

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2013
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NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN 47715
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 26, 27, 28, 29, September 3, 4, 2013</p> <p>Facility number: 002280 Provider number: 155723 AIM number: N/A</p> <p>Survey team: Amy Winger, RN,TC Barb Fowler, RN Denise Schwandner, RN Diane Hancock, RN August 26, 27, 28, and September 3, 4, 2013 Diana Perry, RN August 26-28, 2013 Anna Vallain, RN August 26-28, 2013</p> <p>Census bed type: SNF: 47 SNF/NF: 7 Residential: 38 Total: 92</p> <p>Census payor type: Medicare: 34 Medicaid: 7 Other: 51 Total: 92</p> <p>Residential sample: 7</p>	F000000		

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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	<p>The deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 9, 2013, by Jodi Meyer, RN</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the care plan was revised to include immediate interventions after a fall for 1 of 4 residents reviewed for falls, in the sample of 5 who met the threshold for accidents. (Resident #22)</p> <p>Findings include:</p> <p>The clinical record of Resident #22 was reviewed on 08/28/13 at 9:15 a.m. The record indicated the diagnoses of Resident #22 included,</p>	F000280	F280Res #22 careplans have been reviewed/updated to reflect current interventions.Completion Date 10-4-2013All residents who fall have the potential to be affected by the alleged deficient practice and therefore through corrective action and inservicing will ensure an immediate intervention is initiated after a fall.Completion Date 10-4-2013Licensed nurses inserviced on need for and documentation of an immediated intervention or careplan revision implemented after a fall. Nurses inserviced on expectation.Completion Date 10-4-2013DHS/Designee will review fall documentation and	10/04/2013			

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	<p>but were not limited to, dementia.</p> <p>Resident #22 was observed on 08/26/13 at 10:45 a.m., sitting in a wheelchair with a hematoma on her forehead and two black eyes. During an interview, at that time, Resident #22 indicated she had recently fallen out of the wheelchair while trying to reach for something.</p> <p>The most recent quarterly MDS (Minimum Data Set Assessment) dated 06/03/13 indicated Resident #22 experienced moderate cognitive impairment.</p> <p>A care plan dated 07/06/13 for Falls indicated Resident #22 had a functional limitation of poor balance and included, but was not limited to, interventions of, "... half rails as enabler, call light within reach, dycem [a non-slip surface] to w/c [wheelchair], walker,...remind resident and reinforce safety awareness...". The plan of care included a handwritten note dated 08/19/13 that indicated, "Therapy eval [evaluation]."</p> <p>A Fall Circumstance report dated 08/17/13 indicated Resident #22 had experienced a fall on 08/17/13 at 1930 (7:30 p.m.) that resulted in bilateral eye bruising and a</p>		<p>intervention daily to ensure timeliness. QA committee will be provided a list of residents with falls and type and date of intervention monthly x 6 months and quarterly thereafter.</p>		

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	<p>hematoma to the forehead. The report further indicated Resident #22 was reaching for an object prior to the fall. The Fall Risk Re-assessment indicated Resident number #22 was, "...unable to maintain balance while sitting and required the use of an assistive device and/or often forgets to use device...". The prevention update indicated the intervention was an OT(Occupational Therapy)/PT (Physical Therapy) eval. The report further indicated the root cause of the fall was decreased safety awareness, loss of balance from w/c and UTI (Urinary Tract Infection). The circumstance report lacked any documentation of an immediate intervention being put into place.</p> <p>The Nursing notes from 08/17/13 through 08/26/13 lacked any documentation of an immediate intervention being put into place after the fall of 08/17/13.</p> <p>The Functional Limitation Assessment dated 08/19/13 indicated Resident #22 had a therapy eval on that date and lacked any documentation of a new intervention being put into place after the fall on 08/17/13.</p> <p>During an interview on 09/03/13 at</p>						

