

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2015
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NAME OF PROVIDER OR SUPPLIER  ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00178649.</p> <p>Complaint IN00178649 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F441.</p> <p>Survey dates: August 24 and 25, 2015</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Census bed type: SNF: 16 SNF/NF: 82 Residential: 31 Total: 129</p> <p>Census payor type: Medicare: 29 Medicaid: 51 Other: 59 Total: 129</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p><b>This plan of correction is to serve as Arbor Trace's credible allegation of compliance.</b></p> <p><b>Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</b></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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F 0323 SS=D Bldg. 00	<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. Based on observation, interview and record review, the facility failed to ensure a toilet seat riser was removed from the bathroom of a resident who had been assessed by therapy services to not be in need of the device. This particular device was involved in a slippage for 1 of 3 residents reviewed for therapy services in a sample of 3, resulting in increased pain to the recent surgical area for a resident after the slippage. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 8-24-15 at 2:34 p.m. It indicated she was admitted to the facility on 7-9-15 and discharged from the facility on 7-14-15. Her diagnoses included, but were not limited to, bilateral knee joint replacement in the week prior to admission to the facility.</p> <p>In an interview with a family member of Resident #B on 8-25-15 at 1:40 p.m., she</p>	F 0323	<p><b>F323 483.25(h) FREE OF ACCIDENT/HAZARDS/SUPERVISION/DEVICES</b></p> <p><b>I. Resident B no longer resides in the community.</b></p> <p><b>II. All residents that use toilet risers have the potential to be affected. An audit of all residents with toilet risers has been completed to determine all are correctly placed.</b></p> <p><b>III. The systemic change includes education to therapy staff to remove toilet risers from the room if the patient does not require it for safe transfers. The systemic change also includes all</b></p>	09/14/2015

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	<p>indicated Resident #B had gone to use the bathroom in her room. She indicated was told by [unnamed] facility staff that a housekeeping staff member had been in to the resident's room earlier to clean the room. She indicated the housekeeping staff member had moved the toilet seat riser in order to clean the toilet. When the toilet seat riser was replaced by the housekeeping staff member, it was replaced with the seat of the toilet lowered and the toilet seat riser was on top of it. She indicated the seat of the toilet should have been in a raised position. As a result of the misplacement of the seat of the toilet, the toilet seat riser "ended up being wobbly and caused [Resident #B] to nearly fall [and] caused her right knee...a lot more pain."</p> <p>In review of Resident #B's occupational therapy (OT) "Initial Assessment," dated 7-10-15, it indicated her current level of functioning for "Self-Care: Toileting-General" to be "able to safely perform all toileting tasks utilizing a grab bar and rolling walker PRN [as needed] requiring stand by assistance (close enough to reach patient if needed)." It did not indicate a need for a toilet seat riser.</p> <p>In an interview with OT #1 on 8-25-15 at 10:45 a.m., she indicated she had</p>		<p><b>housekeeping and nursing staff will be educated upon hire and annually how to place a toilet riser correctly after cleaning the equipment.</b></p> <p><b>IV. The DON/Designee will audit 5 residents with toilet risers for correct placement daily for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months.</b></p> <p><b>Results of report findings will be reported to the QA committee monthly. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring.</b></p> <p><b>COMPLIANCE DATE: 9/14/15</b></p>				

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	<p>conducted Resident #B's initial OT assessment. She indicated she assessed her for not requiring toilet seat riser.</p> <p>OT #1 indicated she was working on the day in which Resident #B had a problem with the toilet seat riser. She indicated, "Apparently what happened was the housekeeping person had moved the toilet riser to clean the toilet riser. When she replaced it, the toilet seat was down and the riser was replaced. This caused it to be unstable...She did not fall off the toilet, but said it caused one knee to hurt worse than it normally did." OT #1 indicated she immediately placed the toilet seat in the up position and instructed the resident to always check for placement of the toilet seat prior to use.</p> <p>OT #1 was observed to demonstrate how a toilet seat riser should sit level, with all four legs on the floor with the toilet seat in the up position. She was then observed to demonstrate a toilet seat riser with a toilet seat in the down position. The toilet seat riser was observed to have the four legs slightly off the floor and unstable/wobbling.</p> <p>Review of the nursing progress notes, dated 7-13-15 at 1:00 p.m., indicated Resident #B informed the nursing staff</p>			

