

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2015
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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00183411.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Quality Assurance Walk Through survey completed on 7/23/15.</p> <p>Complaint IN00183411: Substantiated. Federal/State deficiencies related to the allegations are cited at F312, F314, F315 and F502.</p> <p>Survey dates: October 13, 14, 15, 16, 19 and 20, 2015</p> <p>Facility number: 000195 Provider number: 155298 AIMS: 100267690</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicare: 1 Medicaid: 38 Other: 1 Total: 40</p>	F 0000		
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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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F 0164 SS=D Bldg. 00	<p>Sample: 18</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview and</p>	F 0164	F 164	11/18/2015

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	<p>record review, the facility failed to maintain privacy while providing pericare to a dependent resident for 1 of 3 residents observed for pericare (Resident #14).</p> <p>Findings include:</p> <p>Resident #14's record was reviewed on 10/16/15 at 2:38 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, hand contracture, urinary tract infection, and muscle weakness.</p> <p>On 10/16/15 at 3:50 p.m., CNA #5 and CNA #6 were observed transferring Resident #14 to bed with the assist of a hoier lift. After the resident was transferred to the bed she was rolled from side to side by the two CNAs to remove the hoier sling and her pants. The resident's brief was pulled down at that time. She was left completely uncovered. CNA #7 came into the room at that time and CNA #5 told CNA #7 the resident needed pericare.</p> <p>On 10/16/15 at 4:05 p.m., CNA #7 left the room to gather towels and wash cloths, then she gathered the soapy wash water. CNA #6 covered the resident up while CNA #6 was out of the room gathering the supplies. Both CNAs</p>		<p>1.C.N.A.'s #5,6 and 7 were informed of the privacyissue on 10/16/15 Resident #14 shows no signs of residual psycho/socialeffects.</p> <p>2.Peri-care competencies will be completed withC.N.A.'s by 11/18/15 to identify other residents potentially affected byimproper privacy practices; remedial training will be provided when indicated.</p> <p>3.Staff will be-serviced by the DON on providingprivacy during care by 11-18-15. All nursing staff will have skills validationcompleted by11/18/15 providing privacy during care. QA rounds will be completed by assignedstaff, to monitor compliance with bedside privacy practices. This will be completeddaily 5 times per week.</p> <p>4.DON or designee will be responsible formonitoring for compliance. Results of the QA rounds will be reported to the QAcommittee monthly, on going.</p>	

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	<p>donned clean gloves and uncovered the resident completely. CNA #7 went out into the hallway to grab plastic trash bags, while the resident was left completely uncovered. CNA #7 washed the front of the resident's periarea and rolled her over to her right side and washed her left buttock. CNA #6 went into the bathroom and retrieved a wash basin and placed plain water in it. The resident was left completely uncovered at that time. CNA #7 rinsed and dried the front periarea, then placed her on her right and rinsed her left buttock and dried it. The resident was left completely uncovered during this time. The resident was turned to her left side and her left side and her right buttock was washed, rinsed and dried, while being completely uncovered. The drawsheet was wet with urine. CNA #6 removed the top sheet and comforter from the bed and both CNAs changed the bed linens leaving the resident completely uncovered until they could apply the resident's brief.</p> <p>During an interview on 10/16/15 at 4:32 p.m., CNA #6 and #7 were present. CNA #6 indicated she had pulled the blankets up to cover the resident because it was taking CNA #7 too long to retrieve the supplies. CNA #7 indicated if she had to do the task over again she would have had her supplies ready, if she would have</p>			

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F 0241 SS=D Bldg. 00	<p>known she was going to perform pericare when she got into the resident's room.</p> <p>A current policy titled "Perineal Care" dated August 2014, provided by the Director of Nursing on 10/20/15 at 10:10 a.m., indicated "... Procedure... 7. Drape resident for privacy exposing only perineal area and fold top linen to the bottom of the bed..."</p> <p>3.1-3(o)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to maintain visual privacy for a resident sitting in her room for 1 of 33 residents observed for privacy (Resident #12).</p> <p>Findings include:</p> <p>The record of Resident #12 was reviewed on 10/15/15 at 1:30 p.m. Diagnoses included, but were not limited to, delirium, dementia with behavioral disturbance, muscle weakness and Alzheimer's disease.</p>	F 0241	<p>We are requesting an IDR for F241 because we believe there is inaccurate or misleading information. F 241</p> <p>1.C.N.A.'s #5,6 and 7 were informed of the privacy issue on 10/16/15Resident #12shows no signs of residual psycho/social effects.</p> <p>2.Dependent residents have the potential to beaffected. Remedial training will be provided when indicated.</p> <p>3.Nursing staff will be-serviced by the DON onproviding privacy by 11-18-15. All nursing staff will have skills validationcompleted by11/18/15 providing privacy</p>	11/18/2015

