

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
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NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00169352.</p> <p>Complaint IN 00169352- Substantiated. Federal deficiencies related to the allegations are cited at F 441 and F315.</p> <p>Survey dates: April 6, 7, 8, 9, 10 & 13, 2015</p> <p>Facility number: 000106 Provider number: 155199 AIM number: 100266390</p> <p>Census bed type: SNF: 10 SNF/NF: 92 Total : 102</p> <p>Census payor type: Medicare: 8 Medicaid: 71 Other: 23 Total: 102</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>April 24th 2015 Dear Kim Rhoades, Please find the attached Plan of Corrections for the Health Recertification and State Licensure survey in conjunction with complaint survey #IN00169352 performed on April 6,7,8,9,10 and 13, 2015. The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. The facility requests the opportunity for a face to face IDR relating the citation F 314 in regards to the scope and severity level it was cited. Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</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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F 282 SS=D Bldg. 00	<p>Quality Review was completed by Tammy Alley RN on April 16, 2015.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 interview and record review, the facility failed to follow physician orders for insulin coverage for 1 of 2 residents reviewed for following physician orders for insulin coverage. (Resident #73)</p> <p>Findings include:</p> <p>Resident #73's record was reviewed on 4/13/15 at 2:37 p.m. Diagnoses included, but were not limited to, diabetes mellitus, chronic stage III kidney disease, and hypertension.</p> <p>A physician's order report dated 4/1/15 to 4/30/15, included, but were not limited to the following orders: 2/17/15--Novolog Flexpen insulin pen 100 unit/ml (milliliter) by sliding scale subcutaneous four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m. and 8:00 p.m. If BS (blood sugar) is less than 70 Call MD (physician)</p>	F 282	<p>F 282:</p> <p>#1: One resident was listed as being affected by thisdeficient practice. Resident #73 was listed as being affected by the deficientpractice. Per interview of staff Res #73 did receive the correct dose of insulin as prescribed by her physician. The nurse who entered incorrect documentation correctedhis entry to reflect the insulin that was administered accurately per interviewin the 25-67.</p> <p>#2: All residents that have physicians orders to be treatedwith insulin have the potential to be affected by this deficient practice. Afacility audit was performed by the DNS/Designee on or before 4.24.15 to ensurethat all Residents that receive insulin have orders from a physician regardingtheir specific needs, and insulin was despenced and documented per physicianorders.</p> <p>#3: Facility licensed staff were in-serviced by the</p>	04/24/2015			

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	<p>If BS is 70-99-give 0 units. If BS is 100-124-give 2 units. If BS is 125-149-give 3 units. If BS is 150-174-give 4 units. If BS is 175-199-give 6 units. If BS is 200-224-give 8 units. If BS is 225-249-give 9 units. If BS is 250-274-give 11 units. If BS is 275-299-give 12 units. If BS is 300-324-give 14 units. If BS is greater than 324, give 15 units. If BS is greater than 350, call MD.</p> <p>A "Diabetic Administration History" document dated 3/15/15 to 4/13/15, indicated dates and times the following Blood Glucose results with the documented amount of Novolog insulin was given: 3/18/15 at 4 p.m., the BS was 259. The resident received 12 units and should have received 11 units. 4/6/15 at 8 a.m., the BS was 252. The resident received 10 units and should have received 11 units. 4/13/15 at 8 a.m., the BS was 262. The resident received 10 units and should have received 11 units 4/4/15 at 12 p.m., the BS was 250. The resident received 10 units and should have received 11 units. 4/6/15 at 12 p.m., the BS was 277. The resident received 10 units and should have received 12 units</p>		<p>DNS/Designee on or before 4.24.15 in regards to ensuring that insulin medication administration is performed and documented accurately. The DNS/designee will perform audits daily to ensure that insulin administration is performed per physician order and documented accurately. The DNS/designee performed skills validations for med passes. #4: To ensure compliance, The DNS/Designee is responsible for the completion of the Insulin administration and documentation CQI audit tool weekly x 4 weeks, Monthly x 6 months, and the quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved an action plan will be developed to ensure compliance. #5: Date of compliance 4.24.15</p>	

