STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST PARK HEALTH CAMPUS	2401 S L ST RICHMOND, IN 47374

(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
F000000	This visit was for a Recertification and State Licensure Survey. Survey Dates: December 2, 3, 4, 5, 6, 9, & 10, 2013. Facility number: 011387 Provider number: 155762 AIM number: 200853180 Survey team: Angel Tomlinson RN TC [December 2, 3, 4, 5, 6, & 10, 2013] Leslie Parrett RN [December 2, 3, 4, 5, 9, & 10, 2013] Barbara Gray RN Census Bed Type: SNF: 25 SNF/NF: 34 Residential: 22 Total: 81 Census Payor Type: Medicare: 25 Medicaid: 24 Other: 32 Total: 81 Residential sample: 7 This deficiency also reflect State findings cited in accordance with 410	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on December 10, 2013. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	IAC 16.2. Quality review completed on December 12, 2013, by Janelyn Kulik, RN.			

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F000247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on observation, interview, and record review, the facility failed to notify a resident and her Power of Attorney (POA) of a room change for 1 of 1 residents reviewed for a room change, of 1 who met the criteria for a room change. (Resident #4) Findings include: On 12/3/13 at 10:27 A.M., Resident #4 was observed seated in her wheelchair in the television room with peers. She was smiling and provided no verbal responses to questions asked. On 12/3/13 at 1:40 P.M., Resident #4's POA indicated she was not informed the last time Resident #4 was moved to another room. She indicated she wasn't aware of the room change until she went to visit Resident #4. She indicated she became anxious when she discovered Resident #4 no longer lived in the same room. She indicated she received an apology because she had not been notified	F000247	F 247 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #4 - POA was notified of the room change and reason for the change.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Social Service Director or designee will review documentation for room changes in the past 7 days to ensure the resident and Power of Attorney (POA) were notified of the change and the reason for the change. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Executive Director or designee will re-educate the Interdisciplinary Team on completion of the room change form and ensuring the documentation supports that the resident and the POA were notified of the change and the reason for the change. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for each resident requiring a room change will be conducted by the	01/09/2014

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	Resident #4 had been moved to a different room. Resident #4's record was reviewed on 12/5/13 at 8:57 A.M. Diagnoses included but were not limited to, senile dementia and exit seeking behaviors. Resident #4's quarterly Minimum Data Set (MDS) assessments dated 5/28/13 and 8/28/13, indicated she did not speak. She sometimes was understood and sometimes understood others. She was moderately impaired for her cognitive decision making skills. She had wandering behaviors daily. She had no behaviors of rummaging. A review of Resident #4's care plans indicated she wore a wanderguard because she liked to go up and down the halls in her wheelchair. Her care plans did not indicate any behaviors of rummaging. A "Notice of Transfer or Discharge Request For Hearing" form dated 5/20/13, indicated Resident #4 moved from bed 105B to bed 108A. The transfer form did not indicate the reason for Resident #4's room change, she had been notified of the room change, or her POA had been		Social Service Director or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Review documentation for room changes in the past 7 days to ensure the resident and Power of Attorney (POA) were notified of the change and the reason for the change. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	notified of the room change. A review of Resident #4's "Social Service Progress Notes" did not indicate the reason Resident #4 had the room change, the resident had been notified of the room change, or the POA had been notified of the room change. On 12/5/13 at 10:14 A.M., the Assistant Director of Social Services indicated she had spoke with the Director of Social Services by telephone and was informed Resident #4 had a room change on 5/20/13, for bed management. She indicated Resident #4 had been rummaging through her roommates belongings and the roommate thought Resident #4 was trying to steal her belongings. She indicated there was no documentation in Resident #4's record of the reason for the room change, the resident had been notified of the room change, or the POA had been notified of the room change. She indicated the resident and POA are normally notified of a room change and the reason for the room change. On 12/10/13 at 9:02 A.M., the Director of Social Services indicated Resident #4's POA visited the facility			