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	<p>During an observation on 10/14/15 at 3:43 p.m., Resident #12 was observed in her room positioned in her broda chair with the door open and no curtain pulled for privacy. Resident #12 was wearing cotton pants, which were pulled completely down from the waist and gathered at her feet. Resident #12 was wearing a brief and was visible from the doorway. She was pulling at the brief, exposing her genitalia. Licensed Practical Nurse (LPN) #10 was observed walking into Resident #12's room and then walking back out. The resident remained in the same position and the door remained open. When Resident #12's condition was relayed to LPN #10, she indicated Resident #12 may have been pulling at her brief because she needed changed. LPN #10 indicated she would get a CNA to clean the resident up, and again left the room, leaving the resident in the same position, with the door open.</p> <p>During an interview with the Director of Nursing on 10/20/15 at 8:45 a.m., she indicated the nurse may have needed to get assistance to change Resident #12, but she should have provided privacy for the resident.</p> <p>3.1-3(t)</p>		<p>during care. QA rounds will be completed by assigned staff, to monitor compliance with bedside privacy practices. This will be completed daily 5 times per week.</p> <p>4. DON or designee will be responsible for monitoring for compliance. Results of the QA rounds will be reported to the QA committee monthly, on going.</p>	

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide activities for a dependent and cognitively impaired resident for 1 of 3 residents reviewed for activities. (Resident # 26)</p> <p>Findings include:</p> <p>The record review for Resident #26 was completed on 10/19/15 at 8:56 a.m. Diagnoses included, but were not limited to, contractures of the hand, dysphagia and traumatic brain injury.</p> <p>In an observation on 10/13/15 at 3:22 p.m., the resident was observed in bed with his eyes closed, there was a radio on the dresser by his bed that was not turned on. The resident had his television on.</p> <p>In an observation on 10/14/15 at 10:15 a.m., the the resident was observed in bed with his eyes open. The radio on the dresser by his bed was not turned on.</p>	F 0248	<p>F248</p> <p>1. Resident#26 has received 2 1:1 activities per week. Resident shows no psycho/social residual effects.</p> <p>2. Care plans for all residents receiving 1:1 activities were audited to ensure that the treatment plans matched individual care plans. No other concerns were noted.</p> <p>3. Activity staff was in-serviced on 1:1 activities by activity consultant to ensure that care plans and treatment plans match, and 1:1 activities will be monitored weekly.</p> <p>4. HIM or designee will be responsible for monitoring the completion of 1:1 activities as indicated on each residents care plans on weekly basis. The results will be reported to the QA committee monthly, ongoing.</p>	11/18/2015	

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	<p>The resident had his television on.</p> <p>In an observation on 10/14/15 at 2:45 p.m., the the resident was observed in bed with his eyes open. The radio on the dresser by his bed was not turned on. The resident had his television on.</p> <p>In an observation on 10/19/15 at 9:35 a.m., the resident was observed in bed with his eyes closed. There was a radio on the dresser by his bed that was not turned on. The resident had a television that was turned on.</p> <p>The Care Plan (CP) for Activities dated 1/14/15, with revisions 2/9/15 and 8/25/15, indicated: "Engage in music of all kinds, hand massages and reading scripture/inspirational material during one on one (1:1) visits. Invite and encourage resident to attend activities he can passively engage in. Provide 1:1 activities visits 2 times per week...." Resident activity preferences were: music/entertainment movies, and religious groups. Provide sensory stimulating activities to promote positive socialization skills.</p> <p>An Activity Quarterly Assessment dated 6/2/15, indicated, "... the resident passively attends 2-3 group activities weekly. He usually was involved in</p>			

