

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
--	--

(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
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 9, 10, 11, 12, & 13, 2012</p> <p>Facility number: 000162 Provider number: 155261 AIM number: 100284300</p> <p>Survey team: Rita Mullen, RN, TC Michelle Carter, RN</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 9 Medicaid: 48 Other: 18 Total: 75</p> <p>Sample: 15</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 17, 2012 by Bev Faulkner, R.N.</p>	F0000	Submission of this plan of correction shall not constitute or be construed as an admission by Williamsburg Health Care that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Williamsburg Health Care.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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			
F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to assess lung sounds for three residents receiving antibiotic treatment for upper respiratory infections. This affected 3 of 5 residents reviewed for antibiotic treatment of infections in a sample of 15. (Residents #31, 52, & 72)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #72 was reviewed on 4/11/21 at 9:45 A.M.</p> <p>Diagnoses for Resident #72 included, but were not limited to, congestive heart failure (CHF), chronic kidney disease and aortic valve stenosis.</p> <p>A Nursing Note, dated 3/8/12 at 4:45 P.M., indicated "Family in a very concerned about her cough. Asked to have lungs listened too [sic] and fax doctor for something....Listened to lungs and has good air movement in Upper [sic] and lower lungs but expiratory wheezes in lower lobes noted. Temp 97.4. C/O</p>	F0309	<p>F309- Provide Care/Services for Highest Well Being I. The antibiotic regimens for residents #31, #52, and #72 have been completed. Therefore, antibiotic follow up and lung assessments were not completed on said residents.II. As all residents could be affected by lack of lung assessments while receiving antibiotic treatment for upper respiratory infections, the following corrective action was taken:III. As a means to ensure ongoing compliance with the initial and periodic completion of accurate, standardized assessments of each resident's functional capacity, an initial audit was conducted to identify those residents with current concerns regarding lung assessments in conjunction with antibiotic follow up. Administrative nursing staff confirmed that assessments had been completed and any necessary measures taken, as warranted. Nursing staff received in-servicing on lung assessments such as lung sounds, wheezing, crackles, cough, etc. and antibiotic use follow up when an</p>	04/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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>[complains of] sinus drainage with weather changes...."</p> <p>A fax to the resident's physician, dated 3/8/12 (no time noted), indicated "... [increased] coughing, expiratory wheezes, sinus drainage, upper lungs clear....Family in & very concerned about cough; would like her to have something...." The Physician returned the fax on 3/9/12 (no time noted), and indicated Tripack (Zithromax, an anti-infective, one 500 mg (milligrams) tablet by mouth for three days).</p> <p>A Nursing note, dated 3/9/12 at 4:30 P.M., indicated "...initial dose of tripack 1 tab (tablet) 500 mg po (by mouth) given. No s/s (signs or symptoms) adverse reaction noted. Occasional np (non-productive) cough continues." There was no lung assessment regarding lung sounds.</p> <p>A Nursing note, dated 3/10/12 at 4:00 P.M., indicated "Atb (antibiotic) continues for URI (Upper Respiratory Infection). No s/s of adverse reaction to meds (medications) noted. No complaints voiced throughout shift."</p> <p>A Nursing note, dated 3/10/12 at 9:00 P.M., indicated "ATB cont (continues) DX (diagnoses) URI no AVR (adverse</p>		<p>antibiotic is initiated and continued assessments until the respiratory condition is resolved or the antibiotic is completed (whichever is the latter). Following the education, administrative nursing shall monitor daily on their scheduled days of work, reported change in condition and antibiotic initiation, including but not limited to upper respiratory infections and cough or congestion, and ensure that necessary assessment(s) is conducted accordingly. Should concerns be noted, necessary re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Director of Nursing or her designee.IV. As a means of quality assurance, results of continued monitoring and subsequent actions taken shall be reported to the Administrator on a weekly basis. Continued completion of necessary assessments and any corrective action(s) taken to ensure compliance will be reported to the Quality Assurance Committee on a quarterly basis.V. Evidence of the in-servicing is provided in Attachment A and Attachment B. Evidence of the audit is provided in Attachment C and evidence of the antibiotic use follow up monitoring is provided in Attachment D. Monitoring is being done on all antibiotic use follow up and comprehensive</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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>reaction) noted no c/o voiced."