

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2014
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NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: July 7, 8, 9, 10, & 11, 2014</p> <p>Facility number: 000217 Provider number: 155324 AIM number: 100289590</p> <p>Survey team: Diana McDonald, RN-TC Melissa Gillis, RN Angela Patterson, RN Susan Worsham, RN (July 7 & 8, 2014)</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 12 Medicaid: 38 Other: 9 Total: 59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 17,</p>	F000000	<p>This plan of correction is prepared and executed because of the provisions of State and federal law require it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction. *Request paper compliance please</p>	

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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F000323 SS=D	<p>2014; by Kimberly Perigo. RN.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received adequate implementation of an assistance device to alert staff of self transfer/standing, in that a mobility monitor had not have been implemented prior to a fall for 1 of 3 residents reviewed for accidents, which resulted in a mobility alarm not having alerted staff when a resident had attempted to get out of a Broda chair (a medical chair designed to provide comfort and support for individuals with muscle control and muscle support difficulties) unassisted. (Resident #52)</p> <p>Findings include:</p> <p>Resident #52's clinical record was reviewed on 7/9/14 at 10:00 a.m.</p> <p>Diagnoses included, but were not limited</p>	F000323	<p>F 323 1. Resident affected by alleged deficient practice: ·Resident #52 will utilize alarm as ordered and remain free from incident.</p> <p>2. Residents at risk to be affected by alleged deficient practice: ·Residents utilizing personal alarms have the potential to be affected by the alleged deficient practice. ·Plan of care for residents #52 reviewed by nursing admin and updated as indicated on July 21st, 2014. ·Nursing admin completed 100% audit of alarms for placement, audible sound and cord length on 7-8-2014</p> <p>3. Systems to ensure alleged deficient practice does not recur: ·Ongoing education with nurses will be provided as indicated for non-compliance regarding alarm use by nursing admin. ·Nursing admin will audit 5 residents/wk on alternating</p>	07/28/2014

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	<p>to: insomnia, hypertension, gastroesophageal reflux disease, chronic loose stools, dementia, herpes simplex stomatitis, and osteoporosis.</p> <p>The BIMS (Brief Interview for Mental Status) score was a 3, on 3/22/14. A score of 00 - 07 indicates a resident had severe cognitive/thinking impairment and was dependent on nursing staff for daily decision making.</p> <p>The MDS (Minimum Data Set) assessment dated 3/22/14, indicated the assessment for bed mobility and transfer for Resident #52 was, an extensive assistance with two plus person physical assist. The resident is involved in the activity with staff providing weight-bearing support. The activity of walking in the room did not occur and Resident #52 was totally dependent on staff for locomotion on unit.</p> <p>Resident #52 was receiving specialized services, which included but not limited to:</p> <ol style="list-style-type: none"> 1. Restorative level I care with active range of motion to bilateral (both sides) lower extremities and bilateral upper extremities 20 reps (repetition), 2 sets daily. 2. Restorative level I grooming assistance, including Resident #52 to 		<p>shifts using an alarm regarding placement and audible sound 7 days a week X 6 months.</p> <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> ·Plan to be updated as indicated. ·Nursing admin will audit 5 residents/wk on alternating shifts regarding alarm placement and audible sound 7 days a week X 6 months. ·Ensure 100% PI compliance monthly X 6 months. <p>1.Date of compliance: July 28th, 2014</p>	

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	<p>wash face and hands daily with set up help and cueing with assistance of 1 person.</p> <p>3. Bed mobility, Resident #52 will be cued to roll side to side using side rails every 2 hours with staff performing bed check.</p> <p>4. Restorative nursing program level II for AROM (Active Range of Motion), to the bilateral upper extremities 20 reps, 2 sets daily. Resident will be cued to roll side to side using side rail every 2 hours with staff performing bed check.</p> <p>Review of Resident's #52 care plan dated 10/22/13, and remained current at time of survey indicated Resident #52, "... presents with risk for falls, as evidence by history of fall prior to admission relating to cognitive impairment which impacts safety awareness and as side effect of daily antidepressant medication use..." Approaches include "...provide environmental adaptations... 3. tab alarm in place at all times..."</p> <p>Incident Report dated 7/8/2014, reviewed on 7/10/14 at 1:00 p.m., indicated "... Staff responded to resident calling out. Staff entered room to find resident lying on left side. Type of injury/Injuries: Right hip fracture..."</p> <p>Interview on 7/10/14 at 1:39 p.m., with</p>			

