

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2016
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the investigation of Complaint IN00194242.</p> <p>Complaint IN00194242-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: March 1, 2, 3, 4, 7, and 8, 2016</p> <p>Facility Number: 000513 Provider Number: 155131 AIM Number: 100275360</p> <p>Census bed type: SNF/NF: 159 Total: 159</p> <p>Census payor type: Medicare: 26 Medicaid: 111 Other: 22 Total: 159</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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 0371 SS=D Bldg. 00	<p>Quality review completed 3/10/16 by 29479.</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 Based on observation, interview and record review, the facility failed to ensure staff adequately sanitized their hands for 1 of 2 dining observations in the North Unit dining room.</p> <p>Findings include:</p> <p>During the observation of luncheon service in the North Unit dining room, on 3/1/16 at 11:59 a.m., RN #1 was observed to wash her hands, turn off the faucet with her bare hand, and dry her hands with a paper towel. RN #1 then proceeded to serve a tray of food to a resident and assist the resident with meal set up.</p> <p>On 3/1/16 at 12:03 p.m., RN #1 was observed to wash her hands, turn off the faucet with her bare hand, and dry her hands with a paper towel. RN #1 was</p>	F 0371	Residents found to be affected by the deficient practice were not identified in the 2567; however nurse served 4 unidentified residents in the North Unit dining room All 9 residents dining in the North dining room had the potential to be affected by the same deficient practice Staff education has been provided to all employees which includes a hand washing competency completed by each employee following Signature Healthcare's Hand Washing Guidelines The Guidelines include using a dry paper towel to turn off faucet, without contaminating hands by touching sink The SDC and/or her designee will validate staff are adequately sanitizing their hands prior to serving food Finding will be recorded on a monitoring tool. Monitoring will occur in random locations including all dining rooms and with hall trays. The frequency of monitoring will occur every day across all 3 meal	03/31/2016

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F 0431 SS=D Bldg. 00	<p>then observed to assist a resident with meal set up and serve a beverage to another resident.</p> <p>On 3/1/16 at 12:08 p.m., RN #1 was observed to wash her hands, turn off the faucet with her bare hand, and dry her hands with a paper towel. RN #1 proceeded to serve a tray of food to a resident and assist the resident with meal set up.</p> <p>On 3/8/16 at 2:23 p.m., the Director of Nursing (DON) indicated staff serving food to residents should wash or sanitize their hands prior to serving the food. She further indicated when staff wash their hands, they should turn off the faucet with a paper towel, not their bare hand.</p> <p>An undated, but identified as current facility policy, provided by the DON on 3/8/16 at 2:45 p.m., titled, "Signature Healthcare Hand Washing, " included but was not limited to, "Guideline Steps...7. Use a dry paper towel to turn off faucet, without contaminating hands by touching sink "</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the</p>		<p>services. If violations are observed, the action will be corrected immediately, recorded on the monitoring tool and reported to the SDC for follow-up. The SCD will report findings to the Quality Assurance and Performance Improvement Committee monthly until in compliance for at least three consecutive months. The Infection Control Nurse will continue to observe weekly thereafter to ensure sustained compliance. Systemic changes will be completed by 3/31/16</p>		

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	<p>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 1 vial of Aplisol solution were not expired and the facility failed to ensure 2 vials of Aplisol solution were properly labeled for 2 of 3 refrigerators utilized for medication storage.</p>	F 0431	There weren't any residents identified in the 2567 as being affected by the deficient practice. Any resident receiving Aplisol from the unlabeled or expired multi dose vials in the medication room refrigerator could have been affected by the deficient practice.	03/31/2016

