

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155263	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2015
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NAME OF PROVIDER OR SUPPLIER LOGOOTE NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12802 E US HWY 50 LOGOOTE, IN 47553
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: January 15, 16, 20, 21, and 22, 2015.</p> <p>Facility number: 000164 Provider number: 155263 AIM number: 100289550</p> <p>Survey team: Angela Patterson, RN-TC Brooke Harrison, RN Cheryl Mabry, RN (1/15, 1/20, 1/21, 1/22, 2015)</p> <p>Census bed type: SNF/NF: 39 Total: 39</p> <p>Census payer type: Medicare: 6 Medicaid: 30 Other: 3 Total: 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective February 16, 2015 to the State findings of the Recertification and State Licensure survey conducted on January 15th, 16th, 20th, 21st, and 22nd.</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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F000156 SS=A	<p>16.2-3.1.</p> <p>Quality review completed on January 27, 2015; by Kimberly Perigo, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of</p>				

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	<p>services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the</p>			

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	<p>physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure a resident was provided 48 hours notice for non-coverage of skilled services for 1 of 1 resident reviewed for advance beneficiary notice of Medicare non-coverage. (Resident #18)</p> <p>Findings include:</p> <p>On 1/21/15 at 10:38 a.m., the DON (Director of Nursing) provided a "Notice of Medicare Provider Non-Coverage" letter for Resident #18. The letter indicated Resident #18's skilled services would end on 5/13/14. The letter also indicated, "5/20/2014. Notified daughter [Name] of Medicare non-coverage effective 5/13/2014 last day. Apologized for late notice and requested sign form on next visit. Stated she will be here this afternoon to sign." The letter was signed by Resident #18's representative on 5/23/14.</p> <p>During an interview on 1/21/14 at 11:49 a.m., the DON indicated, "I know we are</p>	F000156	<p><i>Corrective action(s) taken for those residents found to have been affected by the deficient practice for; F156 A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. It is the intention of the facility to provide notice of rights, rules, services, and charges in a timely manner to resident and/or family. Actions taken for resident #18 include a review of chart which included physician order stating notification to POA on 5/13/2014 of Medicare services ending 5/14/2014. The measures that have been put into place to ensure that the deficient practice does not recur is that; A communication form, with therapy and nursing, has been developed to notify resident's POA no less than 48 hours in advance of any anticipated discharge from Medicare services. The corrective action taken to monitor to assure compliance is that; During the weekly Medicare meeting, plans for anticipated discharge from skilled services will be reviewed for the week. Completion Date: 2/16/2015</i></p>	02/16/2015

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	<p>supposed to give the residents either 72 or 48 hours notice before the end of Medicare coverage."</p> <p>On 1/21/14 at 12:14 p.m., the DON provided a "Physician Telephone Order Form," dated 5/13/14 with a time of 6:40 p.m. The order indicated, "D/C [discharge] PT/OT [Physical Therapy/Occupational Therapy] effective 5/14/14, maximum benefit reached." The order form indicated that Resident #18's representative was notified of order on 5/13/14.</p> <p>On 1/22/15 at 9:20 a.m., the Administrator provided the facility resident/family admission packet for Resident #18. The packet indicated, " ...If the facility decides your stay is not covered, or is no longer covered, the facility will give you a written notice of its [sic] decision. This notice explains the reason for the decision and your right to request that bill be submitted to the insurance company, which is responsible for Medicare claims for the nursing facility... "</p> <p>The admission paperwork lacked information regarding residents having at least a 48 hour notice before termination of their Medicare benefits.</p> <p>Medicare Advance Beneficiary Notice of</p>			

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F000272 SS=D	<p>Non-Coverage Second Edition dated April 2011 indicated, "A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities ... not later than 2 days before termination of services..."</p> <p>3.1-4(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continenence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information</p>			