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F 314 SS=G Bldg. 00	<p>During a phone interview initiated by the DNS (Director of Nursing Services) on her cell phone on 4/13/15 at 5:45 p.m., RN #2 indicated he gave the resident 11 units of insulin, but he documented 10 units. He indicated he knew there was no 10 units on the resident's insulin sliding scale and he should have documented 11 units. He indicated he documented these dosages on the MAR (Medication Administration Record) incorrectly.</p> <p>During an interview on 4/13/15 5:53 p.m., the DNS indicated she did not know why the nurses documented a different dosage of insulin than what the Physician had ordered.</p> <p>An insulin administration policy and procedure was requested on 4/13/15 at 6:30 p.m. A "Blood Glucose Monitoring" policy and procedure was provided on 4/13/15 by the DNS at 7:35 p.m. As of the exit conference on 4/13/15 at 8:25 p.m., no further information was provided.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of</p>			

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	<p>a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to have new pressure interventions in place to prevent worsening of a pressure ulcer from a Stage 2 to an unstageable ulcer (Resident C) and failed and ensure to ensure infection control procedures were followed to prevent the possibility for an infection for 1 of 3 residents. (Resident #137)</p> <p>Findings include:</p> <p>1. On 4/09/2015 at 2:34 p.m., the record review was completed for Resident C. Diagnoses included, but were not limited to, diabetes, venous insufficiency, stroke, and history of stasis ulcers.</p> <p>The admission nursing assessment dated 7/10/14, indicated the resident had a skin tear below right knee, many scratch marks on the lower right and left extremity and stomach and a scar on left knee. He had three open lesions (damage to skin), two lesions above the right</p>	F 314	<p>The facility wishes to request a face to face IDR in regards to citation F 314. The facility disagrees with the scope and severity of this citation. F 314 #1: Resident (C) and Resident #137 were identified as being affected by the deficient practice. In regards to Resident (C), The Resident no longer resides in the facility. In regards to Res #137, the Resident's dressing referenced was removed and replaced utilizing the proper infection control procedures to prevent the possibility of infection. #2 All residents that have a treatment order to a pressure ulcer have the potential to be affected by this deficient practice. All Residents that receive treatments to pressure ulcers will receive treatments utilizing the proper infection control procedures to prevent the possibility of infection. DNS/designee conducted skin sweeps on all residents to ensure all altered skin integrity was identified and proper treatments were in place for existing altered skin conditions. No issues were</p>	04/24/2015

