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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/19/2012 |
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| NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DR PENDLETON, IN 46064 |
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| F0000 | <p>This visit was for the Investigation of Complaint IN00109801.</p> <p>Complaint IN00109801 substantiated, federal/state deficiencies related to the allegations are cited at F441 and F514.</p> <p>Survey date: June 19, 2012</p> <p>Facility number: 000248 Provider number: 155357 AIM number: 100291470</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF/NF: 99 Residential: 49 Total: 148</p> <p>Census payor type: Medicare: 21 Medicaid: 53 Other: 74 Total: 148</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> | F0000 | <p>Preparation and /or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. COMPLETION DATE: <u>July 13, 2012</u></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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| | Quality review completed 6/20/12 Cathy Emswiller RN | | | |

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| F0441 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure</p> | F0441 | F441 I | | | 07/13/2012 | |

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| | <p>employees washed hands with direct resident care and failed to ensure isolation gowns were applied and disposed of properly to prevent the potential spread of infection for 2 (Residents E and G) of 4 residents among the sample of 7 reviewed for infection control precautions. The facility also failed to educate the visitors of Resident (G) about isolation precautions.</p> <p>Findings include:</p> <p>1. At 10:00 A.M., 6/19/12, observation was made of the toileting and peri care of Resident (E). Certified Nursing Assistants (CNAs) #1 and #2 did not wash hands prior to providing care. After completing the peri care and placing the soiled linens in a plastic bag, CNA # 1 removed the gloves, left the room, and walked 400 feet to a hand sanitizer receptacle at the nursing station. CNA #1 cleaned the hands with the sanitizer.</p> <p>After removing the gloves used for personal care, CNA #2 picked up the plastic bag containing the soiled linens. CNA #2 did not wash hands. CNA #2 carried the soiled linen bag down the hall to a hamper. CNA #2 lifted the lid of the covered hamper and placed the soiled linens inside.</p> | | <p>It is the intent of this facility to ensure employees wash their hands with direct resident care and to ensure isolation gowns are applied and disposed of properly to prevent the potential spread of infection. It is also the intent of the facility to educate the visitors of isolation precautions.</p> <p>Resident E was reviewed and has had no signs or symptoms of infection requiring antibiotic use since the survey completion.</p> <p>Resident G was removed from isolation the day of the survey and was not being treated for MRSA in her nares or sputum due to being colonized.</p> <p>II</p> <p>All nursing staff were educated on the proper procedure after giving peri care regarding washing their hands prior to gloving, removing their gloves and washing their hands after removing their gloves, before leaving a resident room per facility protocol.</p> <p>All staff that would enter an isolation room, including nursing staff, were also educated on the proper procedure on donning gowns, masks and gloves per facility protocol.</p> <p>All staff were educated on hand washing per facility protocol.</p> <p>All nursing staff were also educated on the importance of documenting when instructing visitors to follow special precautions.</p> | |

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| | <p>The acting Director of Nursing (DoN), who had been present during the 6/19/12, 10:00 A.M., toileting and peri care observation, indicated hand washing should have occurred prior to gloving and prior to leaving the room. The Don indicated she would re-educate CNAs #1 and #2 on hand washing techniques.</p> <p>2. At 2:40 P.M., 6/19/12, observation was made of the toileting of Resident (G). A sign on the door indicated Resident (G) was on contact precautions and visitors were to report to the nursing station before entering.</p> <p>CNAs #3 and #4 washed hands and put on gowns, gloves, and masks. Both CNA #3 and #4 tied only the top string of the gown. Both left the waist strings untied.</p> <p>Both CNAs assisted in removing Resident (G) from the bedpan. CNA #3 emptied the urine into the bath room toilet. CNA #3 did not flush the toilet. CNA #4 washed the bedpan at the bathroom sink, which was adjacent to the toilet. As CNA #4 was washing the bedpan, the bottom edge of the isolation gown brushed across the toilet bowl .</p> <p>CNA #3 stepped around by the toilet to obtain supplies, and the bottom edge of the isolation gown brushed across the toilet bowl, which still contained the urine which had been emptied.</p> | | <p>III The systemic change includes that all newly hired staff will be educated on hand washing. All newly hired staff who would have the potential of entering an isolation room will be educated for appropriate infection control practice.</p> <p>IV The Director of Nursing and or designee will audit through direct observations and return demonstrations on infection control practices as related to hand washing, proper procedure when entering an isolation room regarding gowns, gloves and masks 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. <u>See Audit Tool #1 on Hand washing</u> <u>See Audit Tool #2 on proper protocol when entering an isolation room.</u> COMPLETEION DATE: <u>July 13, 2012</u></p> | | | | |