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	<p>regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an accurate assessment of a resident's dental status for 1 of 1 resident reviewed for assessment of dental/oral health. (Resident #44)</p> <p>Findings include:</p> <p>On 01/15/2015 at 1:46 p.m., observation of Resident #44 indicated she was missing a lot of teeth, some were broken. Resident #44 indicated, "Because I have missing and damage teeth I am ashamed to open my mouth. I don't want to see the dentist at my age. My teeth have been like this for awhile." Resident #44 indicated, when food was to tough to eat she would just leave the food on her plate.</p> <p>Resident #44's clinical record was reviewed on 1/21/15, at 10:50 a.m. Diagnoses include, but were not limited to: weak recent fall, ambulatory dysfunction, and frequent falls.</p> <p>Resident #44 was admitted on 12/29/14. There was no documentation of Resident</p>	F000272	<p><i>Corrective action(s) taken for those residents found to have been affected by the deficient practice for; F272 SS=D This tag is being disputed under the IDR process. Please note, Resident #44 was not affected. It is the intention of the facility to conduct initially and periodically a comprehensive accurate standardized reproducible assessment of each resident's functional capacity. Actions taken for resident #44 included a chart audit and revealed a completed oral assessment upon admission on 12/29/2014. Also, on 12/29/2014, resident had a pain assessment completed which identified no complaints of oral pain. Nutrition Assessment completed upon admission indicated resident has own teeth with missing/decayed teeth. Resident answered on Nutrition Assessment no problem with chewing or swallowing. Resident stated on Nutrition Assessment on 12/29/2014 that pain does not affect meal intake. Speech Therapy (ST) evaluation and clarification order on 12/30/2014 to treat resident 5X a week for swallowing with cognitive therapy. There has been no weight loss. Resident and POA consented to</i></p>	02/16/2015

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	<p>#44's cognitive status. Resident #44 was interviewable and able to answer all questions.</p> <p>On 1/22/15 at 8:30 a.m., the DON provided "ADMISSION NURSING ASSESSMENT" dated 12/29/14, which indicated Resident #44 had own teeth and ORAL ASSESSMENT FORM undated indicating Resident #44 had some missing teeth. There was no documentation indicating Resident #44 had broken or damaged teeth.</p> <p>On 1/20/15 at 11:55 a.m., interview with LPN #2 (Licensed Practical Nurse) while reading the oral admission sheet indicated Resident #44 admitted 12/29/14, with some teeth missing. There was no indication at that time of Resident #44 having broken or damaged teeth.</p> <p>On 1/22/15 at 8:25 a.m., the DON indicated, "There is no documentation of [Name of Resident #44] damaged teeth."</p> <p>On 1/22/15 at 8:48 a.m., interview with LPN #3 who admitted Resident #44 indicated, "She [Name of Resident #44] had missing and broken teeth on admission. LPN #3 was observed to looked down at Resident #44's chart. There was no documentation of broken</p>		<p>on-site dental services at facility on 1/6/2015. A dental appointment was made for resident to be seen, resident declined dental services. An update has been made to the oral assessment form to include additional questions of broken/decayed teeth. Staff members have been in-serviced on updated oral assessment form. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that;</i> No residents were affected. A house wide audit has been completed utilizing the updated Oral Assessment form for all residents in the facility. There were no issues identified. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that;</i> Residents will continue to have assessments completed upon admission, quarterly, and/or on a significant change to identify issues. In-service conducted with nursing staff on the revised dental/oral assessment on how to complete form and responsibility in accurately completing the assessment. <i>The corrective action taken to monitor to assure compliance is that;</i> A quality assurance tool has been developed and implemented to audit resident charts to ensure completion of assessments. This tool will be completed by Director of Nurses and/or her designee</p>				

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	teeth provided at that time. 3.1-31(d)		weekly for four weeks, then monthly for three months, and then quarterly for three quarters. The outcome of this audit tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. Completion Date: 2/16/2015 QualityAssurance tool F-272 SS=D Directions: Through observation of the clinical record answer the questions below. Place a "Y" for yes and an "N" for no. Review the outcomes to determine if additional interventions are warranted. INDICATOR: 1. Upon audit of new admission chart, the resident has updated Oral Assessment form completed. 2. Upon audit of new admission chart, there was an appropriate dental referral made if warranted with resident response. RESIDENTS: 1. 2. 3. 4. 5. 6. 7. 8. COMMENTS: _____ Signature of Assessor Date IDR F272 SS=D We are requesting an Informal Dispute Resolution for Tag 272. Resident #44 was admitted to the facility on 12/29/14 and an oral assessment was completed. Also, on 12/29/2014, the resident had a pain assessment completed which identified no complaints of oral pain. Nutrition Assessment on 12/29/2014 indicated resident has own teeth with missing/decayed teeth. Resident answered on Nutrition		