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	<p>LPN #1 (the nurse who was the first to respond to Resident #52's call for help) indicated, I check all my alarms when I come on shift at 3:00 p.m. I had checked Resident #52's alarm for placement and function at approximately 3:10 p.m. I was in another room when I heard Resident #52 calling. I ran down to her room and found her on the floor in front of her Broda chair. I got help so we could get her into bed. The alarm did not sound. "The cord was not attached to the resident."</p> <p>Interview with CNA #1 on 7/9/2014 at 3:20 p.m., indicated Resident #52 had her brief changed and alarm tested at 3:15 p.m., on 7/7/14. CNA #1 left the room to assist another staff member with a different resident. At about 3:30 p.m. on 7/7/14, LPN #1 came and got me to assist with Resident #52, after the resident fell from her Broda chair.</p> <p>Interview on 7/10/14 at 1:25 p.m., with CNA #2 indicated Resident #52 had her brief changed and returned to her Broda chair on 7/7/14 at about 3:30 p.m. When I left the room Resident #52 was in her Broda chair actively watching TV and calm. Her chair alarm was on and working.</p> <p>Interview on 7/11/14 at 11:01 a.m., with</p>						

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	<p>DON. The DON was informed LPN #1 requested a second interview. At that time LPN#1 indicated "the alarm cord was attached to the alarm and not to [Resident # 52 name]."</p> <p>Record review on 7/9/14 at 3:15 p.m., of Treatment Record Dated 7/7/14, 6:00 a.m., to 2:00 p.m., shift indicated tab alarm was checked for sound and function. The nurse indicated the tab alarm was working properly.</p> <p>DON demonstrated the alarm functioning of Resident's #52 alarm on 7/10/14 at 11:05 a.m. The DON indicated the alarm was taken out of service and had not be altered. The DON pulled the cord and the alarm sounded. The DON indicated the alarm was working.</p> <p>3.1-45(a)(2)</p>			

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F000371 SS=D	<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 food temperatures during lunch were at the minimum required temperatures as indicated by facility policy and the 410 IAC 7-24 for 1 of 3 halls. (Hall D) (Resident #23, Resident #104).</p> <p>Findings include:</p> <p>Interview on 7/8/14 at 10:00 a.m., with Resident #104 indicated when asked how the food was, "It usually is cold. The coffee is worse. I hate drinking cold coffee."</p> <p>Interview on 7/7/14 at 3:00 p.m., with Resident #23 indicated when asked how the food was, "It could be warmer. Almost every meal, my food is cold."</p> <p>Observation on 7/10/14 at 11:40</p>	F000371	<p>F 371 1. Residents affected by alleged deficient practice: ·Hot and cold meal items will be delivered to D hall on separate carts so that appropriate temperatures are maintained. ·Dining Services manager will interview resident #104 and resident #23 weekly X 4 weeks to ensure that food temperatures are appropriate. 2. Residents at risk to be affected by alleged deficient practice: ·Hot and cold meal items delivered to all halls for consumption in the resident room will be delivered in separate carts to maintain appropriate temperatures. 3. Systems to ensure alleged deficient practice does not recur: ·Dining Services staff will be re-educated regarding appropriate temperatures for hot and cold foods. ·Meal delivery process for residents eating in their rooms will be changed so that hot and cold foods are not delivered on the</p>	07/28/2014			