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	<p>coffee/social/news, music/entertainment, exercise, sensory and parties. He was receiving two 1:1 visits 2 times weekly. His preferences were music, hand massage and being read to. Continue goals...."</p> <p>An Activity Quarterly Assessment dated 8/25/15 indicated, "...Activity Plan Review...3. Progress Toward Residents Activity goals: d. Goals were not met. 4. Describe changes to goals: 1:1 visits were added as a new goal for resident to passively participate...."</p> <p>The Annual Activity Assessment dated 10/16/15, indicated the Resident "...was able to passively participate in 1:1 activities due to cognitive impairment bible study massage and group activities religious sensory stimulation. Resident enjoyed 1:1 visit bible reading and gospel music resident also enjoyed sensory stimulation and family visit...."</p> <p>A request for activities documentation was made on 10/20/15 at 7:50 a.m., from the Director of Nursing.</p> <p>The 1:1 Activity Documentation for August 2015 was provided by the Nurse Consultant. The documentation indicated there were two 1:1 activities done for the month. During the month of September</p>			

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F 0312 SS=D Bldg. 00	<p>there was only one 1:1 activity done for the month.</p> <p>During an interview on 10/20/15 at 2:15 p.m., the Activity Assistant indicated she did 1:1 activities with Resident #26 one time weekly.</p> <p>3.1-33(a) 3.1-33(b)(8)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to provide oral care for 1 of 3 residents reviewed for Activities of Daily Living (ADL's). (Resident M)</p> <p>Findings include:</p> <p>On 10/14/15 at 10:56 a.m., Resident M's upper and lower teeth were observed to have yellow debris between her teeth. Her bilateral lips and mouth were dry and her bottom lip was cracked with yellow scabbing.</p> <p>During a family interview on 10/15/15 at</p>	F 0312	<p>F312</p> <p>1.Oral care was given to resident M on 10/19/15. 2.All residents' oral cavities were assessed. Nother residents were affected 3.C.N.A.'s will be in-serviced by DON on providingoral care by 11-18-15. C.N.A. oral care skills validation will be completed by11/18/15. Oral care will be monitored by QA rounds on all residents daily 5times per week. 4.The DON or designee will be responsible formonitoring compliance of oral care QA rounds. The results will be reported to the QA committee monthly, ongoing.</p>	11/18/2015

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	<p>9:20 a.m., a family member indicated the resident's oral care was completed occasionally.</p> <p>On 10/16/15 at 10:43 a.m., the resident's upper and lower teeth had yellow debris between her teeth and her bilateral lips were observed to be dry.</p> <p>On 10/19/15 at 8:45 a.m., the resident had yellow debris stuck to the inside of her mouth by her right upper lip area where the right upper and lower lip connected and she had yellow debris on her tongue. The left inside of her mouth in the middle where her molars were located had a ball of yellow debris hanging down, stuck to one of her molar teeth. She had yellow debris formed to the roof of her mouth. Her lips were dry. At this time, CNA #1 and CNA #2 gave the resident personal care, but did not provide oral care for the resident.</p> <p>Resident M's record was reviewed on 10/19/15 at 9:44 a.m. Diagnoses included, but were not limited to, dysphagia, bilateral hand contractures, cognitive communication deficit, cerebrovascular disease, cerebral infarction due to unspecified occlusion stenosis of unspecified cerebral artery and acute kidney failure.</p>			

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	<p>The resident had a Care Plan dated 8/10/15, which addressed the problem she needed extensive to total assist with ADL's related to Cerebrovascular Accident (CVA), impaired decision making, weakness and she was on hospice. Interventions included "... 4/16/15--... Oral/Dental Care-One person physical assist required (Dependent)...."</p> <p>During an observation with CNA #3 and RN #4 on 10/19/15 at 11:07 a.m., CNA #3 was observed using a green swab sponge providing oral care to Resident M's mouth. She wet the first green swab and removed a small amount of yellow debris. She did not wet the second green swab and was not able to remove any yellow debris. She indicated at that time to RN #4 she was trying to get a "dried" piece of yellow debris off the resident's teeth on the left side of her mouth, but it would not come off. RN #4 indicated at that time the debris was "stuck" on there and it would take a couple of times coming back and trying to get it off her teeth. Yellow debris was observed on the inside of the resident's bottom lip.</p> <p>This Federal tag relates to Complaint IN00183411.</p> <p>3.1-38(b)(1)</p>			

