STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DECATUR TOWNSHIP CARE AND REHABILITATION CENTER	4851 TINCHER RD INDIANAPOLIS, IN 46221

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F0000	This visit was for the Investigation of Complaint IN00109951. Complaint: IN00109951 Substantiated, Federal/State Deficiencies related to the allegations are cited at F 441. Unrelated deficiency cited. Survey Dates: July 2, and 3, 2012 Facility Number: 000229 Provider Number:155336 AIM Number:100266850 Survey Team: Patti Allen BSW, T.C. Leia Alley RN Dinah Jones RN Census Bed Type: SNF/NF: 72 _____ Total 72 Census Payor Type: Medicaid: 60 Medicare: 4 Other: 8 _____ Total 72	F0000	1. **F0000** The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Decatur Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Decatur Township Care & Rehabilitation Center is requesting a paper compliance review of this survey.	

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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	Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 10, 2012 by Bev Faulkner,RN			

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F0323 SS=D	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. Based on record review and interview, the facility failed to implement an intervention and provide an assistive device for a hazard free environment for 1 of 1 resident reviewed for accidents in total sample of 5. (Resident #E) Findings Include: The clinical record for Resident #E was reviewed on 7/2/12 at 2:30 p.m. Diagnoses included, but were not limited to, dementia w/behavioral disturbance, difficulty in walking abnormal posture, unspecified cataract. The clinical record indicated Resident #E was admitted on Tuesday, 5/1/12, to the facility. The Interdisciplinary Progress Note indicated that Resident #E on 6-29-12 12:00 p.m., "resident was in dining room & asked CNA for coffee. Resident went to take a drink and spilled	F0323	1. **F 323 Free of Accidents Hazards/Supervision/Devices** A. The Resident E's care plan was amended to include an adaptive device to hot beverages immediately post incident. B. An immediate audit was done on 7/4/12 by DNS to identify any other possible adaptive devices that would potentially affect other residents. No other residents were identified. No other resident were noted to be affected. C. The facility licensed nursing staff, Dietary staff, and Activities staff will be re-educated by ADON/Designee by 7/17/12 on proper use of adaptive devices and tray card communication. Communication of adaptive equipment to the staff is located on the residents' tray card. D. A weekly audit will be done by the DNS/Designee for 5 weeks to monitor for use of adaptive devices, then monthly for 3 months or until 95% of adaptive devices are documented. The audits will be reviewed in the next monthly Performance Improvement meeting by the Administrator for any further recommendations.	07/17/2012

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	coffee on stomach & lap. Resident was rushed to room & ice was applied for 30 min. Area measured 21 cm x 15 cm on (L) leg, 18 cm x 15 cm on (R) leg & 7 cm x 2 cm on stomach. Silvadene 1% was ordered BID x 10 days. Will continue to monitor. On 7/2/12 at 3:30 p.m., interview with Resident E's daughter indicated that the facility called and told her when the accident happen. She then indicated that she had told the staff right after her mother was admitted and prior to the incident that her mom had to have ice in her coffee and a lid on the cup. The Certified Nurse Aide (CNA) took resident to the Dining Room and gave her a cup of coffee and left. "The coffee did not have any ice or a lid on the cup like I told them. They said it was a new CNA and she did not ask anybody if the resident could have any coffee, CNA was not assigned to resident, just taking her to lunch, when mom ask for some coffee." On 7/3/12 at 10:10 a.m., interview with Activity Director indicated that Resident #E had to have ice in her coffee and in a			

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	special cup, after she burned her stomach and legs,when a new CNA left her unsupervised with cup of coffee. The Activity Director indicated right after the resident was admitted to the facility the resident's daughter had requested to have ice put in the resident's coffee and a sip lid for the cup and we discussed in care meeting. The Activity Director could not remember the dates, but it was right after the resident was admitted and before the resident burned herself at the end of June. The Director indicated the activity staff had always served the resident coffee with ice in it and in a cup with a lid. On 7/3/12 at 11:35 p.m., interview with the Dietary Manager indicated Resident #E had to have ice in resident's coffee and in a special mug, since the resident was brought to lunch and resident ask for coffee and CNA got her cup of coffee and left her. The CNA did not ask dietary staff if resident needed any assistive cup or had any special set up. The resident's dietary card included "put ice in coffee and put a sip lid on cup." The D.M. indicated the resident's daughter came to the kitchen when she was a new admit			

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	and said resident needed ice in her coffee and a lid on the cup and it was discussed in care meeting. The D.M. was not sure of the dates, but indicated it right after the resident was admitted and before she burned herself. The dietary staff had been providing resident coffee with ice and a lid on the cup. Now since the resident burned her legs and stomach, dietary card has "Adapt. Equip: Sip Cup W/hot Bev: and Note: Ice in Coffee/Special Mug." On 7/3/12 at 4:35 p.m., interview with Director of Nursing (D.O.N.) indicated the resident's clinical record, care card, care plan, admission assessment, and Minimum Data Set (MDS) had no documentation to indicate resident needed ice in coffee or sip lid on cup. The D.O.N. indicated the CNA should have asked staff if there were any special set up needs for the resident since she was a new staff and was not assigned to the resident. The CNA was counseled about asking about special needs of a resident before granting resident request. Re-education for all staff will be conducted. 3.1-45(a)(2)			

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F0441 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 record review and interview, the	F0441	**F 441 Infection Control, Prevent Spread, Linens** A.	07/17/2012

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	facility failed to administer a Mantoux tuberculosis test (TB test) upon admission to the facility for 1 of 5 residents reviewed for TB testing. Resident #D. Findings Include: The clinical record for Resident #D was reviewed on 7/2/12 at 2:20 p.m. Diagnoses include but were not limited to, joint replacement, osteoarthritis (joint pain and inflammation), edema (swelling) and anxiety. The clinical record indicated Resident #D was admitted on Monday, 5/21/12 to the facility. The Medication Administration Record (MAR) indicated that Resident #D didn't receive a TB test until Friday, 5/25/12. A facility policy and procedure, titled "Sun Bridge... Corporation" , Sub Section "Tuberculosis Screening & Monitoring:" dated January 2008, was provided by the Director of Nursing Services (DNS) on 7/3/12 at 2:00 p.m. The policy indicated a TB test was to be "given upon		Resident D was given a TB test after the regulation time had expired. No adverse effects were noted. B. An immediate audit was done on 7/4/12 by DNS to identify any other possible TB tests that were not given, which could affect other residents. No other residents were affected. C. The facility licensed nursing staff will be reeducated by ADON/Designee by 7/17/12 on timely administration of TB testing. D. A weekly audit will be done by the DNS/Designee for 5 weeks to monitor administration of TB testing, then monthly for 3 months or until 95% of TB testing is documented. The audits will be reviewed in the next monthly Performance Improvement meeting by the Administrator for any further recommendations.	

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	admission". In interview at this time, the DNS, indicated the paperwork she could find was the current policy they would expect staff to follow. This Federal Tag relates to Complaint IN00109951. 3.1-18(e)			