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	<p>ankle, one lesion on the right hip.</p> <p>The physician's orders dated 8/25/14, indicated Roho cushion to the wheelchair and Roho overlay to the bed to promote wound healing. The physician's order dated 9/11/14, indicated daily multivitamin for 60 days for wounds.</p> <p>The nursing notes indicated, "...1/2/15 10:06 p.m. Requested order for reddened area on left buttock...."</p> <p>"...1/3/15 a staff from physician's office called back with regards to elevated lab...call with any other concerns...."</p> <p>"...1/4/15 2:13 a.m...reddened area on left glute blanches...."</p> <p>"...1/5/15 2:45 p.m...resident to have an open area to left gluteal fold, area is completely yellow slough [dead tissue separated from the surrounding living tissue]., measured 4 centimeters x 3.5 cm x 0.1 cm, resident has a ROHO overlay on bed and a ROHO cushion in his chair, staff has been using barrier cream...."</p> <p>"...1/6/15 10:27 a.m...Will continue Santyl [ordered on 1/5/15] with foam to resident's gluteal fold and resident is to be in bed between meals...."</p> <p>The wound events documentation indicated on 1/2/15 at 9:56 p.m., "... a reddened 1.5 centimeter(cm) spot on left buttock...." At that time it measured 1.5</p>		<p>identified. #3 Facility licensed staff will be in serviced by the DNS/Designee on or before 4.24.15 in regards to the ensuring that all pressure areas receive new interventions to prevent worsening and to perform all pressure area treatments are performed utilizing the proper infection control procedures to prevent the possibility of infection. The DNS/designee with perform rounds every shift to ensure that pressure area treatments are performed utilizing the proper infection control procedures to prevent the possibility of infection. DNS/designee conducted skills validation to ensure infection control protocols were followed for dressing changes. DNS/designee will review facility activity report daily to check for new or worsening skin events to ensure MD has been notified and new treatment orders have been obtained. #4: To ensure compliance, The DNS/Designee is responsible for the completion of the pressure wound prevention CQI audit tool and pressure wound infection control CQI audit tool weekly x 4 weeks, Monthly x 6 months, and the quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>cm x 1.0 cm and was a reddened area. The box was marked that the Physician, Nurse Practitioner and family were notified via fax at 10:40 p.m.</p> <p>On 4/13/15 at 10:20 a.m., the Executive Director provided a copy of the fax sent to the physician by LPN #1. The document was dated 1/2/14 and indicated, " May we use Calmoseptine (an ointment used to provide a physical moisture barrier keeping feces, urine and wound drainage from intact and injured skin) on 1.5 x 1.0 cm reddened area on left buttock...." The fax send report indicated the fax was sent 11:49 p.m., on 1/2/15.</p> <p>The Physician's orders dated 1/2/15, indicated, "...Chest x ray due to increased congestion, Lasix [a diuretic which rids body of excess water] 60 milligrams [mg] twice daily for lung congestion and Prednisone 40 milligrams [anti swelling agent] for three days, 30 milligrams daily for three days and then 20 milligrams daily for three days and then 10 milligrams daily for three days and then discontinue...."</p> <p>The Physician's orders dated 1/3/15 indicated, "... 20 milligrams of Lasix daily starting 1/5/15 and BNP [a lab to indicate heart failure...." There was no order</p>		#5: Date of Compliance 4.24.15	

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	<p>found regarding Calmoseptine cream.</p> <p>The Physician's orders dated 1/5/15,"... Clarification : discontinue Lasix 20 milligrams daily Resident to resume Lasix 40 milligrams twice daily for heart. Cleanse left gluteal fold with normal saline [NS], pat dry, apply Santyl [a wound debridement ointment that removed dead skin tissue] and cover with foam dressing change every day...."</p> <p>The wound events documentation indicated on 1/5/15, the resident had a left gluteal fold unstageable area that was existing and originally noted on 1/2/15, was unstageable and the most severe tissue type was slough. The area measured 3.5 x 4 cm x 0.1 cm. The wound was not cultured. The wound treatment order was Santyl covered with foam dressing daily for the treatment.</p> <p>The Physician's order indicated,"... 1/5/15 Cleanse left gluteal fold with NS, pat dry, apply Santyl and cover with foam dressing daily...." The order was discontinued 1/5/15 and restarted 1/6/15 and went through 1/27/15.</p> <p>During an interview on 4/13/2015 at 12:07 p.m., Nurse Practitioner (NP) #5 indicated, on 1/2/15, in her notes the resident was taking thin liquids and she</p>			

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F 315 SS=D Bldg. 00	<p>had given orders to increase Lasix. No other communication was noted from the facility at that time. She indicated that if she had seen the resident, there would be facility documentation in the physician progress notes. She indicated if the office had received a fax, the physician's office would have typed a return reply electronically and would have send it back to the facility so that it would be placed in the chart. She indicated there was no documentation in her notes regarding any skin concerns until 1/5/15.</p> <p>During an interview on 4/13/2015 11:10 a.m., The Executive Director (ED) indicated there was no documentation that the barrier creme was applied from 1/2/15 through 1/5/15. The ED indicated there was no physician's order for Calmoseptine and they could not find any other documentation of any other new interventions put into place after reddened area was noted on 1/2/15.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a</p>			