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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to perform a urinary culture in a timely manner to determine if a Urinary Tract infection was present for timely treatment (Resident J).</p> <p>Findings include: The record of Resident J was reviewed on 10/19/15 at 1:00 p.m. Diagnoses included, but were not limited to, history of urinary tract infection and altered mental status.</p> <p>A Quarterly Minimum Data Set Assessment, dated 06/12/15, indicated Resident J was frequently incontinent of both bowel and bladder, required extensive assist of one person for toileting and personal hygiene, and had a urinary tract infection within the past 30 days.</p>	F 0315	<p>We are requesting an IDR because we believe there is inaccurate or misleading information</p> <p>F315</p> <ol style="list-style-type: none"> 1. Resident J was discharged. 2. The medical records of all residents with scheduled labs were audited by the HIM for compliance with timeliness of completion on 10/23/15. No other residents were affected. 3. Nursing staff will be in-serviced by 11-18-15 on lab procedures. Labs are audited on a daily basis 5 times a week. 4. Don or designee will be responsible for ensuring compliance with lab audits. The results will be reported to the QA committee monthly ongoing. 	11/18/2015

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	<p>A Physician's Order, dated 07/20/15, indicated Urinalysis C&S (culture and sensitivity). One time only for pain for 2 days. May I&O cath (in and out catheterize) if unable to obtain random urine sample. UA (urinalysis), C&S due to painful urination.</p> <p>Progress notes from Resident J's medical record indicated the following: 07-20-15 - "Therapy reported to therapy staff, that she was experiencing pain upon urination. Resident confirmed, primary physician notified, received order for UA, C&S, may I&O cath if unable to obtain...." 07-23-15 - "Urine obtained and lab order faxed to lab for pick up." 07-24-15 - "Resident U/A c&s picked up this a.m...." 07-26-15 - "...Currently on Cipro [antibiotic] without adverse reactions...Lethargic. Polyuria noted. Awaiting susceptibility results of UA." 07-26-15 - "Preliminary results received. Organisms resistive to Cipro." 07-26-15 - "New orders rec'd [received] to DC [discontinue] Cipro and start Macrobid this evening."</p> <p>A physician's progress note, dated 7/26/15, indicated "... + [positive] urine culture...Review of systems: ...Genitourinary...frequency, urgency...."</p>			

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F 0328 SS=D Bldg. 00	<p>During an interview with the Executive Director on 10/19/15 at 2:15 p.m., he indicated there was no documentation that the resident refused the I & O catheterization or the physician was informed of the three day delay in obtaining the specimen.</p> <p>This Federal tag relates to complaint IN00183411.</p> <p>3.1-41(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper colostomy care for 1 of 1 residents reviewed for colostomy care. (Resident #43)</p> <p>Findings include:</p>	F 0328	<p>F328</p> <p>1.Resident #43 colostomy care was given by staff. Resident # 43 care plan was checked againstthe C.N.A. assignment sheets and treatment plan for consistency.</p> <p>2.There are no other residents with colostomies atthe present</p>	11/18/2015

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	<p>On 10/18/15 at 9:45 a.m., the record review for Resident #43 was completed. Diagnosis included, but were not limited to, ulcerative colitis and gastric reflux.</p> <p>A physician's order dated 5/16/15 indicated to perform Ileostomy care every shift. There was also an as needed (PRN) order for change of Ileostomy bag for soilage and dislodgement. Assure area around stoma and abdomen is clean as needed for attention to colostomy.</p> <p>The resident had Care Plan dated 4/15/15. The Care Plan revision date of 5/17/15, indicated, "...the resident attempts to care for own ostomy bag and is focused on care of the bag, but does not ask for assistance and was unsuccessful with care. The resident needs to allow staff in care of ostomy bag at least twice a shift. Interventions: Change bag as needed, inspect skin around colostomy sight and clean with soap and water and use wash cloth, Nurse to change colostomy bag resident will empty bag but may need assistance at times. Staff need to take resident to bathroom and is incontinent of urine. (5/17/15)...."</p> <p>On 10/14/15 at 10:43 a.m., the resident was observed sitting in the bathroom</p>		<p>time.</p> <p>3.All nursing staff was in-serviced by 11-18-15 oncolostomy care, and consistency of information on the care plans, c.n.a.assignment sheets and treatment plans. QA rounds will be completed daily 5times per week to ensure resident has not removed his own colostomy bag andndthat restroom is clean.</p> <p>4.Don or designee will be responsible for monitoringfor compliance of the daily colostomy audits 5 times a week. The results willbe reported to the QA committee monthly, on going.</p>	

