevent infection including handwashing and glove application/changing. Skills will be re-evaluated on an annual basis for competency. DHS/Designee will monitor direct resident care that includes handwashing/glove usage after care and techniques of all care provided 5 days/week x one month, 3x/week x one month, weekly x one month, monthly x 3 months, then quarterly thereafter.</p> <p>Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter. for review and further suggestions/comments.</p>	08/07/2015	

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	<p>the pericare.</p> <p>2. During an observation on 7/1/15 at 3:12 p.m., CNA #2 and CNA #3 were observed to take Resident #5 to the room to transfer the resident into bed. CNA #2 and CNA #3 were observed to wash their hands and apply gloves. After transferring the resident into bed, CNA #2 was observed to remove the resident's soiled, wet brief. CNA #2 obtained a wipe and wiped the resident's rectal area and buttocks. CNA #2 obtained a clean wipe and provided pericare to the resident. CNA #2 was observed to apply a clean brief and assist the resident to turn. No hand hygiene or glove changed was observed.</p> <p>During an interview on 7/1/15 at 9:27 a.m., CNA #1 indicated hands should be washed when going from dirty to clean.</p> <p>During an interview on 7/1/15 at 3:30 p.m., CNA #2 indicated he/she should have removed his/her gloves and washed his/her hands when going from a dirty area to a clean area when providing care.</p> <p>A policy titled, "Guideline for Handwashing/Hand Hygiene," dated 10/2004 and reviewed 8/2014 and obtained from the Adm (Administrator) on 7/7/15 at 2:15 p.m., indicated hands</p>			

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R 0000 Bldg. 00	<p>should be washed after removing gloves worn per Standard Precautions for direct contact with excretions resident equipment, mucous membranes, et cetera.</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>This visit was for a Residential Licensure Survey.</p> <p>Residential Census: 69</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a recertification/licensure survey review concluding on July 8, 2015. Please accept this plan of correction as the provider's	

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R 0272 Bldg. 00	<p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was served at a safe temperature, in that, food was temped too hot prior to the residents being served. This had the potential to affect all 28 (twenty-eight) residents on the Legacy unit. (Cook #1, Cook #2)</p> <p>Findings include:</p> <p>During an observation of the Legacy kitchen on 7/7/15 at 11:50 a.m., Cook #1 was observed to be placing Alfredo noodles with sauce into bowls for the residents on the Legacy unit. Cook #2 was observed to place the bowls onto trays and cover the bowls with plastic wrap. Cook #1 was observed to removed bowls of Sicilian vegetables that were covered with a clear wrap from the oven.</p> <p>During an interview on 7/7/15 at 11:55 a.m., Cook #1 indicated she had temped the foods approximately an hour earlier.</p>	R 0272	<p>credible aggregation of compliance effective on or before August 7 , 2015. We respectfully request a desk review to substantiate compliance.</p> <p>No residents were affected as a result of this alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing we will take corrective actions to ensure food is at the appropriate temperature of >135 degrees and remains palatable. Cooks #1 and #2 have received direct education on food temperatures and logging them. All dietary staff will be in serviced on food temperatures for both appropriate cooking and prior to serving. Systemic change will be to implement food temperature log that will record record two separate temperatures for each meal served: first temperature to be logged will record appropriate cooking temperature of prepared food for each meal and second temperature to be logged will ensure appropriate serving temperature immediately prior to serving each meal. DFS/Designee will monitor food temperature immediately prior to serving for one meal daily x 5</p>	08/07/2015