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	<p>resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure catheter care and incontinent care was provided and the catheter drainage bag and tubing were positioned in a manner to prevent the possibility of infection for 1 of 3 residents reviewed for incontinent and catheter care and urinary tract infections. (Resident E)</p> <p>Findings include:</p> <p>On 4/10/15 at 10:06 a.m., CNA #11 and NA #12 went into Resident E's room to complete ADL (Activity of Daily Living) care for him to prepare him for an appointment. CNA #11 pushed the mechanical lift into Resident E's room. CNA #11 donned clean gloves without washing her hands. NA #12 washed her hands and donned clean gloves. CNA #11 was observed providing incontinent care for Resident E and cleansing an incontinent BM (bowel movement) off him. After providing the incontinent care, she reached into the resident's bottom drawer of his night stand and obtained his urinal, then emptied his Foley drainage bag hanging on the bed frame without changing her gloves or</p>	F 315	<p>F 315</p> <p>#1 Resident (E) was identified as being affected by the deficient practice. In regards to Resident (E), his catheter bag, urinal, and catheter tubing were replaced using proper infection control procedures. Res(E)'s Broda chair, night stand drawers, and lift were also sanitized. Res (E)'s catheter bag was placed below his bladder after his care. CNA #11 was in-serviced regarding catheter and incontinence care on 4.10.15</p> <p>#2 All residents that have catheters have the potential to be affected by this deficient practice. All Residents that receive catheter and incontinence care will receive care utilizing proper infection control procedures to prevent infection. The DNS/designee will perform rounds every shift to ensure compliance.</p> <p>#3 All Nursing staff were in-serviced in regards to proper catheter care and incontinence care on or before 4.24.15. The DNS/designee will perform daily rounds to ensure that catheter care and incontinence care are performed utilizing proper infection control procedure to prevent infection. DNS/designee conducted skills</p>	04/24/2015	

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	<p>washing her hands in between the incontinent care and emptying the drainage bag. She emptied the urine then returned the urinal to the drawer and removed her gloves.</p> <p>During the dressing change at that time, CNA #11 was observed providing BM incontinent care for the resident in the middle of the nurse performing wound care. After the nurse completed the wound care, CNA #11 was observed assisting the resident to dress without changing her gloves or washing her hands. She placed Resident E's catheter drainage bag through his pant leg with the same gloves on she provided his BM incontinence care. CNA #11 brought the mechanical lift and Broda chair over towards his bed with the same gloves she provided BM incontinence care to him earlier. She removed her gloves and her hands were not washed. The resident was observed being transferred with the mechanical lift into his Broda chair. The resident's catheter bag was observed hanging on the guide bar of the mechanical lift at the level of the bladder during the transfer, it was above the level of the bladder when he was being lowered into the Broda chair.</p> <p>Resident E's record was reviewed on 4/10/15 at 4:00 p.m. Diagnoses included,</p>		<p>validation for all CNA's regarding incontinence care and catheter care.</p> <p>#4: To ensure compliance, The DNS/Designee is responsible for the completion of the catheter care CQI audit tool and the incontinence care CQI audit tool bi weekly x 4 weeks, Monthly x 6 months, and the quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved an action plan will be developed to ensure compliance.</p> <p>#5 Date of Compliance: 4.24.15</p>	