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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 as indicated by the facility policy, the Center for Disease Control, and the 410 IAC Retail Food Establishment Sanitation Requirements Manual that staff used proper handwashing in the kitchen, outdated food was discarded from 1 of 1 walk in freezer and the dry storage room, labeling of unidentifiable foods for 1 of 1 walk in refrigerator, and</p>	F000371	<p>Assessment no problem with chewing or swallowing. Resident stated on Nutrition Assessment that pain does not affect meal intake. Speech Therapy (ST) evaluation and clarification order on 12/30/2014 to treat resident 5X a week for swallowing with cognitive therapy. There has been no weight loss. Resident and POA consented to on-site dental services at facility on 1/6/2015. A dental appointment was made for resident to be seen, resident declined dental services. An update has been made to the Oral Assessment form to include additional questions of broken/decayed teeth.</p> <p><i>Corrective action(s) taken for those residents found to have been affected by the deficient practice for; F371 SS=F A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. It is the intent of this facility to store, prepare, distribute, and serve food under sanitary conditions. The 2567 indicated that the issues identified during the survey</i></p>	02/16/2015

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	<p>cooking pans were completely dried before storing to prevent lime build up. This deficient practice had the potential to affect 39 of 39 residents being served meals from the kitchen. (Cook #1, Dietary Manager)</p> <p>Findings include:</p> <p>On 1/16/15 at 9:50 a.m., the following was observed during the kitchen tour:</p> <p>1). Cook #1 was observed to enter the kitchen from the back hallway. She walked over to the prep counter and removed some bowls from under a cabinet. Cook #1 scooped sherbet into the bowls. There was no handwashing observed.</p> <p>2). The covered floor mixer had flaking metal on the top of the machine over the mixing bowl. The Dietary Manager (DM) indicated, "I don't know if they have to replace it or seal it [indicating the mixer]."</p> <p>3). There was an open box on the floor by the 3 compartment sink with dead spiders inside of it. The DM was observed to pick up the box and throw it in the trash. The DM walked over to the sink and placed her hands under the water while rubbing them together for 6 seconds. The</p>		<p>have the potential to affect 39 of the 39 residents, please note none of these individuals have displayed a negative outcome/illness as a result of these findings. 1.) A one on one in-service has been provided for Cook #1 on the facility's hand washing policy and procedure. Cook #1 is practicing hand hygiene in accordance with facility policy. 2.) The floor mixer has been sanded to remove any flaked paint and has been sealed to prevent future flaking of paint. 3.) A one on one in-service has been provided to DM on the facility's hand washing policy and procedure. DM is practicing hand hygiene in accordance with facility policy. 4.) An in-service has been provided to all Dietary personnel on proper disposal of all expired food and non-food products. 5.) An in-service has been provided to all Dietary personnel on proper labeling and disposal of all expired food and non-food products. 6.) An in-service has been provided to all Dietary personnel on proper disposal of all expired food and non-food products. 7.) An in-service has been provided to all Dietary personnel on proper disposal of all expired food and non-food products. 8.) All pans noted to have lime build up have been discarded and replaced. Staff has been educated on importance of not using worn cookware and reporting of need for new. 9.) An</p>	