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	<p>a.m., indicated the lunch trays for D hall arrived on the unit. At 12:05 p.m., the food temperatures were taken by the Dietary Manager (DM) on the last tray in the cart. The temperature of the coleslaw was 61 degrees Fahrenheit, the vanilla pudding was 67 degrees Fahrenheit, and the milk was 48 degrees Fahrenheit.</p> <p>Observation on 7/11/14 at 11:30 a.m., indicated the DM took the temperatures of the food that was on the food service line and documented the temperatures.</p> <p>Interview on 7/11/14 at 12:10 p.m., with the DM indicated when asked what the temperature was suppose to be for cold foods, "41 degrees or below."</p> <p>On 7/14/14 at 2:00 p.m., the DM provided the "Dietary Service Plan." The DM indicated the kitchen staff follows this with every meal. The plan indicated, "... cold food holding temperature of 50 degrees or less..."</p> <p>Review on 7/14/14 at 9:10 a.m., of The Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, Section 187 indicated, "...potentially hazardous food shall be</p>		<p>same cart.</p> <ul style="list-style-type: none"> ·Dining Services Manager will interview one resident from each hall every week to ensure that delivered meal temperatures are acceptable. Resident interviews on each hall will rotate through all residents capable of participating in an interview. 4. Monitoring to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> ·Weekly resident food interviews will be documented and brought to the monthly PI meeting. ·Dining Services will audit food tray temperatures delivered for consumption in a resident's room; the last tray served for one breakfast, one lunch, and one dinner will be tested weekly X 6 months ·Results of weekly tray audits will be documented and presented during the monthly QI meeting X 6 months. <p>1.Date of compliance: July 28th, 2014</p>		

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F000441 SS=E	<p>maintained as follows:...(2) At a temperature specified in the following: (A) at forty-one (41) degrees Fahrenheit or less..."</p> <p>3.1-21(a)(2)</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</p>			

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	<p>The facility must establish an Infection 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</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper handwashing was used by staff as indicated by the facility policy in that 2 nurses did not wash their hands for twenty seconds while administering medication for 4 of 10 randomly observed residents during medication administration. (Resident #5, Resident #75, Resident #16, Resident #75) (LPN #2, LPN #3)</p>	F000441	<p>F 441 1. Resident affected by alleged deficient practice:</p> <ul style="list-style-type: none"> ·Residents #5, #16, #75, and #92 remain free of facility acquired infection. <p>2. Residents at risk to be affected by alleged deficient practice:</p> <ul style="list-style-type: none"> ·Residents receiving staff support for care have the potential to be affected by the alleged deficient practice. ·Plan of care for residents #5, 	07/28/2014

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	<p>Findings include:</p> <p>1). On 7/10/2014 at 11:10 a.m., an observation of LPN #2 washing her hands after administering medication to Resident #92 indicated she washed her hands for 15 seconds.</p> <p>On 7/10/2014 at 1:25 p.m., an observation of LPN #2 washing her hands after administering medication to Resident #16 indicated LPN #2 washed her hands for fifteen seconds. At that time, an interview with LPN #2 indicated she sings the ABC song twice so that she knows that she has washed her hands for long enough.</p> <p>2). On 7/10/2014 at 8:52 a.m., an observation of LPN #3 washing her hands after administering medication to Resident #75 indicated she washed her hands for 10 seconds.</p> <p>On 7/10/2014 at 9:00 a.m., an observation of LPN #3 washing her hands after administering medication to Resident #5 indicated she washed her hands for 10 seconds. At that time, an interview with LPN #3 indicated the proper amount of time for hand washing is 20 seconds and indicated she counts 1 Mississippi, 2 Mississippi, until she gets</p>		<p>#16, #75, and #92 were reviewed by nursing admin and updated as indicated on July 21st, 2014.</p> <ul style="list-style-type: none"> ·Nursing admin to educate nurses by July 28th, 2014 regarding Handwashing during Medication Pass. ·LPN #2 and #3 have been in serviced and competencies completed on the appropriate protocol and policy of handwashing. <p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> ·Ongoing education with nurses will be provided as indicated for non-compliance regarding Handwashing during Medication Pass by nursing admin. ·Nursing admin will audit 5 residents/wk on alternating shifts receiving staff support for care regarding Handwashing during Medication Pass 7 days a week X 6 months. <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> ·Plan to be updated as indicated. ·Nursing admin will audit 5 residents/wk on alternating shifts receiving staff support for care regarding Handwashing during Medication Pass 7 days a week X 6 months. ·Ensure 100% PI compliance monthly X 6 months. <p>1.Date of compliance: July 28th, 2014</p>				

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	<p>to 20 Mississippi.</p> <p>On 7/10/2014 at 8:33 a.m., the DON (Director of Nursing) provided the "Hand Hygiene" policy, dated 5/1/2012, and indicated the policy was the one currently used by the facility. The policy indicated, " Handwashing: ...2. Moisten hands with soap and water and make a heavy lather. 3. Wash well under running water for a minimum of 20 seconds, using a rotary motion and friction"</p> <p>3.1-18(l)</p>				