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	<p>2:00 p.m., the DoN (Director of Nursing) indicated no immediate intervention had been put into place after the fall. The DoN further indicated, at that time, the therapy eval occurred two days after the fall.</p> <p>During an interview on 09/03/13 at 4:00 p.m., the HFA (Health Facilities Administrator) indicated an immediate intervention should have been put into place after the fall of Resident #22.</p> <p>3.1-35(d)(2)(B)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, and record review, the facility failed to ensure a resident received monitoring after dialysis for 1 of 1 residents reviewed for dialysis. (Resident #144)</p> <p>Findings include:</p> <p>Resident #144 was observed on 08/26/13 at 10:50 a.m. lying in bed.</p> <p>The clinical record of Resident #144 was reviewed on 08/29/13 at 10:28 a.m. The record indicated the diagnoses of Resident #144 included, but were not limited to, End Stage Renal Disease.</p> <p>The record further indicated Resident #144 was admitted on 08/05/13 and received dialysis on the following dates: 08/06/13, 08/08/13, 08/10/13, 08/13/13, 08/15/13, 08/17/13, 08/20/13, 08/22/13, and 08/24/13.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/06/13</p>	F000309	F309Res #144 suffered no ill effects from the alleged deficient practice and will have an assessment done after returning from dialysis. Completion Date 10-4-2013 Any resident receiving dialysis has the potential to be affected by the alleged deficient practice and through corrective actions and in-servicing will ensure residents are assessed when returning from dialysis. Completion Date 10-4-2013 Systemic change is the documentation of vital signs/assessment completed when resident returns to campus from dialysis. Completion Date 10-4-2013 Licensed nurses will be in-serviced on expectation of assessment. Completion Date 10-4-2013 DHS/Designee will audit all dialysis residents chart daily x30 days, weekly x 6 months and monthly thereafter to ensure that documentation and thorough assessment is completed. Results of audits will be forwarded to QA committee for review of compliance and suggestions monthly and suggestions monthly x 6 and quarterly thereafter.	10/04/2013	

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	<p>lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/08/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/10/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/13/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/15/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/17/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and</p>			

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	<p>Data Collection dated 08/20/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/22/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Skilled Nursing Assessment and Data Collection dated 08/24/13 lacked any documentation related to monitoring Resident #144 after dialysis for complications.</p> <p>The Vital Signs and Weight Record dated 08/05/13 lacked any documentation of vital signs since admission.</p> <p>A Care Plan dated 08/07/13 for dialysis included, but was not limited to, interventions of "...monitor for complications following dialysis: i.e. hypotension [low blood pressure], febrile reaction, hemorrhaging, ... septic shock[a life-threatening infection]..."</p> <p>The policy and procedure for "Guideline for Dialysis Provider Communication" provided by the DoN on 09/04/13 at 8:15 a.m. indicated,</p>						

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	<p>"...5. Upon return from the Dialysis Provider the campus shall a. Provide ongoing monitoring [sic] of the shunt site for signs of complication...".</p> <p>During an interview, at that time, the DoN indicated there was not a policy specific to patient monitoring for complications after dialysis.</p> <p>During an interview on 08/29/13 at 11:00, RN #1 indicated a dialysis patient should be assessed for complications upon returning from dialysis.</p> <p>During an interview on 09/03/13 at 10:30, LPN #4 indicated Resident #144 usually returned from dialysis on her shift around 4:00 p.m. and was not assessed for complications because he typically left the unit for several hours.</p> <p>3.1-37(a)</p>						

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication was clinically indicated for 1 of 5 residents reviewed for unnecessary medications, in the sample of 5 residents reviewed for unnecessary medications. (Resident #15)</p> <p>Findings include:</p> <p>Resident #15 was observed on</p>	F000329	F329Res #15 had a dosage reduction and attempts for further reduction trials are scheduled. Resident #15 suffered no ill effects from receiving antipsychotic medication. Completion Date 10-4-2013 All residents receiving antipsychotic medications have the potential to be affected by the alleged deficient practice therefore DHS/designee have reviewed their medications and evaluation of necessity with physician for continued use or reduction trials. Completion Date	10/04/2013			