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	<p>when she sat on the toilet riser, it moved and her right leg "slipped" and resulted in increased pain to the surgical area of her knee. The notes indicated there was no edema or drainage of the area. The notes indicated the resident was observed at 1:40 p.m., and at 2:49 p.m., walking in the halls with a family member. Review of the "Controlled Drug Record" indicated the resident received PRN pain medication of two tablets of Norco 7.5/325 milligrams at 12:40 a.m., 7:00 a.m., 12:00 p.m., and 6:00 p.m., on 7-13-15 and 12:00 a.m., and 6:00 a.m., on 7-14-15, prior to discharge at 7:30 a.m.</p> <p>In interview with the Director of Nursing on 8-25-15 at 4:15 p.m., she indicated she would have thought the therapy staff would remove a piece of equipment from the resident's room if it was not needed. She indicated she felt a toilet seat riser "could be a fall risk." At 5:05 p.m., she indicated the therapy department did not have any policies or procedures related to the removal of unneeded equipment.</p> <p>This Federal tag relates to Complaint IN00178649.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F 0441 SS=D Bldg. 00	<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. Based on interview and record review,</p>	F 0441		09/14/2015
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	<p>the facility failed to ensure a facility bed was properly cleaned/disinfected prior to the admission of of a resident for 1 of 3 residents reviewed for clean environment in a sample of 3. This deficient practice has the potential to spread pathogens to the resident population of the facility. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 8-24-15 at 2:34 p.m. It indicated she was admitted to the facility on 7-9-15 and discharged from the facility on 7-14-15. Her diagnoses included, but were not limited to, bilateral knee joint replacement in the week prior to admission to the facility.</p> <p>In an interview with a family member of Resident #B on 8-25-15 at 1:40 p.m., she indicated the side rails of the bed were obviously soiled upon the resident's arrival to her room. She indicated she chose to clean them herself. She indicated the paper towels she used were quite soiled from the side rails.</p> <p>The Director of Nursing (DON) provided a copy of a "Resident/Family Concern/Grievance Form" from the family of Resident #B on 8-25-15 at 2:00 p.m. This form was dated 7-13-15. It</p>		<p><b>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p><b>I. Resident #B no longer resides in the community.</b></p> <p><b>II. All new admissions have the potential to be affected. All bed rails have been inspected for cleanliness and any issues noted have been corrected.</b></p> <p><b>III. The systemic change includes that a resident room checklist will be used when cleaning resident rooms/beds. A deep clean checklist will be used with deep cleans for resident rooms. The housekeeping staff will be educated on proper attention to detail when cleaning resident rooms/beds along with checklists to be used.</b></p> <p><b>IV. The housekeeping supervisor/designee will audit all deep cleaned rooms to determine cleanliness daily for 30 days, then 5 times per</b></p>				

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	<p>indicated, "...The hospital bed was dirty, which she also had a picture of, she cleaned the bed and took a picture of the rags that she washed the bed with."</p> <p>An email response from the Director of Environmental Services , dated 7-14-15 at 7:41 a.m., indicated, "It is my understanding after talking with [name of Maintenance staff] that he brought the bed in from the garage and put a new mattress on the bed-he passed on that the bed needed cleaning since it had been in the garage it was not a housekeeper that he told so it [is] my guess that it might not have gotten passed on for her to clean it down [sic]. I'm having a meeting with the housekeepers to go over room cleaning..."</p> <p>An email response from the Director of Environmental Services, dated 7-17-15 at 7:34 a.m., indicated, "After my investigation as to why the bed was dirty maintenance had brought the bed in from the garage and passed it on to the nursing staff that the bed was in the room it never got passed on to housekeeping so they could clean it-as far as housekeeping knew the room was ready with the other bed that was in the room [sic]...I had a staff meeting with all of the housekeepers concerning room cleaning..."</p>		<p><b>month for 150 days, then 3 times per month for 180 days to total 12 months.</b></p> <p><b>Results of report findings will be reported to the QA committee monthly. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring.</b></p> <p><b>COMPLIANCE DATE: 9/14/15</b></p>		

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	<p>In an interview with the DON on 8-25-15 at 4:15 p.m., she indicated all room are to be "deep cleaned after a discharge [of a resident] and before a new person [resident] is admitted."</p> <p>On 8-25-15 at 5:15 p.m., the Executive Director provided a copy of a procedure entitled, "Deep Cleaning Rooms." The procedure was undated, but was indicated to be a current procedure for the facility. This procedure indicated, "...Wash the bed down using [trade name of] cleaning solution..."</p> <p>This Federal tag relates to Complaint IN00178649.</p> <p>3.1-18(a)</p>						