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| | <p>After flushing the toilet and returning to the bedside to change Resident (G), CNA #3 told LPN #1 linens were needed. LPN #1 removed the isolation gown and gloves and placed them into a small trash basket with a plastic liner which was placed directly by the head of the bed of Resident (G). LPN #1 washed hands and left to obtain the linens.</p> <p>Family member #1 was seated at the bedside of Resident (G) without gown or mask. Family member #1 indicated Resident (G) had been in isolation since the past Friday, 4 days ago, and he had not been instructed by the nursing staff on special precautions.</p> <p>LPN #1 returned and handed the linens to CNAs #3 and #4. CNA #3 performed peri care while CNA #4 assisted in holding the resident over on one side. Resident (G), who had a trach, coughed and LPN #1 raised the head of the bed.</p> <p>Following care, the small bedside trash container with the plastic liner was full. LPN #1 removed gown, mask, and gloves, then washed hands in the bath room which was adjacent to the foot of the resident's bed. LPN #1 removed the soiled trash liner, walked across the length of the room, and left.</p> <p>CNA #4 reached underneath the gown and pulled out a plastic liner from her</p> | | | | | | |

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| | <p>uniform pocket.</p> <p>The liner was placed in the small trash container which had been moved next to the door entrance.</p> <p>CNAs #3 and #4 removed the gowns, masks, and gloves, and placed them into the small trash container.</p> <p>CNA #3 indicated there was to be a hand sanitizer outside the room on a cabinet. There was no sanitizer outside the room. CNA #3 went to a supply room and returned with the hand sanitizer, CNAs #3 and #4 used the sanitizer to cleanse the hands.</p> <p>At 3:00 P.M., 6/19/12, at the Rehab nursing station, LPN #2 indicated she had observed an unknown female visitor (#2) leave the room of Resident (G) at lunch time. LPN #2 indicated Visitor #2 did not have on isolation garb. LPN #2 indicated she had educated (Visitor #2) to the special precautions which were required before visiting.</p> <p>At 3:10 P.M., the DoN, was advised of the contact isolation precaution concerns. The DoN indicated the family of Resident (G) had been educated on precautions on the 6/15/12, admission.</p> <p>The Don also indicated all staff had been inserviced on the use of plastic liners in the small trash cans instead of a larger hamper, and proper disposal of soilage.</p> | | | | |

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| | <p>The DoN also indicated infection control monitoring was ongoing with the quality assurance process.</p> <p>The record of Resident (G) was reviewed at 3:20 P. M., 6/19/12, and indicated a 6/18/12, admission. Diagnoses included chronic obstructive lung disease (COPD), with methicillin resistant staphylococcus aureus (MRSA) of the sputum and nares. A concern of tracheostomy with MRSA was addressed on the 6/16/12, plan of care. The intervention was contact isolation as ordered.</p> <p>The facility's 2009 Handwashing/Hand Hygiene was provided by the DoN at 11:00 A.m., 6/19/12. The purpose was to recognize hand hygiene as the primary means to prevent the spread of infection. Point #2 indicated all personnel were to follow the hand washing/hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. Point #3 indicated hand hygiene products and supplies (sinks, soap, towels, alcohol based hand rub) would be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Point #4 indicated all resident, family</p> | | | | | | |