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	<p>08/26/13 at 2:00 p.m., lying in bed asleep.</p> <p>Resident #15 was observed on 08/27/13 at 10:00 a.m., lying in bed asleep.</p> <p>The clinical record of Resident #15 was reviewed 08/28/13 at 10:11 a.m. The record indicated the diagnoses of Resident #15 included, but were not limited to, dementia with psychosis.</p> <p>The August 2013 Physician Order Recap included, but was not limited to, an order for "...Risperdal constra [a long-acting anti-psychotic] 12.5 inject 1 ml [milliliter] 12.5 mg IM [intra-muscularly] every other week [14 days] for dementia/psychosis..."</p> <p>During an interview on 08/29/13 at 10:55 a.m., UM #1 (Unit Manager) indicated the physician was visiting and heard Resident #15 yell out. UM #1 further indicated, at that time, she told the physician Resident #15 yelled out more towards the end of the Risperdal constra cycle, so the physician had increased the dose by decreasing the timeframe between doses.</p> <p>A Physician's Telephone Order dated 07/03/13 indicated "Change Risperdal</p>		<p>10-4-2013 Licensed nursing personnel and Social Service Director inserviced on indications for use of antipsychotic medication and lowest therapeutic dose as well as requirement for dosage reductions per OBRA guidelines. All nursing and SS staff inserviced on documentation. Completion Date 10-4-2013 SSD/Designee will monitor diagnoses that support use of antipsychotic medication as well as active behaviors daily and when increase in med is not warranted or when reduction of med is reasonable based on those behaviors to request from physician. Completion Date 10-4-2013 Results of audits and complete list of those residents receiving antipsychotic medications will be forwarded to QA monthly x 12 months for review and suggestion.</p>		

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	<p>constra to 12.5 mg/1 ml IM Q [every] 10 days..."</p> <p>A behavior detail indicated Resident experienced no psychotic episodes or behaviors from June 01, 2013 through July 03, 2013.</p> <p>During an interview on 08/29/13 at 11:00 a.m., CNA #2 indicated Resident #15 did not typically yell out unless something was needed and stated, "...if [Resident #15] is going to yell [Resident #15] will yell out... own name, ... never is vulgar or anything... is sometimes resistive to care but... likes babies and chocolate, so I can usually re-direct ... and ... will work with us..."</p> <p>The care plan for Mood dated 08/20/13 included, but was not limited to, interventions of "...staff to offer chocolate and/or Coke to promote increased mood. Encourage visits with dog..."</p> <p>The Nursing notes from 06/01/13 through 07/03/13 lacked any documentation related to Resident #15 experiencing psychotic episodes or behaviors.</p> <p>The Monthly Nursing Assessment and Data Collection dated 06/05/13</p>			

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	<p>lacked any documentation related to Resident #15 experiencing psychotic episodes or behaviors.</p> <p>During an interview on 09/04/13 at 10:30 a.m., the DoN (Director of Nursing) indicated if Resident #15 had experienced any psychotic episodes or behaviors behavior they should be reflected in the nursing notes or in a Mental Health Wellness Circumstance, Assessment and Intervention form. The DoN further indicated, at that time, she could not find any documentation from 06/01/13 through 07/03/13 of clinical justification for an increase in the Risperdal dosage.</p> <p>3.1-48(a)(4)</p>			

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F000371 SS=F	<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 Based on observation, interview, and record review, the facility failed to ensure open foods were covered, a trash can was not overflowing, a dirty broom was not stored in a food prep area, and the floor was clean of debris. These observations were made during 1 of 1 kitchen observations on 08/28/13. This had the potential to affect 54 residents who currently reside in the facility.</p> <p>Findings include:</p> <p>During the kitchen observation on 08/28/13 at 8:11a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. A broom with visible debris was hanging on the wall and a trash can was overflowing with trash near a food prep table that contained uncovered fruit cups and an open container of grape juice. 2. Cook #1 was observed to wear a ball cap and have her hair in a 	F000371	<p>F371Broom stored in an area outside of kitchen, trash cans emptied and lids in place, shelf above food prep area cleaned, floor between stove and deep fryer cleaned. Wheels placed on stove to ease rolling out to clean behind. There were no residents affected by the alleged deficient practice and through corrective actions and inservicing will prevent further recurrence of sanitation issues.Completion Date 10-4-2013Systemic change is that wheels placed on stove, new storage location for broom, inservice of kitchen staff regarding hair restraints, prepared food covered, cleaning schedules. All dietary staff will be inserviced on these procedures and expectations.Completion Date 10-4-2013Director of Food Service/Designee will monitor and/or verify sanitation compliance daily by rounds checklist. Immediate intervention and counseling of employees of correct procedures to prevent recurrence of identified deficiencies.Completion Date 10-4-2013Results of audits will be forwarded to QA committee</p>	10/04/2013	