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	<p>facing the toilet, there was clear fluid all over floor in restroom directly in front of toilet. The resident's colostomy bag was observed setting on the edge of the toilet. At 10:50 a.m., the resident was observed sitting by his bed in wheelchair eating his breakfast.</p> <p>On 10/14/15 at 2:35 p.m., there was a strong odor of feces coming out of the resident's room into the hallway. The resident's bathroom was observed to have a colostomy bag setting on the edge of the toilet and feces smeared on the edge of the toilet seat.</p> <p>On 10/20/15 at 2:18 p.m., CNA #18 indicated she was to check the resident hourly to see if the colostomy was intact. She indicated this information was on the CNA sheet.</p> <p>The Activities of Daily Living care documentation for October 2015 indicated the staff were taking the resident to change only once per shift.</p> <p>The Treatment Administration Records indicated:</p> <p>July 2015: care done each shift except on: 7/8- evening shift 7/9- day shift</p>			

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	<p>7/16- evening shift 7/17- evening shift 7/20-evening shift 7/21- evening shift 7/22- evening shift 7/31- evening shift</p> <p>August 2015 indicated : The colostomy care documentation indicated the care was done every shift except: 8/17- on evening, 8/19- on evening and nights 8/20-8/22/15 resident was in the hospital 8/23 no AM documentation.</p> <p>September 2015 indicated: each shift colostomy care was done and PRN on 21st and 26th</p> <p>The nurses notes indicated documentation regarding colostomy: 10/9/15: At 9:51 p.m., the resident was observed in the bathroom picking at his ostomy bag. The resident had taken off all of his clothes, was wearing rubber gloves, and using paper towels to clean off his ostomy site. There was bowel movement noted to be on the floor, toilet and wall from the resident. All of the attempts to encourage the resident to allow staff to assist him was met with resistance. The resident finally agreed to allow help when informed it was dinner</p>			

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F 0371 SS=F Bldg. 00	<p>time and time for his pain pain pill. Allowed CNA to get him cleaned up and new ostomy bag one. no issues once dressed again.</p> <p>On 10/20/15 at 8:07 a.m., the Director of Nursing was informed of infection control concerns with the resident, request was made for any interventions the facility had in place for the resident's inability to care for his own colostomy.</p> <p>On 10/20/15 at 11:45 a.m. she provided the Care Plan dated 4/15/15. She indicated at that time this was the only information she could provide regarding the interventions they have put into place for Resident #43 and his colostomy care.</p> <p>3.1-47(a)(3)</p> <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</p>	F 0371	We are requesting an IDR for 371 because we believe there is inaccurate or misleading	11/18/2015			