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	<p>DM indicated she should handwash for 20 seconds.</p> <p>4). There was an open box of baking soda on the shelf in the dry storage room with an expiration date of 9/7/13.</p> <p>5). There were 6 pieces of unidentifiable meat in a container with a use by date of 1/12/15. The DM indicated the meat was Swiss steak.</p> <p>6). The walk in freezer had a baggie of ham on a shelf, with an expiration date of 9/4/14, with what appeared to be freezer burn over it and sausage gravy on the shelf with use by date of 1/14/14. Observed the DM to remove and discard the ham and gravy at that time.</p> <p>On 1/22/15 at 9:13 a.m., the Director of Nursing indicated there was no policy/procedure for discarding expired food.</p> <p>7). The dry storage room had a box of cream of wheat on the shelf with a used by date of 1/14/15. There was a container of oats with a used by date of 1/14/15. The DM was observed to remove foods at that time.</p> <p>On 1/20/15 at 3:05 p.m. the following was observed in the kitchen:</p>		<p>in-service has been provided to all Dietary personnel on proper disposal of all expired food and non-food products. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that; A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. An audit of all food items has been completed and there are no outdated or expired food items in the dietary department. Maintenance has repaired the area of concern with mixer. Staff in-serviced on proper hand hygiene, food labeling and storage, and the disposal of expired food and non-food products. Worn pans have been discarded and staff has been educated on not using worn cookware and reporting need for new. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that; A mandatory in-service has been conducted for the dietary staff on proper handwashing, food storage and labeling, disposal of expired food and non-food products, and not using worn cookware. <i>The corrective action taken to monitor to assure compliance is that; A Quality Assurance Tool has been developed and implemented to observe proper hand hygiene and glove use. This tool will be</i></i></i></p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>8). There were 3 dirty shallow baking pans stored under the counter. There were 2 small pans, 2 medium pans, 4 large cookie sheets, and 1 colander stored on a rack in the kitchen. All the pans were observed with lime build up on the bottom. The DM indicated the lime build up came from the facility's water. The DM was observed to remove and pour delimer into the pans and let them soak. The DM indicated, "Well there is nothing I can do about lime."</p> <p>9) On 1/20/15 at 10:05 a.m., with the Dietary Manager present, observed 2 bottles of chlorine test strips with an expiration date of 8/2012. The chlorine strips were used to test the level of chlorine in the dishwasher's water for sanitizing of the dishes. The DM indicated there were no current chlorine test strips on site.</p> <p>On 1/22/15 at 8:58 a.m., the Administrator (ADM) provided the policy "Food and Non-Food Storage" revised date 2011, and indicated the policy was the one currently used by the facility. The policy indicated, "...Refrigerated and Frozen Storage, ...8. Foods that have been removed from their original containers are clearly marked with contents, dated and wrapped to</p>		<p>completed by the Administrator and/or her designee weekly for four weeks, monthly for three months, and then quarterly for three quarters. Additional education and/or counseling will be provided if any area of concern is identified. The Quality Assurance tools will be reviewed at the facility quality assurance meetings to determine if additional action is warranted. Completion Date: 2/16/2015 Quality Assurance tool F-371 Directions: Through observation of the clinical record answer the questions below. Place a "Y" for yes and an "N" for no. Review the outcomes to determine if additional interventions are warranted. INDICATOR 1. Upon observation of the dry food storage area, all items are labeled with open date and expiration date. 2. Upon observation of the walk in cooler area, all items are labeled with open date and expiration date. 3. Upon observation of the walk in freezer area, all items are labeled with open date and expiration date. 4. Upon observation of dietary staff during food preparation, food storage, and during tray line all dietary staff are washing their hands and utilizing acceptable standards of hand washing practices. 5. Upon observation of dry food storage area, no expired food or non-food items are noted. 6. Upon observation of walk in cooler area, no expired</p>		

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	<p>exclude as much as possible. ... Dry Food Storage ...9. All products, previously opened, are labeled and dated. ..."</p> <p>On 1/22/15 at 9:11 a.m., the Administrator (ADM) provided the policy "Food Preparation and Safety" revised date 2011, and indicated the policy was the one currently used by the facility. The policy indicated, "...7. Leftovers are checked daily to determine proper usage within a 3-day span. 8. Leftovers are discarded after 72 hours after initial preparation."</p> <p>On 1/22/15 at 8:57 a.m., the Administrator provided the policy "Environmental Sanitation/Infection Control" revised date 2011, and indicated the policy was the one currently used by the facility. The policy indicated ... C. Soap is applied and all surfaces of the hands and fingers are rubbed together vigorously with friction for at least 20 seconds, ... D. Hands are rinsed thoroughly with clean, warm running water. ...2. Hands are properly washed before and/or after the following activities, ...1. When entering a food preparation area. 2. Before putting on clean, single use gloves for working with food and between glove changes, 3. Before engaging in food preparation. 4. Before handling clean equipment and</p>		<p>food or non-food items are noted. 7. Upon observation of walk in freezer area, no expired food or non-food items are noted. 8. Upon observation of cookware in dietary area, no items were noted to be worn. FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 1. 2. 3. 4. 5. 6. 7. 8. COMMENTS</p> <p>_____ Signature of Assessor Date</p>	

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	<p>serving utensils, ..."</p> <p>On 1/22/15 at 2:37 p.m., review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, "Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6) After handling soiled surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>On 1/22/15 at 2:37 p.m., review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24-304, dated November 13, 2004, indicated, "Equipment and utensils; air drying required, ... (a) After cleaning and sanitizing, equipment and utensils:(1) shall be air-dried or used after</p>			