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	<p>but were not limited to, neurogenic bladder, urine retention and constipation.</p> <p>An "Infection Control Individual Report" dated 3/10/15, indicated the resident had a possible UTI (Urinary Tract Infection). Signs and symptoms of infection was milky white urine, penile pain/burning and fever (99.5). The report indicated the resident had an invasive device, which was a urinary catheter.</p> <p>A nursing progress note dated 3/11/15 at 2:27 a.m., indicated a urine sample was obtained and sent to the lab.</p> <p>A nursing progress note dated 3/22/15 at 1:46 p.m., indicated the final urine results indicated probable contamination noted. The physician was notified and no repeat urine was ordered due to the resident was symptomatic at that time.</p> <p>During an interview on 4/10/15 at 11:11 a.m., CNA #11 indicated she had not taken off her gloves and washed her hands after she washed the BM off Resident E's bottom either time, then she emptied the resident's catheter bag with the same dirty gloves. CNA #11 indicated the resident's catheter bag was hung on the guide bar of the mechanical lift during the transfer to the Broda chair and it was not below the resident's bladder.</p>			

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NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074		
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F 371 SS=E Bldg. 00	<p>At that time the Director of Nursing indicated CNA #11 knew she was suppose to change her gloves and wash her hands after providing incontinent care for a resident.</p> <p>This Federal tag relates to complaint IN 00169352.</p> <p>3.1-41(a)(2)</p> <p>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</p> <p>Based on observation and interview, the facility failed to serve food in a sanitary manner in the Moving Forward dining room for 2 of 25 residents observed receiving food being served. (Resident #10 and #13)</p> <p>Findings include:</p> <p>On 4/6/15 at 12:23 p.m., NA #10 was</p>	F 371	F 371 #1: Residents #10 and #13 were identified as being identified as being affected by this deficient practice. CNA #10 was in-serviced on 4.6.15 regarding proper infection control and the handling of resident food. #2: All residents have the potential to be affected by this deficient practice. All food will be served in a sanitary manner to residents. All staff were in-serviced in regards	04/24/2015	

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	<p>observed serving residents in the Moving Forward dining room, then before washing or sanitizing her hands she was observed serving Resident #10 his lunch tray. She asked him if he wanted his bread buttered and he indicated yes. NA #10 was observed picking up Resident #10's breadstick with her left hand and his butter knife with her right hand. She held the breadstick in her left palm and used the butter knife and cut the breadstick in half and opened the breadstick. She placed the breadstick that was cut in half on the resident's plate, then took the butter and the knife and buttered the inside of the breadstick down the middle. The resident consumed one-half of the breadstick.</p> <p>On 4/6/15 at 12:37 p.m., NA #10 was observed serving residents in the Moving Forward dining room without washing or sanitizing her hands. She was observed at that time delivering Resident #13's lunch tray to her. She asked the resident if she wanted Mayonnaise on her sandwich and the resident indicated yes. NA #10 was observed using the resident's fork tines to open the corner of the packet of Mayonnaise. NA #10 was observed picking up Resident #13's top bun with her left hand and squeezing the packet of Mayonnaise around the bun with her right hand. She placed the bun back on</p>		<p>to proper food service and handling in a sanitary manner by the ED/designee on or before 4.24.2015. #3: All staff were in-serviced in regards to proper food service and handling in a sanitary manner by the ED/Designee on or before 4.24.15. The ED/Designee will perform daily food service audit for each meal to ensure food is being delivered and handled in a sanitary manner. #4: To ensure compliance, The DNS/Designee is responsible for the completion of the meal monitoring observation CQI audit tool weekly x 4weeks, Monthly x 6 months, and the quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee and overseen by the ED. If a threshold of 100% is not achieved an action plan will be developed to ensure compliance. #5: Date of Compliance 4.24.15</p>				

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F 441 SS=D Bldg. 00	<p>the sandwich, then held the sandwich with her left hand and cut the sandwich in half with her butter knife with her right hand. She was observed picking one-half of the sandwich up with her left hand and giving it to the resident to eat. The resident consumed one-fourth of the half of the sandwich.</p> <p>During an interview on 4/10/15 at 6:01 p.m., the ED indicated the staff were aware the resident's food should not be touched.</p> <p>3.1-21(i)(3)</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 - (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</p>			