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	<p>provide a sanitary environment in 1 of 1 kitchens and 1 of 2 dining rooms in regards to food preparation and serving of food items for 37 out of 40 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>1. On 10/13/15 at 12:04 p.m., during an observation of testing of the food temperatures, Cook # 12 was observed having her thumb of her unsanitized and ungloved hand in the rice when she placed the thermometer into the rice. The Dietary Manager indicated to Cook #12 watch your hands. At that time Cook #12 lifted the thermometer and her hand out of the rice. The rice was not changed or thrown out and was served as part of the lunch meal. Cook #12 was observed several times placing the thumb of her ungloved and unwashed hand over the edge of plate and onto the top surface of the plate. Cook #12 removed the lid cover from a clean plate and the plate had visible water droplets on it and she wiped the water off the plate with a white cloth and used the plate in food service.</p> <p>On 10/13/2015 at 12:12 p.m., Cook #12 was observed opening the oven with her ungloved hand. She also touched the handle of a drawer to grab an oven mitt, touched the refrigerator door by using the</p>		<p>information F371</p> <p>1.No resident showed any residual effects fromeating the rice, hand washing, glove usage, not air drying dishes and hair netusage. The blade to the robo food processor was replaced 10/28/15.</p> <p>2.Each week for 3 months, the facility willutilize kitchen sanitation and dinning compliance tools to identify improperfood handling practices that could potentially affect residents. Remedialtraining will be provided when indicated.</p> <p>3. Dietary staff will be in-serviced by the ED on properhand washing, glove usage, air drying dishes and proper way to wear hair netsby 11-18-15.</p> <p>4.ED or designee will be responsible formonitoring the compliance with kitchen sanitation and dinning room monitoringtools. The results will be reported to the QA committee monthly, ongoing.</p>	

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	<p>handle, and had gotten into the refrigerator for cheese for grilled cheese sandwiches. Cook #12 then went and retrieved the loaf of bread and opened it and without gloves, touched the bread and the cheese. Cook #12 had not washed hands before making grilled cheese sandwiches.</p> <p>On 10/13/15 at 12:13 p.m., the Dietary Manager (DM) was observed answering the phone, going into the refrigerator, and touching the handles of the drawers and then retrieved 6 pieces of bread to make 3 peanut butter and jelly sandwiches. The DM also answered the phone, went into the refrigerator to get ham for a sandwich, then retrieved two pieces of bread and made a ham sandwich for a resident.</p> <p>On 10/13/15 at 12:33 p.m., the DM was observed having her bangs sticking outside of her hair net .</p> <p>On 10/13/15 at 12:41 p.m., Cook #12 was observed taking the blade from the food processor that was in the 3 compartment sink and dried the blade with a white dry towel before placing into the food processor. The blade was made of plastic and had visible ragged edges.</p> <p>On 10/15/15 at 2:19 p.m., the Registerd</p>			

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F 0441 SS=E Bldg. 00	<p>Dietician indicated the hair nets should cover all hair. She also indicated if DM and Cook #12 were touching items between touching food items, they should have stopped and washed their hands. She indicated the blade for the robo food processor did need to be replaced.</p> <p>The Indiana State Department of Health "Retail Food Establishment Sanitation Requirements" dated 11/13/14 indicated, "...HAND WASHING 410 IAC 7-24-129 Sec. 129(a) (6) After handling soiled surfaces, equipment, or utensils (7) During food preparation , as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks...(9) Before touching food or food-contact surfaces. (10) Before placing gloves on hands (11) After engaging in other activities that may contaminate hands...EMPLOYEE HEALTH 410 IAC 7-24-138 (a)...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting (1) exposed food...."</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an</p>			

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	<p>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. Based on observation, interview and record review, the facility failed to ensure handwashing was completed and gloves were changed during pericare for 3 of 3 residents reviewed for pericare</p>	F 0441	F441 1.Residents M and B were not identified so immediate intervention could not be done. Residents 14 and 43 were noted to have no s/s of infection	11/18/2015

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	<p>(Residents #14, M, and B) and failed to assist a resident with dementia with his colostomy for 1 of 1 residents reviewed for colostomies (Resident #43).</p> <p>Findings include:</p> <p>1. Resident #14's record was reviewed on 10/16/15 at 2:38 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, hand contracture, urinary tract infection, and muscle weakness.</p> <p>On 10/16/15 at 3:50 p.m., CNA #5 and CNA #6 donned clean gloves without washing their hands. CNA #5 and CNA #6 was observed transferring Resident #14 to bed with the assist of a hooyer lift. CNA #7 came into the room at that time and CNA #5 told CNA #7 the resident needed pericare.</p> <p>On 10/16/15 at 4:05 p.m., CNA #7 left the room to gather towels and wash cloths, then she got the soapy wash water ready. Both CNAs donned clean gloves without washing their hands. CNA #7 removed her gloves and went out into the hallway to grab plastic bags, then came back into the room and donned clean gloves without washing her hands. CNA #7 washed the front of the resident's periarea and rolled her to her right side</p>		<p>unrelated to previously noted etiologies.</p> <p>2.All dependant residents will receive peri-careaudit to validate care.</p> <p>3. Nursing staff will be in-serviced on peri-careprocedure to infection control standards by 11-18-15. Staff has completed skills validation onperi-care usage by 11/18/15. Peri-care will be monitored daily 5 times per weekon QA rounds. All nursing staff wasin-serviced by 11-18-15 on colostomy care, and consistency of information onthe care plans, c.n.a. assignment sheets and treatment plans. QA rounds will becompleted daily 5 times per week to ensure resident has not removed his owncolostomy bag and that restroom is clean.</p> <p>4.Don or designee will be responsible formonitoring the compliance of peri-care audits. The results will be reported to the QA committee, monthly on going.</p>				