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	on 5/24/13. She indicated Resident #4's POA approached her and the former Assistant Director of Health Services (ADHS) and informed them she had noticed Resident #4 had been moved to another room. She indicated the former ADHS then spoke with Resident #4's POA regarding the room change. She indicated the former ADHS apologized to Resident #4's POA for not contacting her. She indicated Resident #4 was a wanderer. She indicated Resident #4 had been know to enter other Resident's rooms and rummage. She indicated there had been an issue when Resident #4 had been unmaking her roommates bed. The roommate had been tearful over the situation. She indicated Resident #4 was moved into a room with a more compatible roommate. She indicated the only documentation in Resident #4's record regarding a room change was the "Notice of Transfer or Discharge Request For Hearing" form dated 5/20/13. She indicated the only information on Resident #4's transfer form was the date, the name of Resident #4's representative, and the room number change from 105B to 108A. She indicated the transfer form did not indicate the reason for the room change or the resident or POA had			

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	been notified. She indicated the facility was responsible to notify the resident and their POA of a room change. On 12/10/13 at 10:02 A.M., the Executive Director provided information a resident receives when they move into the facility. The information indicated the following "1.) The facility will provide you and your representative (sponsor) with an advance notice of a change in your room assignment or when there will be a change in your roommate. 2.) The notice may be oral or in writing, or both, and will include the reason(s) for the room or roommate change. 3.) The facility will attempt to accommodate your wishes and preferences in roommates whenever possible." 3.1-3(v)(2)			

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F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to post nurse staffing information accessible to the public for 1 of 7 survey days.	F000356	F 356 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The nurse staffing information is posted on a daily basis in the Health Campus.Identification of	01/09/2014

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	Findings include: An initial tour of the facility was conducted on 12/2/13 at 9:04 A.M. The last nurse staff posting available on the wall near the nurses station indicated a date of 12/1/13. On 12/2/13 at 9:18 A.M., the facility's Scheduler indicated the last nurse staff posting information available on the wall near the nurses station was dated 12/1/13. She indicated the Director of Health Services (DHS) usually posted the daily nurse staffing. She indicated the DHS was scheduled off for the day. She indicated she was not sure who was responsible to post the nurse staffing when the DHS was absent. She indicated she had never posted the nurse staffing before but would try and make sure it was posted. The "Guidelines for Staff Posting" provided by the Executive Director on 12/10/13 at 8:58 A.M., indicated the following: "Purpose: To ensure compliance with federal regulations requiring posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care. Procedure: 1.) Prior to the beginning of each shift, the number and amount of hours of		other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing leadership team on the following: Guideline for staff Posting How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit will be conducted by the DHS or designee 5 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Ensure the nurse staffing information is posted for the day. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	licensed nurses (RN and LPN) and the number of hours of unlicensed nursing personnel who provide direct care to residents will be posted. 2.) Handwritten numbers must be legibly printed in black ink at least 1.5 to 2 inches tall and should be easily seen and read by residents, staff, visitors and others who are interested in our campus daily staffing information. 3.) Staffing sheets should be posted in a common area easily visible upon entry to the campus. 4.) Inquiries concerning our direct care staffing information should be referred to the Director of Health Services. 5.) Staffing sheets should be kept for 18 months." 3.1-13(a)			

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F000441 SS=D	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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F000441	F 441 Corrective actions accomplished for those residents	01/09/2014