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	<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 handwashing and glove use was implemented while providing incontinent care for 1 of 1 residents reviewed for proper handwashing and glove use. (Resident E)</p> <p>Findings include:</p> <p>On 4/10/15 at 10:06 a.m., CNA #11 and NA #12 went into Resident E's room to complete ADL (Activity of Daily Living) care for him to prepare him for an appointment. CNA #11 pushed the mechanical lift into Resident E's room. CNA #11 donned clean gloves without washing her hands. NA #12 washed her hands and donned clean gloves. CNA</p>	F 441	<p>F 441 #1 Resident (E) was identified as being affected by the deficient practice. In regards to Resident (E), his catheter bag, urinal, and catheter tubing were replaced using proper infection control procedures. Res(E)'s Broda chair, night stand drawers, and lift were also sanitized. Res (E)'s catheter bag was placed below his bladder after his care. CNA #11 was in-serviced regarding catheter and incontinence care on 4.10.15 #2 All residents have the potential to be affected by this deficient practice. Residents will be provided incontinent care utilizing proper hand-washing and glove use as indicated per policy and procedure. The DNS/designee will perform rounds every shift to ensure</p>	04/24/2015

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	<p>#11 was observed providing incontinent care for Resident E and cleansing an incontinent BM (bowel movement) off him. After providing the incontinent care, she reached into the resident's bottom drawer of his night stand and obtained his urinal, then emptied his foley drainage bag hanging on the bed frame without changing her gloves or washing her hands in between the incontinent care and emptying the drainage bag. She emptied the urine then returned the urinal and removed her gloves. CNA #11 went out into the hallway to the linen closet on the other hall of the Moving Forward unit and retrieved two wash clothes, then donned clean gloves after returning to Resident E's room.</p> <p>During the dressing change at that time, CNA #11 was observed providing BM incontinent care for the resident in the middle of the nurse performing wound care. After the nurse completed the wound care, CNA #11 was observed assisting the resident to dress without changing her gloves or washing her hands. She placed Resident E's catheter drainage bag through his pant leg with the same gloves on she provided his BM incontinence care. CNA #11 brought the mechanical lift and broda chair over towards his bed with the same gloves she provided BM incontinence care to him</p>		<p>compliance.</p> <p>#3 All nursing staff were in-serviced in regards to properhand-washing and glove use by the DNS/designee on or before 4.24.15. TheDNS/designee will perform audits daily to ensure that proper hand-washing andglove use are performed during incontinence care.</p> <p>#4 To ensurecompliance, The DNS/Designee is responsible for the hand-washing and glove useCQI audit tools and the incontinence care CQI audit tool bi weekly x 4 weeks,Monthly x 6 months, and then quarterly until continued compliance is maintainedfor 2 consecutive quarters. The results of these audits will be reviewed by theCQI committee and overseen by the ED. If a threshold of 100% is not achieved anaction plan will be developed to ensure compliance.</p> <p>#5 Date of Compliance: 4.24.15</p>	

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	<p>earlier. She removed her gloves and her hands were not washed. The resident was transferred with the mechanical lift into his broda chair.</p> <p>During an interview on 4/10/15 at 11:11 a.m., CNA #11 indicated she had not taken off her gloves and washed her hands after she washed the BM off Resident E's bottom either time, then she emptied the resident's catheter bag and touched objects in his room with the same dirty gloves. At that time the Director of Nursing indicated CNA #11 knew she was suppose to change her gloves and wash her hands after providing incontinent care for a resident.</p> <p>A skills validation for a CNA titled "Gloves" dated 2/2010 and revised 3/2012, provided by the Executive Director on 4/13/15 at 10:19 a.m., indicated "Procedure Steps: 1. Wash hands 2. Put on gloves... 4. Perform procedure... 8. Dispose of gloves in waste basket... 9. Wash hands."</p> <p>This Fedral tag relates to complaint IN00169352.</p> <p>3.1-18(l)</p>			