

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
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NAME OF PROVIDER OR SUPPLIER  CHATEAU OF BATESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 CHATEAU BLVD BATESVILLE, IN 47006
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 18 &amp; 19, 2014</p> <p>Facility number: 006489 Provider number: 006489 AIM number: N/A</p> <p>Survey team: Julie Dover, RN-TC Rita Bittner, RN Tammy Forthofer, RN Angela Halcomb, RN</p> <p>Census bed type: Residential: 43 Total: 43</p> <p>Census payor type: Medicaid: 15 Other: 28 Total: 43</p> <p>Sample: 7</p> <p>This State Residential findings is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on June 27, 2014, by Brenda Meredith, R.N.</p>	R000000	<p>This Plan of Correction is neither an agreement nor an admission of wrong doing by this facility or its staff members. Rather, it is submitted for compliance purposes. The facility will be in substantial compliance with this plan of correction as of July 18, 2014 and requests paper compliance for this survey.</p>	
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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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R000414	<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 on observation and interview, the facility failed to ensure hand washing was performed before and after blood sugar testing for 1 of 1 residents reviewed for blood sugar testing. (Resident #8)</p> <p>Findings include:</p> <p>On 6/19/2014 at 11:15 a.m., LPN #1 was observed to perform a blood sugar on Resident #8. LPN #1 entered Resident's #8 room carrying blood sugar supplies and placed them down on the kitchen counter. LPN #1 donned a pair of disposable gloves, no hand washing or hand gel was observed. LPN#1 proceeded to obtain Resident #8's blood sugar and administered insulin as ordered. LPN #1 was observed to gather used supplies and carried them to nurses</p>	R000414	<p>a.) There were no residents affected negatively as a result of this noncompliance issue. b.) The facility has identified that all residents have potential to be affected by this noncompliance issue.c.) The measures to be put in place to ensure compliance for this issue going forward are: All care staff will be inserviced on proper hand washing and glove use policy. All care staff will show knowledge of procedure thru return demonstration. All new care staff will be trained during orientation to ensure consistency with this procedure. d.) The corrective action will be monitored by DON, who will conduct monthly practice reviews for 3 months to ensure consistency and compliance with appropriate hand washing and glove use procedure. Executive Director will verify monthly that training has</p>	07/18/2014

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	<p>station while still wearing the disposable gloves. LPN #1 removed disposable gloves in the nurses station and charted blood sugar results in Resident #8 MAR (medication administration record). No hand washing or hand gel use was observed to have been completed after LPN #1 removed the disposable gloves.</p> <p>During an interview on 6/19/14 at 11:32 a.m., The DoN (Director of Nursing) indicated that hand washing procedure for nursing staff was washing hands before and after glove use. Policy and Procedures are covered monthly with staff meetings. Gloves were to be removed prior to leaving residents room.</p> <p>On 6/18/14 at 12:20 p.m., the Administrator provided the policy and procedure for Hand Washing, dated February 2007. The policy indicated, but was not limited to, ..."You should wash your hands before and after client contact. Wearing gloves is necessary when you will be in contact with blood or body fluids. You must still wash hands before putting on gloves and after removing gloves...:</p> <p>"Gloves need to be changed after each client contact and disposed of in the trash...Hands need to be washed before and after wearing gloves..."</p>		<p>been completed and policy is being followed. After 3 months, 1-2 random return demonstration audits will be conducted by the DON and/or the Executive Director quarterly to ensure ongoing consistency and compliance. Care staff will sign inservice log to verify training conducted and completed. DON will provide audit results to ED for review and verification. e.) This corrective action will be initiated by 07/07/2014 and will be completed by 07/18/2014</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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