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	<p>and reached over her left side and washed her left buttock. CNA #7 removed her gloves and donned clean gloves without washing her hands. CNA #6 went into the bathroom and got a washbasin and placed plain water in it without removing her gloves and the CNA's finished the resident's perineal care.</p> <p>During an interview on 10/16/15 at 4:32 p.m., CNA #6 and CNA #7 indicated they should have washed their hands in between glove changes.</p> <p>2. On 10/19/15 at 8:45 a.m., CNA #1 and CNA #2 entered Resident M's room to provide personal care. Both CNA's donned clean gloves without washing their hands. CNA #1 came from the bathroom with wash cloths with soapy water and washed the front of the resident's peri area. The resident was turned onto her right side and CNA #1 washed the resident's buttocks. She had a medium soft bowel movement and a small amount of urine in her brief. CNA #1 removed her gloves and left the room, then returned to the room and continued care.</p> <p>On 10/19/15 at 11:07 a.m., CNA #3 and CNA #8 provided personal care for the resident. Both CNAs washed their hands and donned clean gloves, then CNA #3</p>			

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	<p>removed her gloves and gathered her water to wash the resident. She donned clean gloves that she retrieved from her pants pocket. Both CNAs turned the resident onto her back and CNA #3 washed her peri area. CNA #3 removed her right glove, then donned a clean glove she retrieved from her pants pocket and turned the resident onto her left side. The resident had a loose small bowel movement. CNA #3 placed the brief in the plastic trash bag and removed her right glove, then donned a clean glove she retrieved from her pocket and washed the resident's buttocks. She removed both gloves. CNA #3 donned a clean glove on her right hand, which she retrieved from her pants pocket and rinsed and dried the resident's buttocks with her right hand only and held the resident over with her left hand. She removed her right hand glove and donned a new right hand glove that she got from a box and placed the brief on the resident and used her right hand to pull the resident towards her and onto her back and she dried the front of the resident.</p> <p>3. In an observation on 10/19/15 at 10:30 a.m., CNA #16 and CNA #17 transferred the resident per hoyer and provided pericare to Resident B. CNA #16 and CNA #17 washed hands after transferring resident. The resident was dry, but had a small amount of stool in her brief. CNA</p>			

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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>#16 cleaned the resident while CNA #17 assisted by holding resident as well as helping to reposition the resident and help to put on brief. CNA #17 after transferring the resident, helping to remove the old brief, had washed hands and donned new gloves. The gloves ripped when he donned them, but CNA #16 continued providing care. He had to reach into his pocket of his pants at one point to grab the small packet of ointment. He then proceeded to help in turning the resident, putting on her brief and putting on resident's clothes without changing gloves.</p> <p>On 10/20/15 at 1:38 p.m., the DON indicated she would expect an aid to change their gloves if they were ripped or soiled.</p> <p>A current policy titled "Perineal Care" dated August 2014, provided by the Director of Nursing (DON) on 10/20/15 at 10:10 a.m., indicated "...Female perineal care... a. If resident is soiled with feces, place resident on side and clean perineum and rectal area. b. Change water and discard soiled linen appropriately. c. Change gloves. d. Turn resident on her back. e. Ask resident to separate her legs and flex knees...."</p>			