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	<p>ponytail. Cook #1 was observed to not have her hair completely contained in the ball cap or ponytail while preparing food. During an interview, at that time, Cook #1 indicated she did not have a hairnet on because she had on a ball cap and her hair was in a ponytail. The DM #1 indicated, at that time, hair should be completely contained in the kitchen area.</p> <p>3. The shelf above a food prep area was observed to have multiple areas of a brown sticky substance. The DM #1 indicated, at that time, the substance was spilled dried syrup and should have been cleaned up immediately.</p> <p>4. The floor between the stove and deep fryer was observed to be covered with grime and black debris. During an interview, at that time, the DM #1 indicated the debris had built up over time because the stove was not movable.</p> <p>During an interview on 08/28/13 at 8:45 a.m., the DM #1 indicated the floors of the food prep area had not been thoroughly cleaned for about six weeks. The DM #1 stated, at that time, "...supposed to sweep in between but it doesn't always</p>		monthly for 6 months and quarterly thereafter for review and further recommendations.	

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	<p>happen...". The DM #1 further indicated, at that time, the uncovered food should have been covered, and she was unsure where the broom should be stored.</p> <p>The Policy and Procedure for Food Production Guidelines-Sanitation and Safety provided by the DM #1 on 08/28/13 at 10:00 a.m. indicated, "...3. Approved hairnets, caps or other effective hair restraints shall be used by employees who engage in the preparation and service of food...7. Food prepared in advance must be covered...". During an interview, at that time, the DM #1 indicated there was not a policy related to where the brooms should be stored when not in use.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure controlled medications were</p>	F000431	F431All residents have the potential to be affected by the alleged deficient practice and through altercations in process and inservicing will	10/04/2013			

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	<p>accurately reconciled, in that narcotics were not reconciled by comparing the medications in the cart to the count sheets for 1 of 4 units. (Unit #300 South)</p> <p>Findings include:</p> <p>During a random observation of a narcotic count on 08/27/13 at 2:00 p.m. between LPN #2 and LPN #3, LPN #2 was observed to have a binder opened and was observed to turn through the papers. LPN #3 was observed to call out numbers while looking at the medication cards in the narcotic box. At one point, LPN #2 indicated to LPN #3 to slow down as she thought she had lost her place.</p> <p>During an interview on 09/3/13 at 11:23 a.m. LPN #4 indicated when doing a narcotic count one nurse should look at the resident's narcotic sheet and note the resident's name, name of the medication, and the amount of the medication available listed on the narcotic sheet. LPN #4 further indicated, at that time, the second nurse should look at the medication card and verify the actual amount of the medication remaining on the card.</p> <p>During an interview on 09/3/13 at</p>		<p>ensure correct actions to reconcile controlled medication upon shift change is followed. Completion Date 10-4-2013 LPN #2 and LPN #3 will have individualized inservice and counseling on correct reconciling procedure of controlled substances. Completion Date 10-4-2013 Licensed nursing staff will be inserviced on proper procedure for reconciling controlled substances at shift change. Completion Date 10-4-2013 DHS/Designee will randomly observe narcotic count on varying shifts daily x 2wk, then 3 x wk for 2 wks and 1 x monthly. Audits will be forwarded to QA committee monthly x 6months and quarterly thereafter for review and to ensure compliance with requirement.</p>		

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	<p>1:23 p.m., the DHS (Director of Health Services) indicated the narcotics should be counted between shifts with one nurse indicating the resident's name, the name of the medication, and the amount remaining on the card.</p> <p>A "Guidelines for Shift to Shift Narcotic Count" obtained from the DHS on 9/3/13 at 2:23 p.m., indicated, "...3. the narcotics shall be reconciled by comparing the medications in the cart to the count sheets."</p> <p>3.1-25(e)(2)</p>				

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F000441 SS=E	<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 (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 observation, interview and</p>	F000441	F441Res #107, #145, #39 and #93 suffered no ill effects from	10/04/2013			

