

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00128602 and IN00128052.</p> <p>Complaint IN00128602-Substantiated. Federal/state deficiencies related to the allegation are cited at F441.</p> <p>Complaint IN00128052-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 9 & 14, 2013</p> <p>Facility number: 000029 Provider number: 155072 AIM number: 100275200</p> <p>Survey team: Diana Zgonc, RN-TC</p> <p>Census bed type: SNF: 15 SNF/NF: 99 Residential: 10 Total: 124</p> <p>Census payor type: Medicare: 26 Medicaid: 76 Other: 22</p>	F000000	Request paper compliance for F441?	
---------	--	---------	------------------------------------	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2013
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107		
(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>Total: 124</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 16, 2013; by Kimberly Perigo, RN.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2013	
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107			
(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			
F000441 SS=D	<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 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, interview and record review the facility failed to</p>	F000441	1. The Utility and Shower room	05/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2013
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107		
(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>ensure staff followed proper handwashing protocol for a resident in isolation for 1 of 4 resident's reviewed for isolation (Resident E, CNA #1, Maintenance Assistant # 2).</p> <p>Findings include:</p> <p>The record for Resident E was reviewed on 5/9/13 at 1:35 P.M.</p> <p>Resident E was admitted on 2/28/13 and readmitted on 4/22/13 with a diagnosis that included, but was not limited to, Methicillin-resistant Staphylococcus aureus (MRSA).</p> <p>During observation of Resident E's room, Maintenance Assistant # 2 (MA#2) had his tools laying on the floor in the bathroom while repairing the toilet in Resident E's room. CNA # 1 donned a gown and gloves and entered the resident's room. While care was being provided, MA#2 completed the repair to the toilet and washed his hands for 20 seconds. He then picked up the portable grab bars for the toilet and put them in the shower pulling the shower curtain closed. The MA#2 retrieved his tools from the floor and left the bathroom without washing his hands. CNA # 1 finished Resident E's care, removed her gloves and gown and disposed of</p>		<p>was deep cleaned immediately for any possible contamination from touching the keypad of each door and room. Both the aide #1 and maintenance #2 were immediately in serviced and demonstrated proper hand washing technique and educated regarding infection control. Nurse consultant immediately began skill validation of hand washing to all staff. Resident E will only receive care after proper hand washing and infection control practices are followed.</p> <p>2. All residents who reside in this facility have the potential to be affected by the alleged deficient practice. All Staff including Maintenance will be in-serviced by the Staff Development Coordinator and/or designee by May 28, 2013 on Infection Control Policies and Procedures including hand washing, contact precautions, and conditions of isolation including MRSA.</p> <p>The Interdisciplinary Team will review labs, physician's orders, and facility activity report in the clinical meeting to ensure that proper infection control practices are initiated and maintained. Skills validations on hand washing will be performed on all staff by the SDC and/or designee by May 28, 2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2013
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107		
(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>them in the hamper provided. She picked up the bag of soiled clothing and linens and walked out of the resident's room without washing her hands. CNA # 1 proceeded down the hallway to the soiled utility room, punched in the code on the key pad and entered the room. An unknown staff member was in the utility and CNA #1 opened the soiled utility bin and placed the bag in it and left the room without washing her hands. She continued down to the community shower room, punched in the code on the key pad and entered the shower room to wash her hands.</p> <p>During an interview with CNA # 1 on 5/9/13 at 11:15 A.M., she indicated she thought the MA #2 was in the bathroom so she went to the soiled utility room and someone was in there too so she couldn't wash her hands.</p> <p>An undated current facility policy titled "Methicillin-Resistant Staphylococcus Aureus (MRSA) and provided by the Nurse Consultant on 5/9/13 at 2:40 P.M., indicated: "Policy: The facility shall utilize proper infection control and prevention when dealing with residents with Methicillin-resistant Staphylococcus aureus. Procedure: ... f. i. ...wash hands</p>		<p>3. Staff will be in-serviced by the Staff Development Coordinator and/or designee by May 28, 2013 on Infection Control Policies and Procedures including hand washing, contact precautions, and conditions of isolation including MRSA</p> <p>The Interdisciplinary Team will review labs, physician's orders, and facility activity report in the clinical meeting to ensure that proper infection control practices are initiated and maintained.</p> <p>Skills validations on hand washing will be performed on all staff by the SDC and/or designee by May 28, 2013.</p> <p>The Director of Nursing or designee will conduct daily rounds on all shifts to ensure that infections control practices and proper hand washing are occurring.</p> <p>4. Hand washing CQI tool (or infection control CQI) will be utilized weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for one year. Data will be presented to the Continuous Quality Improvement committee for follow up.</p> <p>If a 95% threshold is not achieved, an action plan will be developed to ensure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107
---	--

(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>before leaving resident's room or performing care to another resident. After removing gloves and washing hands ensure hands do not touch potentially contaminated surfaces or items in the resident's room."</p> <p>An undated current facility policy titled "Hand Hygiene" and provided by the Administrator on 5/14/13 at 11:45 A.M., indicated:</p> <p>"... Note: 5 Moment of required hand hygiene: ... After body fluid exposure risk ... After patient contact ... After contact with patient surroundings"</p> <p>3.1-18(l)</p>			