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	<p>Finding includes:</p> <p>During an observation on 3/7/16 at 3:00 p.m., A vial of Aplisol solution was in the North unit medication room refrigerator with an open date of 1/10/16.</p> <p>During an observation on 3/7/16 at 3:00 p.m., A used multi dose vial of Aplisol solution was in the North unit medication room refrigerator with no open date on the vial.</p> <p>During an observation on 3/7/16 at 3:05 p.m., A used multi dose vial of Aplisol solution was in the South unit medication room refrigerator with no open date on the vial.</p> <p>During an interview on 3/7/16 at 3:02 p.m., Unit Manager # 3 indicated a vial of Aplisol is good for 30 days from the open date.</p> <p>During an interview on 3/7/16 at 3:08 p.m., Unit Manager # 4 indicated a vial of Aplisol is good for 30 days from open date and then discarded. She further indicated if there is no open date label on the vial then it should be discarded because they would not be able to tell when the solution has expired.</p>		<p>Education is being provided to each licensed nurse to ensure drugs and biological are properly labeled with date open stickers to identify expiration dates Further, education will include disposing of expired drugs and biological when expiration dates are reached. The ADON and/or her designee will inspect medication rooms/refrigerators and medication carts to ensure compliance. Inspections will occur in random locations at least five days each week. Negative findings will be corrected immediately, an investigation will be completed to identify the nurse in violation of our policy. Reeducation and disciplinary action will follow as appropriate. If unable to identify nurse, all nurses that could have been responsible will receive education. The ADON will report to the Quality Assurance and Performance Improvement Committee monthly until in compliance for at least three consecutive months. The Infection Control Nurse will continue to observe weekly thereafter to ensure sustained compliance. Systemic changes will be completed by 3/31/16.</p>	

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F 0441 SS=D Bldg. 00	<p>During an interview on 3/7/16 at 3:33 p.m., RN # 3 indicated medication should be labeled and dated as soon as it is opened.</p> <p>During an interview on 3/8/16 at 9:18 a.m., DON (director of nursing) indicated medications should be labeled once they have been opened so staff will know when to discard the medication. She further indicated the facility follows manufacturer guidelines for Aplisol solution.</p> <p>On 3/8/16 at 9:10 a.m., A pharmlological insert undated was received by DON and was identified as the current policy the facility uses for Aplisol. The insert included but was not limited to, ... "Storage"... "Vials in use for more than 30 days should be discarded"....</p> <p>3.1-25(o)</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</p>			

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	<p>Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <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 staff washed their hands after direct contact with the residents for 2 of 3 residents observed during medication pass. (Resident # 204 and 231).</p> <p>Findings include:</p> <p>1. During an observation on 3/4/16 at 8:00 a.m., LPN # 3 entered Resident #</p>	F 0441	Licensed nurses will sanitize their hands after direct contact with residents and prior to preparing and administering medications to residents #204 and #231 All residents receiving medications have the potential to be affected by the same deficient practice Education is being provided to each licensed nurse to help prevent transmission of disease and infection during medication passes The education will include hand washing after direct	03/31/2016

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	<p>231's room and obtained resident's blood pressure using a blood pressure cuff on his arm and gave resident his medications. LPN# 3 exited the room when tasks were completed and was observed returning to her medication cart. LPN # 3 proceeded to prepare medication for another resident without washing her hands.</p> <p>2. During an observation on 3/17/16 at 8:20 a.m., LPN # 3 entered Resident # 204's room and obtained resident's blood pressure using a blood pressure cuff on his arm and gave resident his medications. LPN # 3 exited the room when tasks were completed and was observed returning to medication cart. LPN # 3 proceeded to prepare medication for another resident without washing her hands.</p> <p>During an interview on 3/8/16 at 2:43 p.m., ADON (assistant director of nursing) indicated staff should wash their hands after coming in contact with residents.</p> <p>A policy titled, "Medication Administration, General Guidelines" dated 12/2012 and provided by Director of Nursing on 3/8/16 at 9:10 a.m., included but not limited to, "...11. Hands are washed with soap and water again</p>		<p>resident contact and before proceeding to the medication cart to prepare medications for the next resident The ADON and/or her designee will observe medication passes to validate nurses are sanitizing their hands after each direct resident contact and prior to proceeding to the medication cart to prepare medications for the next resident Findings will be recorded on a monitoring tool Monitoring will occur daily on random halls, at random times across all 3 shifts The ADON will report to the Quality Assurance and Performance Improvement Committee monthly until in compliance for at least three consecutive months Systemic changes will be completed by 3/31/16</p>	

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	after administration and with any resident contact...." 3.1-18(l)				