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	<p>The temperatures of the foods were as follows: Alfredo sauce: 194 degrees F (Fahrenheit) Alfredo noodles: 197 degrees F Sicilian vegetables: 203 degrees F Cook #1 indicated the Alfredo sauce and noodles were placed together and placed onto the stove top on low and the vegetables were placed into the oven at 200 degrees F. Cook #1 indicated she did not retemp the food prior to serving it to the residents.</p> <p>Upon query, Cook #2 indicated meats should be served at a temperature between 165 degrees F and 169 degrees F and vegetables should be served at a temperature between 135-145 degrees F. Cook #1 indicated she was not certain what the temperatures should be for the food. Upon further query, Cook #1 and Cook #2 indicated they did not know what to do if foods were too hot.</p> <p>During an interview on 7/7/15 at 12:30 p.m., the Adm (Administrator) indicated the temperature of the food was too hot for the residents and the food should be temped prior to serving.</p> <p>A policy titled, "Food Temperature - Serving Line," dated 7/20/13 and obtained from the DON (Director of</p>		<p>days x one month, then 3 x week x one month, then weekly x one month, then monthly x 3 months, then quarterly. Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.</p>	

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R 0414 Bldg. 00	<p>Nursing) on 7/8/15 at 11:50 a.m., indicated temperatures of food were to be taken prior to service.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) 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>Based on observation, interview, and record review, the facility failed to ensure the infection control program was maintained to prevent potential infections of residents who are in the dining room, in that, handwashing or sanitization procedures were not completed as necessary. This had the potential to affect all 28 residents who ate in the dining room on the Legacy (an Alzheimer's unit) unit. (Legacy Director, RCA (Resident Care Assistant) #1, Resident #120 , Resident #121)</p> <p>Findings include:</p> <p>During an observation on 7/7/15 at 11:43 a.m., the Legacy Director was observed to be delivering plates and silverware to resident's dining tables. Legacy Director</p>	R 0414	<p>Resident #121 and resident #120 suffered no adverse effects by the alleged deficient practice.</p> <p>All residents have the potential to be affected by the alleged deficient practice. Systemic change will include alteration in processes and in servicing will ensure corrective actions to prevent spread of infection are followed.</p> <p>Legacy Director and CNA #4 have received directed in-service on glove use, hand washing policy and infection control procedures.</p> <p>Legacy staff will be in serviced on proper hand washing and glove usage procedures to prevent the</p>	08/07/2015

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	<p>was observed to hand some of the services to Resident #120 and Resident #121 to deliver to the tables also. The Legacy Director was observed to be moving dining room chairs from one table to another in between delivering the plates and silverware to Resident #120 and Resident #121 and the tables. The director was observed to assist residents from one chair to another. No handwashing or sanitization was observed by the Legacy Director or the residents.</p> <p>During an observation on 7/7/15 at 12:15 p.m., CNA #4 was observed to be delivering Sicilian vegetables to the residents on the Legacy unit. CNA #4 was observed to move his hand up and down the handle of the scoop and also was observed to use his serving hand to wipe his face. No handwashing or sanitization was observed.</p> <p>During an interview on 7/8/15 at 11:03 a.m., the Legacy Director indicated hands should be washed and/or sanitized between resident contacts and prior to distributing the plates and silverware. The director indicated the residents who assisted with delivering the plates and silverware to the tables had not sanitized yesterday prior to delivering them. The director further indicated hands should be</p>		<p>spread of infection during meal service.</p> <p>Legacy staff will have return demonstration of skills to prevent infection including hand washing and glove application/changing. Skills will be re-evaluated on an annual basis for competency.</p> <p>DHS/Designee will monitor meal service that requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice 5x/week x one month, 3x/week x one month, weekly x one month, monthly x 3 months, then quarterly.</p> <p>Results of audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.</p>	

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	<p>washed and/or sanitized if you touch your body.</p> <p>A policy titled,"Guidelines for Handwashing/Hand Hygiene," dated 10/2004 and reviewed 8/2014, was received from the Administrator on 7/7/15 at 2:15 p.m., indicated residents should be given assistance to wash their hands and health care workers should wash their hands after having contact with residents and resident equipment. The policy further indicated health care workers should wash their hands after smoking, toileting, blowing nose, coughing, sneezing, et cetera.</p>			