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	properly disinfect a glucometer machine after a blood sugar check, for 1 of 3 blood sugar observations, having the potential to affect 20 residents who have their blood sugars checked. (Resident #94) Findings include: On 12/2/13 at 11:47 A.M., LPN #1 was observed checking Resident #94's blood sugar with the use of a glucometer machine. Resident #94's name was on the glucometer machine. After completing the blood sugar check LPN #1 placed Resident #94's glucometer machine back in the the medication cart. On 12/2/13 at 11:50 A.M., LPN #1 indicated all residents had their own glucometer machines. When queried, she indicated she wasn't sure of the procedure for cleaning the glucometer machines. She indicated she had been employed at the facility approximately 3 weeks. She then indicated that the glucometer machines were to be cleaned with an alcohol wipe. She removed Resident #94's glucometer machine from the medication cart, cleaned it with an alcohol wipe, and placed it back in the medication cart.		found to be affected by the alleged deficient practice: Resident #94 glucometer machine was cleaned with a sani-cloth wipe.Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will clean all glucometers with a sani-cloth wipe. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following: Glucometer cleaning guidelineHow the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following observations for 5 residents, random shifts will be conducted by the DHS or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Observe accu check to ensure glucometer machine is cleaned appropriately with a sani-cloth wipe. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	On 12/2/13 at 2:46 P.M., LPN #1 indicated LPN #2 had explained to her the correct procedure for cleaning the glucometer machines. She indicated the procedure was to clean each resident's glucometer machine before and after each use with a Sani-Cloth Germicidal disposable wipes provided by the facility. She indicated the Sani-Cloth wipes were stored in the bottom of the medication cart and provided an observation they were. On 12/2/13 at 3:21 P.M., the Director of Health Services (DHS) indicated the staff were to use the Germicidal Sani-Cloth wipes to clean the glucometer machines with each use. Resident #94's record was reviewed on 12/9/13 at 11:15 A.M. Diagnosis included but was not limited to diabetes mellitus. A December, 2013 recapitulation order for Resident #94 indicated the following: 7/19/13 - Resident #94 received Humalog insulin on a sliding scale according to her blood sugar readings, before meals and at bedtime. The glucometer machine was to be cleaned after each use. On 12/9/13 at 11:28 A.M., the DHS			

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	indicated staff should be informed on how to clean the glucometer machines during their orientation. She indicated new nurse hires have a mentor while working the floor. She indicated the nurse mentor would check off the newly employed nurse's skills on a checklist as they were completed. She indicated the checklist were turned into the business office after the new hire had completed their 90 day orientation. On 12/10/13 at 1:26 P.M., the Assistant Director of Health Services indicated she had just recently took on the position to orient new nurse hires. She indicated she had not oriented any new nurse hires yet. She indicated previously when she had worked the floor and mentored new hires she trained them to clean the glucometer machines with the Sani-Cloth Germicidal wipes provided by the facility, before and after each use. A copy of the "Glucometer Cleaning Guidelines" provided by the DHS on 12/3/13 at 10:45 A.M., indicated the following: "Introduction: The CDC states that HBV can survive for at least one week in dried blood on environmental surfaces or on contaminated instruments. The			

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	following recommendations provide the guidance for cleaning and decontamination of glucometer's that may be contaminated with blood and body fluids. Recommendations: 1.) If glucometer's are used from one resident to another they should be cleaned and disinfected after each use. 2.) Clean glucometer surface when visible blood or bloody fluids are present by wiping with a cloth dampened with soap and water to remove any visible organic material. 3.) If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA -registered detergent/germicide with a tuberculocidal or HBV/HIV label claim or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration. (NOTE: recommend the Sani-cloth bleach wipe by PDI ordered through our clinical medical supplier). > Directions for glucometer disinfection vary between manufacturers and models within brands. Alcohol should not be used because it can damage the light emitting diodes (LED) readout, causing "fogging" of the plastic screens. Alcohol is also not an EPA-registered detergent/disinfectant. > Many			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/10/2013
NAME OF PROVIDER OR SUPPLIER FOREST PARK HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374	

(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
	manufacturers do no recommend the use of quaternary ammonium products that combine bleach with detergents or disinfectants. > All manufacturers caution that having the cloth too saturated could allow liquid to get inside the glucometer and cause damage. Screens and ports currently are not sealed on these devices. Therefore, using a bleach-only disinfecting wipe is less likely to cause damage. 4.) Single use glucometer's should be cleaned when soiled and disinfected periodically. a.) Single use glucometer's should be stored in the resident's bedside stand or b.) In the med cart in the individual case to separate it from the other items in the cart. 5.) Appropriate infection control practices should be utilized noting the clean/dirty techniques".... 3.1-18(a)			