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	<p>record review, the facility failed to ensure infection control procedures were followed to prevent potential infection, for 1 of 6 residents observed receiving personal care, in that, the LPN failed to use gloves prior to applying a clean item on a resident in contact isolation. (Resident #107) and the facility failed to ensure contact precautions were implemented during a meal service for 2 of 2 residents observed during room tray delivery and identified as having Clostridium Difficile, in that, gloves and handwashing were not done between tray delivery (Resident #107, Resident #145) and the facility also failed to ensure handwashing/sanitation was done between resident contacts for 2 of 2 residents of 7 residents observed in the restorative dining room, in that, handwashing was not performed between resident contacts. (Resident #39, Resident #93).</p> <p>Findings include:</p> <p>1. Resident #107's record was reviewed on 8/28/13 at 11:33 a.m. Resident #107 had diagnoses including, but not limited to, infected decubitus ulcer with possible osteomyelitis, Clostridium Difficile (a highly infectious disease involving</p>		<p>the findings on the 2567L and staff have been inserviced on glove usage/changing and handwashing procedures. Completion Date 10-4-2013 All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and inservicing will ensure corrective actions to prevent spread of infection are followed. Completion Date 10-4-2013 LPN #1, RN #1 and CNA #1 have received directed inservice on glove use, handwashing policy and infection control procedures during ADL care/resident contact. Completion Date 10-4-2013 Nursing staff will be inserviced on proper handwashing/sanitizing and glove usage procedures to prevent spreading of infection and post test of skill competency. Completion Date 10-4-2013 DHS/designee will monitor resident care that includes handwashing/glove usage, feeding after care and techniques of all care provided daily x 5 days, 3 x wk for 2 weeks, then weekly. Results of audits will be forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p>				

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	<p>diarrhea stools), and a chronic urinary tract infection (UTI).</p> <p>During an observation of a dressing change of Resident #107's pressure area on 8/29/13 at 10:09 a.m., LPN #1 was observed to remove her gloves at the end of the dressing change. LPN #1 proceeded to turn Resident #107 to her right side, obtained a clean diaper and placed it under Resident #107's buttocks, LPN #1 pulled the diaper up between Resident #107's legs. LPN #1 turned the resident onto her right side. LPN #1 indicated she needed to obtain gloves at that point, as she had not brought in enough gloves prior to the dressing change. LPN #1 indicated she could not wear the gloves in the room.</p> <p>During an interview with the DHS (Director of Health Services) on 9/3/13 at 1:23 p.m., the DHS indicated all staff should use gloves for any contact with the resident.</p> <p>A policy titled, "Management of Residents with Clostridium Difficile" and obtained from the ADHS (Assistant Director of Health Services) on 9/3/13 at 4:20 p.m., indicated contact precautions would be initiated at the onset of diarrhea and continue</p>						

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	<p>until the disease is ruled out or resolved.</p> <p>A policy titled, "Contact Precautions" obtained from the ADHS on 9/3/13 at 2:40 p.m., indicated gloves should be changed and hands washed before and after having direct contact with the resident or environmental objects.</p> <p>2. During the initial tour, on 8/26/13 at 9:50 a.m., RN #2 indicated two residents on the 400 Unit were being treated for Clostridium Difficile (an infection resulting in diarrhea), Residents #145 and #107. She indicated they were using Contact Precautions in caring for the residents to prevent the spread of infection to other residents.</p> <p>On 8/26/13 at 12:45 p.m., CNA #1 was observed to be passing lunch trays on the 400 Unit. The resident prepared a tray from a cart outside of Resident #145's room. She entered the room with the tray and placed it on the overbed table. She did not put on gloves or gown. She used bare hands to move the overbed table closer to the resident, asked the resident if she needed further assistance and then left the room. She did not wash or sanitize her hands.</p>			

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	<p>CNA #1 proceeded to set up another tray at the cart. She carried the tray to Resident #107's room and set it on the table in the room. She did not put on any gloves or gown. While in Resident's room, she handled the resident's wheelchair, moving the resident to the table. She then exited the room. She proceeded to enter the nurses' station and get some alcohol gel from the top of the medication cart and use it on her hands. She then went to the cart and proceeded to set up another tray.</p> <p>The Assistant Director of Health Services provided copies of the policies and procedures for Management of Residents with Clostridium Difficile and Contact Precautions (no dates), on 9/3/13 at 4:20 p.m. The policies and procedures included, but were not limited to, the following: "Contact Precautions will be initiated at the onset of diarrhea of unknown origin and continue until disease is ruled out or resolved." "Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the resident's environment." "Contact Precautions are indicated to</p>			