</p> <p>A Nursing note, dated 3/11/12 at 7:00 P.M., indicated "Last dose ATB given this pm [sic] DX URI no AVR noted thus far, no c/o s noted. Temp 98.1."</p> <p>A Fax to the resident's Physician, dated 3/12/12 (no time noted), indicated "Resident just completed a tripack but continues to have expiratory wheezes through out and what sounds like rubs in lower lobes. Could she have another round of ATB and cough syrup please?" The Physician returned the fax on 3/12/12 (no time noted), with the response, "You may send her to ER (emergency Room)."</p> <p>A Nursing Note, dated 3/12/12 at 6:30 P.M., indicated "Called ER. Resident was admitted to Hosp. with CHF and dyspnea (shortness of breath).</p> <p>During an interview with the Director of Nursing on 4/11/12 at 11:00 A.M., she indicated the staff should have written a lung assessment, if not in the nursing notes then on the "Clinical Monitoring Log for Acute Episodes."</p> <p>2. The clinical record for Resident #31 was reviewed on 4/9/2012 at 3:00 P.M.</p> <p>Diagnoses for Resident #31 included, but were not limited to, congestive heart</p>		<p>follow up and not just those related to upper respiratory infections or specifically lung sounds. The facility currently has no resident on an antibiotic for an upper respiratory infection. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F309.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
--	--

(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>failure, chronic obstructive pulmonary disease, insulin dependant diabetes mellitus, diabetic neuropathy, and renal impairment.</p> <p>An initial Minimum Data Set assessment, dated 2/12/2012, indicated a Brief Interview of Mental Status (BIMS) score of 15/15. A score of 13-15/15 indicates cognitively intact.</p> <p>The following paragraphs</p> <p>Nursing notes, dated 3/13/2012, indicated a Z-pak tripack (Zithromax, an anti-infective) be used to treat a loose, non-productive cough. Nursing notes dated 3/15/2012, indicated the Z-pak was completed on 3/15/2012. There was no prior documentation regarding signs or symptoms to indicate the need for a call to the physician or a physician visit.</p> <p>A nursing note, dated 3/14/2012 at 4:00 A.M., indicated, "ATB (antibiotic) continues per order. No adverse reactions noted...." There was no indication of a lung sound assessment.</p> <p>A nursing note, dated 3/14/2012 at 1:00 P.M., indicated, "ATB (antibiotic) continues for cough, no S/S (signs or symptoms) of adverse reaction noted...." There was no indication of a lung sound</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933		
(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>assessment.</p> <p>A nursing note, dated 3/15/2012 at 3:00 A.M., indicated, "ATB (antibiotic) continues per order. No adverse reactions noted... " There was no indication of a lung sound assessment.</p> <p>A nursing note, dated 3/15/2012 at 4:00 P.M., indicated, "...last dose of z-pak given..." There was no indication of lung sound assessments.</p> <p>Nursing notes, dated 3/16/2012 at 4:00 P.M., indicated, "Writer talked with office nurse et (and) received order for Omnicef (an anti-infective) 300 mg (milligram), one tab, BID (twice per day) for 10 days..." Prior nursing notes did not indicate assessments or complaints or reason for antibiotic treatment.</p> <p>Nursing notes, dated 3/16/2012 to 3/19/2012, indicated Resident #31 was being treated for an upper respiratory infection with the ATB (antibiotic). There was no indication of lung sound assessments.</p> <p>A nursing note, dated 3/20/2012 at 11:00 A.M., indicated, "ATB (antibiotic) continues for URI (upper respiratory infection). Lungs coarse.[sic] Occasional loose nonproductive cough noted...."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>A nursing note, dated 3/20/2012 at 8:00 P.M., indicated, "cxr (chest x-ray) negative for pulmonary disease but the PET (Positron Emission Tomography) scan did show left lower lobe infiltrate."</p> <p>Nursing notes, dated 3/21/2012 to 3/26/2012, indicated the resident continued antibiotic therapy. There was no indication of lung sound assessments.</p> <p>A nursing note, dated 3/26/2012 at 1:00 P.M., indicated, "ATB (antibiotic) completed for URI (upper respiratory infection), no s/s (signs or symptoms) of adverse reaction, no cough noted, no s/s (signs or symptoms) of respiratory distress." There was no indication of lung sound assessments.</p> <p>During an interview with the Administrator on 4/12/12 at 4:00 P.M., additional information was requested that pertained to lung sound assessments while Resident #31 was being treated for an upper respiratory infection. No additional information was provided.</p> <p>3. The clinical record for Resident #52 was reviewed on 4/12/2012 at 1:00 P.M.</p> <p>Diagnoses for Resident #52 included, but were not limited to, hepatitis, depression,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