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F000372 SS=D	<p>adequate draining as specified in the 21 CFR 178.1010(a), before contact with food; and (2) may not be cloth-dried except the utensils that have been air-dried may be polished with cloths that are maintained clean and dry. ... "</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure as indicated by facility policy and the 410 IAC Retail Food Establishment Sanitation Requirements Manual the garbage was properly disposal of for 1 of 1 outdoor waste receptacle.</p> <p>Findings include: On 1/21/15 at 11:05 a.m., with the Dietary Manager (DM) present, observed both lids on the dumpster off and on the ground. The gates of a wooden fence surrounding the dumpster area were damaged. There was one lid behind the dumpster with trash on top of lid and the</p>	F000372	<p>Corrective action(s) taken for those residents found to have been affected by the deficient practice for; F372 SS=D This tag is being disputed under the IDR process. A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. It is the intention of the facility to establish and maintain proper disposal of garbage and refuse. Actions taken for proper disposal of garbage and refuse include outdoor waste receptacle being repaired and area cleaned immediately upon observation of disarray. Contacted trash disposal company to make aware of maintenance to dumpster. A letter has been mailed to the</p>	02/16/2015

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	<p>other dumpster lid was on the side of dumpster leaning on the fence enclosing the dumpster area. There was a large black trash bag on the ground aside of the dumpster. The DM indicated the lids should be on the dumpster. She indicated that maintenance was working on getting the fence fixed and dumpster lids put back on the dumpster. When asked how long had the fence been damaged and lids off the dumper, the DM indicated, "I don't know ask maintenance or [Name of the Administrator]. I think it was the last snow or when we had the ice." Observed the DM to pick up the garbage bag from the side of the dumpster and throw the bag inside the dumpster.</p> <p>On 1/21/15 at 11:30 a.m., interview with the Administrator indicated she was not aware the outside dumpster lids were off. She indicated that she would call the trash company to inform them so they could come fix the dumpster.</p> <p>On 1/22/15 at 8:57 a.m., the Administrator provided the policy "Disposal of Garbage" undated, and indicated the policy was the one currently used by the facility. The policy indicated, "...1. Containers shall be ... kept covered when not in actual use. ..."</p> <p>On 1/22/15 at 4:32 p.m., review of</p>		<p>trash disposal company to inform them of our policy and procedure of proper disposal of garbage and refuse. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that;</i> A mandatory in-service has been conducted for all staff on proper disposal of garbage and refuse. <i>The corrective action taken to monitor to assure compliance is that;</i> Staff will be educated on importance of reporting any concerns with outside waste receptacle to the Administrator, DON, and/or designee Completion Date: 2/16/2015 IDR F372 SS=D We are requesting an Informal Dispute Resolution for tag F372. Within 20 minutes of observation of disarray caused by recent inclement weather, the outside waste receptacle lid was repaired and area was cleared of debris. The trash disposal company was notified of repair completed by maintenance staff at Loogootee Nursing Center. A letter has been mailed to the trash disposal company to inform them of our policy and procedure of proper disposal of garbage and refuse.</p>		

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F000441 SS=E	<p>"RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24," dated November 13, 2004, indicated, ...410 IAC 7-24-385 Outside receptacles Sec. 385. (a) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the retail food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers. ..."</p> <p>3.1-21(i)(5)</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 (1) When the Infection Control Program</p>				

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	<p>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>A. Based on observation, interview, and record review, the facility failed to ensure staff changed soiled gloves and performed handwashing as the facility policy indicated, while providing care to residents during 2 resident observations for infection control practice. (Resident #46, Resident #22) (CNA #1, CNA #2)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure handwashing was completed as the facility policy indicated during Medication Administration for 4 of 17 residents observed during medication administration. (Resident #3) (Resident #13) (Resident #14) (Resident #37) (LPN #1)(LPN #2)</p> <p>Findings include:</p>	F000441	<p><i>Corrective action(s) taken for those residents found to have been affected by the deficient practice for; F441 SS=E A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. It is the intention of the facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary, comfortable environment, and to help prevent the development and transmission of disease and infection. Actions taken for residents identified on form 2567 is that care is being provided using acceptable standard of practices as it relates to hand washing and glove use. Upon assessment of each of the identified residents, no residents suffered any negative outcome or illness based on the issues</i></p>	02/16/2015