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	<p>prevent and control nosocomial transmission of infection with any of the following: ...Clostridium difficile..." "Wear latex gloves when entering the room before contact with the resident or environmental objects. Change gloves and wash hands after having direct contact with the resident, possible infective material, or potentially contaminated environmental objects and between each resident care intervention..."</p> <p>3. During an observation in the restorative dining room on 8/26/13 at 12:05 p.m., RN #1 was observed to be feeding Resident #39 using her right hand. While feeding Resident #39, RN #1 observed Resident #93 was sleeping at the table. RN #1 stopped feeding Resident #39 and attempted to wake Resident #93 using her right hand to rub Resident #93's left arm. RN #1 proceeded to feed Resident #39 using her right hand. At 12:09 p.m., RN #1 stopped feeding Resident #39 and moved Resident #93's wheelchair closer to the table. Resident #39 picked up the utensil and proceeded to eat two (2) bites of food. RN #1 sat down and continued feeding Resident #39.</p> <p>During an interview with the DHS</p>			

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R000000	<p>(Director of Health Services) on 9/3/13 at 2:32 p.m., the DHS indicated RN #1 should have sanitized her hands between feeding and caring for residents.</p> <p>3.1-18(b)(1) 3.1-18(j)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R000000		

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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure at least one staff member was on duty at all times who was certified in CPR and First Aid, for 10 of 10 days reviewed, in that 2 days lacked a CPR certified staff member on evenings and/or nights and 10 days lacked a First Aid certified staff member on evenings, nights and/or days. This had the potential to affect 38 residents who currently reside in the</p>	R000117	R117All residents have the potential to be affected by the deficient practice and through in-servicing and training staff we will ensure that 1 staff on each shift is certified.Completion Date 10-4-2013Systemic change will be that scheduling nurse will oversee and coordinate all daily sheets to ensure a code is indicative of staff that are certified on Assisted Living.Completion Date 10-4-2013DHS/designee will audit all schedules for proper	10/04/2013			

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	<p>facility. (8/26/13-9/4/13)</p> <p>Finding includes:</p> <p>The nursing department schedule for 8/26/13 through 9/4/13 was provided by the Administrator on 9/3/13 at 10:00 a.m. The file containing CPR and First Aid Certifications was also provided at that time.</p> <p>Nursing staff with CPR and First Aid certifications were lacking for the following dates and shifts:</p> <p>8/26/13 First Aid staff lacking on evenings and nights 8/27/13 First Aid staff lacking on evenings and nights 8/28/13 First Aid staff lacking on evenings and nights 8/29/13 First Aid staff lacking on evenings and nights 8/30/13 First Aid staff lacking on evenings and nights 8/31/13 First Aid staff lacking on days, evenings and nights 9/1/13 First Aid staff lacking on days, evenings and nights 9/2/13 CPR staff lacking on evenings and nights, First Aid staff lacking on evenings and nights 9/3/13 First Aid staff lacking on evenings and nights 9/4/13 CPR staff not scheduled for nights, First Aid staff not scheduled</p>		<p>procedure daily and to ensure there is certified employee on each shift. Results of the audits will be forwarded to the QA committee monthly for 6 months and quarterly thereafter.</p>				

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	<p>for evenings or nights</p> <p>Interview with the Administrator on 9/3/13 at 11:05 a.m. indicated they had a class scheduled for the next week. She indicated she knew it was an issue (staff not being certified for First Aid and CPR).</p>			

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R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure open foods were covered, a trash can was not overflowing, a dirty broom was not stored in a food prep area, and the floor was clean of debris. These observations were made during 1 of 1 kitchen observations on 08/28/13. This had the potential to affect 38 residents who currently reside in the facility.</p> <p>Findings include:</p> <p>1. During the kitchen observation on 08/28/13 at 8:11a.m., the following was observed:</p> <p>a. A broom with visible debris was hanging on the wall and a trash can was overflowing with trash near a food prep table that contained uncovered fruit cups and an open container of grape juice.</p> <p>b. Cook #1 was observed to be preparing food and not have her hair completely contained in a hairnet.</p>	R000154	<p>R154Broom stored in an area outside of kitchen, trash cans emptied and lids in place, shelf above the food prep area cleaned, floor between stove and deep fryer cleaned. Wheels placed on stove to ease rolling out to clean behind. There were no residents affected by the alleged deficient practice and through corrective actions and in-servicing will prevent further recurrence of sanitation issues. Completion Date 10-4-2013 Systemic change is that wheels placed on stove, new storage location for broom, in-service of kitchen staff regarding hair restraints, prepared food covered, cleaning schedules. All dietary staff will be in-serviced on these procedures and expectations. Completion Date 10-4-2013 Director of food service/designee will monitor and/or verify sanitation compliance daily by rounds checklist. Immediate intervention and counseling of employees of correct procedures to prevent recurrence of identified deficiencies. Completion Date 10-4-2013 Results of audits will be forwarded to QA committee monthly for 6 months and</p>	10/04/2013	