--	--

(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>history of urinary tract infections, history of alcohol abuse, osteoporosis, and high blood pressure.</p> <p>A quarterly Minimum Data Set assessment, dated 3/7/2012, indicated a Brief Interview for Mental Status (BIMS) score of 15/15. A score of 13-15/15 indicates cognitively intact.</p> <p>A nursing note, dated 3/6/2012 at 4:30 P.M., indicated, "Writer called Dr. (name of physician) office, resident pale, T (temperature) 100.9, sinus drainage, cough, inc (incontinent) of urine, new order for Cefzil (anti-infective) 500 mg (milligram) times 7 days ordered...." There was no indication of prior signs/symptoms or lung sound assessments or reason for pharmacological therapy.</p> <p>A nursing note, dated 3/7/2012 at 1:00 P.M., indicated, "...ATB (antibiotic) continued for URI (upper respiratory infection), no s/s (signs or symptoms) of adverse reaction, no cough noted, no c/o (complaints of) sore throat." There was no indication of a lung sound assessment.</p> <p>Nursing notes, dated 3/7/2012 to 3/13/2012, indicated the continued treatment for upper respiratory infection with antibiotic. There was no indication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933		
(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>of lung sound assessments on those dates.</p> <p>A nursing note, dated 3/13/2012 at 1:00 P.M., indicated, "...ATB (antibiotic) completed for URI (upper respiratory infection), no s/s (signs or symptoms) of adverse reaction, no s/s (signs or symptoms) of respiratory distress." There was no indication of lung sound assessments.</p> <p>During an interview with the Administrator on 4/12/12 at 4:00 P.M., additional information was requested that pertained to lung sound assessments for Residents #31, 52 and 72 while being treated for an upper respiratory infection. No additional information was provided.</p> <p>3.1-37(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933		
(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	
F0441 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 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 of infection.</p> <p>Based on clinical record review and interviews, the facility failed to ensure a</p>	F0441	F441-Infection Control I. Please note that residents #19 and #23	04/20/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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>tuberculin skin test was administered annually to Resident #19 and failed to ensure a second step tuberculin test was administered to Resident #23. This affected 2 of 15 residents reviewed for tuberculin skin testing in a sample of 15. (Residents #19 & 23)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #19 was reviewed on 4/12/2012 at 9:15 A.M.</p> <p>Diagnoses for Resident #19 included, but were not limited to; quadriplegia, amyotrophic lateral sclerosis (a disease characterized by muscle weakness and muscle wasting), acute respiratory failure, insulin dependant diabetes mellitus, dysphasia, peripheral edema, and ventilator dependant.</p> <p>Review of the immunization record indicated Resident #19 was due for an annual PPD Mantoux test in September, 2011. There was no documented evidence the annual PPD was completed.</p> <p>During an interview with the Administrator, on 4/12/12 at 5:00 P.M., she indicated she was aware of the lack of an annual PPD Mantoux for Resident #19. She did not have an explanation as to why it was not administered.</p>		<p>were not negatively affected as a result of failure to administer the yearly PPD or second step PPD. Residents #19 and #23 received a tuberculin skin test immediately upon discovery of the issue.II. As all residents could be affected, the following corrective action was taken:III. As a means to ensure ongoing compliance with ensuring administration of appropriate two step tuberculin skin tests upon admission, annual tuberculin skin tests, or annual chest x-rays, all nursing staff received in-service training on tuberculin skin testing. Additionally an initial audit was conducted to identify those residents with current concerns regarding proper administration of a two step tuberculin skin test upon admission or an annual tuberculin skin test. For those residents found without a current PPD (tuberculin skin test), tuberculin skin testing was performed. Following education provided, observations shall be conducted a minimum of monthly to confirm continued compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Director of Nursing or her designee. IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>2. The clinical record of Resident #23 was reviewed on 4/12/12 at 1:00 P.M.