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	<p>A. 1. On 1/21/15 at 11:31 a.m., CNA (Certified Nursing Assistant) #1 was observed to place on clean gloves and assist Resident #46 from his chair and to the bathroom. After Resident #46 used the toilet, CNA #1 cleaned Resident #46's perineal area with the gloved hand. With the soiled glove on, CNA #1 pulled up his pants and assisted the resident back to his chair.</p> <p>On 1/21/15 at 11:37 a.m., CNA #1 indicated, "Yes, I did wipe him and then pull up his pants with the same glove. I know I should change my gloves after toileting him and before I pull up his pants. I never thought about it, but we should have the racks for the gloves in the bathroom and not just by the hallway door. We probably should though, because we have to change our gloves in the bathroom." CNA #1 also indicated, "I'm going to talk to the Administrator about that."</p> <p>2. On 1/21/15 at 2:41 p.m., CNA #2 was observed to put on clean gloves and assist Resident #22 to bed. CNA #2 removed Resident #22's incontinence brief and wiped the resident clean of bowel and urine. CNA #2 disposed of the soiled gloves into the waste basket and immediately put on clean gloves. CNA</p>		<p>identified during the survey process. Residents identified as #3, #13, #14, and #37 are now receiving their medications in accordance with acceptable standards of infection control practice during medication administration. The facility's hand washing policy was updated on 1/21/2015 to reflect proper length of time for hand washing. A1.) CNA#1 has been re-educated on the proper use of gloves during personal care and the resident identified as resident #46 is receiving personal care in accordance with acceptable standards of practice related to the proper use of gloves and hand washing. A2.) CNA #2 has been re-educated on the proper use of gloves during personal care and the resident identified as resident #22 is receiving personal care in accordance with acceptable standards of practice related to the proper use of gloves and hand washing. B1.) A one on one in-service has been provided for LPN #1 on the facility hand washing policy and procedure. LPN #1 is practicing hand hygiene in accordance with facility policy. B2.) A one on one in-service has been provided for LPN #2 on the facility hand washing policy and procedure. LPN #2 is practicing hand hygiene in accordance with facility policy. B3.) A one on one in-service has been provided for LPN #2 on the facility hand</p>	

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	<p>#2 was observed to not handwash or use handgel after removing the soiled gloves and before putting on clean gloves.</p> <p>During an interview on 1/21/15 at 2:49 p.m., CNA #2 indicated, "You use gloves and handwash any time you toilet someone." In regard to knowledge of handwashing policy and procedure, CNA #2 indicated, "I don't really know for sure..."</p> <p>On 1/21/15 at 2:56 p.m., the DON (Director of Nursing) provided the facility's policy on "Gloves, Non-Sterile," undated, and indicated it was the policy currently being used by the facility. The policy indicated: "...[Guidelines]... 2. Disposable gloves shall be replaced when contaminated, torn, punctured, or when their function as a barrier has been compromised..." The policy also indicated, "...[Donning Gloves] 1. Wash hands..." The policy further indicated, "... [Removing gloves]... 5. Dispose of gloves without contaminating your hands. 6. Wash your hands..."</p> <p>B. 1. On 1/16/2015 at 11:50 a.m., an observation of LPN (Licensed Practical Nurse) #1 indicated she administered a subcutaneous injection of Novolog Flexpen (fast acting insulin used for diabetes) for Resident #37, then removed her gloves and washed her hands for 10</p>		<p>washing policy and procedure. LPN #2 is practicing hand hygiene in accordance with facility policy. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that;</i> A house wide audit of all residents has been conducted. No residents were found to have a negative outcome/illness based on the issues identified during survey. <i>The measures that have been put into place to ensure that the deficient practice does not recur is that;</i> A mandatory in-service has been conducted for all staff on proper hand washing techniques and glove use. The in-service included acceptable standards of infection control practices related to hand washing and glove usage while providing personal care and administering medication. New staff will be in-serviced during orientation on proper technique for hand washing and glove use. <i>The corrective action taken to monitor to assure compliance is that;</i> A Quality Assurance Tool has been developed and implemented to observe proper hand hygiene and glove use. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, monthly for three months, and then quarterly for three quarters. Additional education and/or counseling will be provided if any area of concern is identified. The</p>				