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	<p>During an interview, at that time, Cook #1 indicated she did not have a hairnet on.</p> <p>c. The food prep shelf was observed to have multiple areas of brown sticky substance. The DM #1 indicated, at that time, the substance was spilled dried syrup.</p> <p>d. The floor between the stove and deep fryer was observed to be covered with grime and black debris. During an interview, at that time, the DM #1 indicated the debris had built up over time because the stove was not movable.</p> <p>During an interview on 08/28/13 at 8:45 a.m., the DM #1 indicated the floors of the food prep area had last been cleaned about six weeks prior. The DM #1 stated, at that time, "...supposed to sweep in between but it doesn't always happen...". The DM #1 further indicated, at that time, hairnets should be worn at all times, the uncovered food should have been covered, and all kitchen surfaces should be clean.</p> <p>The Policy and Procedure for Food Production Guidelines-Sanitation and Safety provided by the DM #1 on 08/28/13 at 10:00 a.m. indicated,</p>		quarterly thereafter for review and further recommendations.				

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	"...3. Approved hairnets, caps or other effective hair restraints shall be used by employees who engage in the preparation and service of food...7. Food prepared in advance must be covered...". During an interview, at that time, the DM #1 indicated there was not a policy related to where the brooms should be stored when not in use.			

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure residents were aware of Service Plans and Service Plans were signed by the resident, for 3 of 3 residents interviewed (Resident #155, Resident #163, and Resident #177) and for 4 of 7 resident</p>	R000217	R217Resident #155, #163, #177, #165, #187 and #190 have had service plan reviewed with them and signed.Completion Date 10-4-2013Since all residential residents have the potential to be affected by the alleged deficient practice a review of all service plans was conducted and signed.Completion Date	10/04/2013			

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	<p>records reviewed (Resident #163, Resident #165, Resident #187, and Resident #190).</p> <p>Findings include:</p> <p>1. During the following interviews of residents, all indicated they were unaware of their Service Plan: Resident #155 on 8/28/13 at 11:30 a.m., "...not familiar with..." Resident #163 on 8/28/13 at 3:10 p.m., "...not aware of that..." Resident #177 on 8/28/13 at 10:00 a.m., indicated she didn't know anything about it.</p> <p>2. During reviews of the following clinical records, the service plans were not signed by the resident or family, nor was there indication the service plans were reviewed with the resident/family:</p> <p>Resident #163's clinical record was reviewed on 8/27/13 at 4:30 p.m. Service Plans dated 7/8/13 and 8/23/13 were reviewed and failed to have signatures of the resident or family.</p> <p>Resident #165's clinical record was reviewed on 8/27/13 at 3:45 p.m. The resident's Service Plans, dated 5/2/13 and 8/9/13, were not signed by the</p>		<p>10-4-2013Systemic change will include AL Manager appointed to oversee the process and ensure timely completion of service plans.Completion Date 10-4-2013AL manager/designee will audit all service plans monthly for changes, new admissions, and quarterly or with significant change to ensure they are complete and the resident/family have gone over them with staff and signed.Results of audits will be forwarded to QA for review monthly x 12 months.</p>		

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	<p>resident or family.</p> <p>Resident #187's clinical record was reviewed on 8/28/13 at 8:45 a.m. The resident's Service Plans, dated 1/9/13 and 7/17/13, were not signed by the resident or family.</p> <p>Resident #190's clinical record was reviewed on 8/28/13 at 1:20 p.m. The resident's Service Plans, dated 4/4/13 and 7/17/13, were not signed by the resident or family.</p>			