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	<p>A current policy titled "Hand Washing" undated, provided by the DON on 10/20/15 at 7:40 a.m., indicated "...General Instructions: Wash hands before and after resident contact..."</p> <p>4. On 10/18/15 at 9:45 a.m., the record review for Resident #43 was completed. Diagnosis included, but were not limited to, ulcerative colitis and gastric reflux.</p> <p>The resident had Care Plan dated 4/15/15. The Care Plan revision date of 5/17/15, indicated, "...the resident attempts to care for own ostomy bag and is focused on care of the bag, but does not ask for assistance and was unsuccessful with care. The resident needs to allow staff in care of ostomy bag at least twice a shift. Interventions: Change bag as needed, inspect skin around colostomy sight and clean with soap and water and use wash cloth, Nurse to change colostomy bag resident will empty bag but may need assistance at times. Staff need to take resident to bathroom and is incontinent of urine. (5/17/15)..."</p> <p>On 10/14/15 at 10:43 a.m., the resident was observed sitting in the bathroom facing the toilet, there was clear fluid all over floor in restroom directly in front of toilet. The resident's colostomy bag was</p>			

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F 0502 SS=D Bldg. 00	<p>observed setting on the edge of the toilet. At 10:50 a.m., the resident was observed sitting by his bed in wheelchair eating his breakfast.</p> <p>On 10/14/15 at 2:35 p.m., there was a strong odor of feces coming out of resident room into the hallway. The resident's bathroom was observed to have the colostomy bag setting on the edge of the toilet and feces smeared on the edge of the toilet seat.</p> <p>On 10/20/15 at 2:18 p.m., CNA #18 indicated she was to check the resident hourly to see if the colostomy was intact. She indicated this direction was on the CNA sheet.</p> <p>3.1-18(a)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interview and record review, the facility failed to collect a sample for laboratory testing in a timely manner to determine if a Urinary Tract infection was present for timely treatment for 1 of 3 residents reviewed for following</p>	F 0502	<p>F502 1.Resident J was discharged. 2.The medical records of all residents withscheduled labs were audited by the HIM on 10/23/15 for compliance withtimeliness of completion of</p>	11/18/2015

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	<p>physician orders (Resident J).</p> <p>Findings include:</p> <p>The record of Resident J was reviewed on 10/19/15 at 1:00 p.m. Diagnoses included, but were not limited to, history of urinary tract infection and altered mental status.</p> <p>A Physician's Order, dated 07/20/15, indicated Urinalysis C&S (culture and sensitivity). One time only for pain for 2 days. May I&O cath (in and out catheterize) if unable to obtain random urine sample. UA (urinalysis), C&S due to painful urination.</p> <p>Progress notes from Resident J's medical record indicated the following: 07-20-15 - "Therapy reported to therapy staff, that she was experiencing pain upon urination. Resident confirmed, primary physician notified, received order for UA, C&S, may I&O cath if unable to obtain...." 07-23-15 - "Urine obtained and lab order faxed to lab for pick up." 07-24-15 - "Resident U/A c&s picked up this a.m...." 07-26-15 - "...Currently on Cipro [antibiotic] without adverse reactions...Lethargic. Polyuria noted. Awaiting susceptibility results of UA."</p>		<p>most recent labs. No other residents were affected.</p> <p>3. Nursing staff were in-serviced by 11-18-15 onlab procedures. Labs will be auditedeach week by the HIM or designee to monitor timeliness of completion asordered.</p> <p>4. Don or designee will be responsible for ensuringcompliance with lab audits. The results will be reported to the QA committeemonthly ongoing.</p>	

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	<p>07-26-15 - "Preliminary results received. Organisms resistive to Cipro."</p> <p>07-26-15 - "New orders rec'd [received] to DC [discontinue] Cipro and start Macrobid this evening."</p> <p>A physician's progress note, dated 7/26/15, indicated "... + [positive] urine culture...Review of systems: ...Genitourinary...frequency, urgency...."</p> <p>During an interview with the Executive Director on 10/19/15 at 2:15 p.m., he indicated there was no documentation that the resident refused the I & O catheterization or the physician was informed of the three day delay in obtaining the specimen.</p> <p>This Federal tag relates to complaint IN00183411.</p> <p>3.1-49(a)</p>			