</p> <p>Diagnoses for Resident #23 included, but were not limited to, high blood pressure and depression.</p> <p>A review of the immunization record on 4/12/12, indicated Resident #23 received a tuberculin (TB) skin test on 5/11/11. The results were read on 5/13/11, results were 0 millimeters (negative). There was no second step tuberculin skin test on the immunization form.</p> <p>During an interview with the facility Administrator, on 4/13/12 at 9:50 A.M., she indicated the second step TB skin test was not done, there was no record of it having been done.</p> <p>A Facility Policy for "Two-Step PPD (TB</p>		<p>Committee during quarterly meetings.V. Evidence of the in-servicing is provided in Attachment A and Attachment B. Evidence of the audit and subsequent monitoring is provided in Attachment E. Proof of administration of PPDs for Resident #19 and #23 are provided in Attachment F and Attachment G, respectively. Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F441.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>skin test) Policy-Procedure (no date), received from the facility administrator, on 4/13/12 at 12:00 P.M., indicated the following:</p> <p>"...iv. Read the skin test in 48-72 hours recording the measurement in millimeters (mm) on the immunization record....</p> <p>v. If the first step is negative the second step will be completed following the same procedure as above within 1 - 3 weeks...."</p> <p>3.1-18(d) 3.1-18(f)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933			
(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			
F0516 SS=E	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation and interview, the facility failed to ensure the door to 1 of 2 medical records offices was locked and medical record file cabinets were locked to prevent unauthorized use.</p> <p>Findings include:</p> <p>During the environmental tour with the Administrator and the Housekeeping Director on 4/10/12 at 9:30 A.M., the door to a medical records office located by Nursing Station 3, was found to be unlocked and unattended. Six of eight, four drawer file cabinets were not locked. There were 10 boxes of medical records setting on metal shelves. There were loose chart papers setting on the metal shelves.</p> <p>During an interview with the</p>	F0516	<p>F516 – Release Res Info, Safeguard Clinical Records</p> <p>I. Please note that no residents were negatively affected as a result of medical records staff failing to lock the office door.</p> <p>II. As all residents for whom records are maintained could be affected, the following corrective action was taken:</p> <p>III. As a means to ensure ongoing compliance with safeguarding clinical records automatic closing devices and automatic locking door handles were applied to the doors of both medical records offices. Medical records staff were in-serviced on the importance of ensuring that the doors were allowed to fully close upon exiting the office. Following education provided, observations of the medical records rooms shall be completed at least weekly to ensure</p>	04/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155261	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1609 LAFAYETTE RD CRAWFORDSVILLE, IN 47933		
(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>Administrator on 4/10/12 at 9:35 A.M., she indicated the door to that medical records office should have been locked and not left unattended.</p> <p>3.1-50(d)</p>		<p>continued compliance. Should concerns be noted, re-education and/or disciplinary action shall be taken as warranted. Monitoring for compliance will be conducted by the Administrator or her designee.</p> <p>IV. As a mean of quality assurance, results of the aforementioned monitoring and subsequent actions taken shall be reported to the Quality Assurance Committee during quarterly meetings.</p> <p>V. Evidence of the in-servicing is provided in Attachment H and I. Evidence of the monitoring is provided in Attachment J. Evidence of the automatic closers is provided in Attachment K, L, M, and N. Photos of the automatic locks are provided in attachment O (inside and outside) and attachment P (inside and outside). Due to the evidence provided, Williamsburg Health Care requests paper compliance on tag F516.</p>		