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	<p>seconds.</p> <p>On 1/16/2015 at 3:45 p.m., an interview with LPN #1 indicated the correct amount of time for hand washing was 15 seconds.</p> <p>2. On 1/21/2015 at 11:27 a.m., LPN (Licensed Practical Nurse) #2 administered Resident #3's medications and hand washed for 15 seconds.</p> <p>3. On 1/21//2015 at 11:29 a.m., LPN #2 administered medication to Resident #14 and then washed her hands for 10 seconds.</p> <p>On 1/21/2015 at 11:30 a.m., an interview with LPN #2 indicated she sings the happy birthday song twice to know she's washed her hands long enough.</p> <p>4. On 1/21/2015 at 11:49 a.m., an observation of LPN #1 indicated she administered Resident #13's NovoLog subcutaneous injection (a fast acting insulin for diabetes) then removed her gloves and washed her hands for 15 seconds.</p> <p>On 1/21/2015 at 2:30 p.m., after giving Resident #13 her medication LPN #1 washed her hands for 10 seconds.</p>		<p>Quality Assurance tools will be reviewed at the facility quality assurance meetings to determine if additional action is warranted. Completion Date: 2/16/2015 QualityAssurance tool F-441 Directions:Through observation of the clinical record answer the questions below. Place a "Y" for yes and an "N" for no. Review the outcomes to determine if additional interventions are warranted. INDICATOR 1.Upon observation of nursing staff during resident care, staff was observed to perform proper hand hygiene. 2.Upon observation of nursing staff during resident care, staff was observed to display proper glove use. 3.Upon observing medication administration, nurse was observed to practice acceptable standards of infection control. Staff 1. 2. 3. 4. 5. 6. 7. 8.</p> <p>COMMENTS</p> <p>_____ Signature of Assessor Date</p>		

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	<p>On 1/21/2015 at 10:35 a.m., an interview with the Director of Nursing indicated, the Handwashing policy was updated since the original hand washing policy did not meet the recommendations of the CDC (Centers for Disease Control) on handwashing. The original policy indicated the proper amount of time for handwashing was 15-20 seconds. The Director of Nursing indicated she was going to re-educate staff on the new policy.</p> <p>Review of the Centers for Disease Control and Prevention dated December 16, 2013, "Handwashing: Clean Hands Save Lives ... When and How to Wash Your Hands ... How should you wash your hands?" indicated, "...Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them ..."</p> <p>3.1-18(I)</p>			

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NAME OF PROVIDER OR SUPPLIER LOGOOTE NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 12802 E US HWY 50 LOGOOTE, IN 47553			
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F000456 SS=D	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure the stove was maintained in proper working condition in that the left front corner burner would not ignite when the knob was turned on for 1 of 1 stove in the kitchen.</p> <p>Findings includes:</p> <p>1). On 1/16/15 at 9:50 a.m., with the Dietary Manager (DM) present observed the front left corner burner not to ignite when turned on. The DM indicated, "We have to light it with a lighter when we use it. Maintenance is aware." The DM was not able to indicate how long the left front stove burner had not been functioning correctly.</p> <p>On 1/22/15 at 9:22 a.m., the Administrator indicated the maintenance man does not do random check of the kitchen equipment. He will only check if the Dietary Manager notifies him of a problem.</p> <p>3.1-19(bb)</p>	F000456	<p><i>Corrective action(s) taken for those residents found to have been affected by the deficient practice for; F456 SS=D This tag is being disputed under the IDR process. A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. It is the intention of the facility to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. The left front corner burner of the stove has been repaired and is in good functioning condition. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that; A house wide audit of all residents has been conducted and no residents were found to be affected by these findings. An audit of all dietary equipment has been completed and all equipment is in good functioning condition. The measures that have been put into place to ensure that the deficient practice does not recur is that; A mandatory in service was conducted with dietary staff on the proper reporting to Administrator or management</i></p>	02/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155263	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/22/2015
NAME OF PROVIDER OR SUPPLIER LOGOOTEENURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12802 E US HWY 50 LOGOOTEEN, IN 47553		
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			when there is any equipment failures for proper and timely repairs. <i>The corrective action taken to monitor to assure compliance is that;</i> Maintenance Supervisor and/or his designee will conduct monthly audit of kitchen equipment for proper functioning. Completion Date: 2/16/2015 IDR F456 SS=D We are requesting an Informal Dispute Resolution for tag F456, upon notification of concern of front left corner burner, repairs were made and burner is in good functioning condition.		