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| | <p>members and/or visitors would be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and/or other written materials provided at the time of admission and posted throughout the facility.</p> <p>Point #5 indicated employees were to wash hands 10-15 seconds using antimicrobial soap and water under the following conditions:</p> <p>(a) Before and after direct contact with residents.</p> <p>(d) After removing gloves.</p> <p>Point #6 indicated in most situations, the preferred method of hand hygiene was with an alcohol based hand-rub. If hands were not visibly soiled, use of the alcohol based hand rub was recommended for the following:</p> <p>(a) Before and after direct contact with residents.</p> <p>(j) After removing gloves.</p> <p>This federal tag relates to Complaint IN00109801.</p> <p>3.1-18(l)</p> | | | | |

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| F0514 SS=D | <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the complete and accurate documentation of weights and the nutritional status following a significant weight loss for 1 (Resident A) of 5 residents among the sample of 7 reviewed for nutrition.</p> <p>Findings include:</p> <p>The record of Resident (A) was reviewed at 1:45 P.M., 6/19/12, and indicated a 2/14/12, admission. Diagnoses included dementia and an accidental overdose of thyroid medications (prior to admission).</p> <p>Documentation indicated a significant weight loss on 2/28/12, with a complete nutritional assessment, review of labs, and addition. of supplements.</p> | F0514 | <p>F514 It is the intent of this facility to ensure the complete and accurate documentation of weights and the nutritional status following a significant weight loss.</p> <p>I Resident #A was being reviewed at the At Risk meeting every week by nursing regarding her weights, addition of dietary supplements, placed on a feeding program, notification of physician of weights, intake and appetite, including physician orders for intravenous fluids for hydration until it was determined by family to stop intravenous fluids and no feeding tube. Resident A was a Hospice resident.</p> <p>II Nursing managers were educated on Weight protocol regarding weight loss or weight gain.</p> | 07/13/2012 |

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| | <p>There was no documentation of the monitoring of weights nor nutritional status in the nutrition progress notes from 3/15/12, to 4/30/12.</p> <p>Resident (A) was placed on hospice services, comfort care measures on 5/2/12, and expired on 5/18/12.</p> <p>The DoN was interviewed at 3:45 P.M., 6/19/20, and indicated the nutritional at risk (NAR) committee met weekly to review weights, notify the physician, and discuss interventions including supplements.</p> <p>The DoN, provided a copy of the NAR progress notes of Resident (A), which were not a part of the clinical record.</p> <p>The 3/5/12-5/5/12, NAR progress notes indicated monthly weights with review, addition of dietary supplements, placement on a feeding program, physician notification of weights, intakes and appetite; 4/29-4/30/12, physician orders for intravenous (IV), fluids for hydration over 48 hours with a re-evaluation, and the 4/30/12, family decision for no further IVs, nor placement of a feeding tube.</p> <p>The Registered Dietician (RD #1) was interviewed at 3:45 P.M., 6/19/12, and indicated she pulled a weight report monthly. RD #1 provided a copy of the monthly weights of Resident (A) from</p> | | <p>Dietary Manager was educated on facility weight protocol regarding weight loss or weight gain.</p> <p>Registered Dietician was educated on facility weight protocol regarding weight loss or weight gain.</p> <p>III</p> <p>The systemic change includes that the Director of Nursing, Nursing Managers, Dietary Manager and Registered Dietician will follow proper protocol per facility policy regarding the Weight Protocol.</p> <p>IV</p> <p>The Director of Nursing or designee will audit residents with weight loss or weight gain per Weight Protocol 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months. Results of report findings will be reported to the QA committee monthly for 12 months.</p> <p>After compliance is reached the QA committee will determine the frequency of continued monitoring.</p> <p><u>See #3 Weight Protocol</u></p> <p><u>See #4 Inservice on Weight Protocol</u></p> <p>-</p> <p>COMPLETION DATE: July 13, 2012</p> | | |

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| | <p>2/2012-5/2012, RD #1 indicated she depended on the nursing staff to update, document, and notify her of changes throughout the remainder of the month.</p> <p>This federal tag relates to complaint IN00109801.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p> | | | | |