

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2015
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NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: September 30, October 1, 2, 5, 6, and 7, 2015</p> <p>Facility number: 012854 Provider number: 155797 AIM number: 201104690</p> <p>Census bed type: SNF/NF: 58 Residential: 31 Total: 89</p> <p>Census payor type: Medicare: 8 Medicaid: 30 Other: 20 Total: 58</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on October 14, 2015.</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 0244 SS=E Bldg. 00	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to respond to and resolve grievances brought forth by the Resident Council in a timely manner for 6 of 9 months of Resident Council Meeting Minutes reviewed.</p> <p>Findings include:</p> <p>During an interview with the Resident Council President on 10/06/2015 at 2:09 P.M., he indicated the facility was not doing anything for staffing issues. He further indicated, "when other residents need help getting to the bathroom, staff sit at the nurse's station and don't go and help". He also indicated staffing comes up at the Resident Council meetings every month, the activities director tells him they will follow up on it and he never hears back from them. He indicated, "evidently they don't [follow up] because the people (residents) are</p>	F 0244	<p>F244 An emergent resident council meeting was held on 10/20/15 with all campus resident council members to review the purpose and the expectations of the Resident Council. Executive Director asked to be invited to the meeting and it was approved by residents prior to the meeting. This meeting was conducted by the Executive Director , Divisional Life Enrichment Support and the campus Life Enrichment Director. All areas of concern were identified and documented for appropriate follow up and resolution. These identified concerns, interventions for correction and status will be reported in the next meeting for follow up and input by the residents to verify improvement and resolution of identified concerns. Divisional Life enrichment Support Director met with the campus Director of Life Enrichment on 10/16/15. Divisional Support of Life</p>	10/20/2015

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	<p>still sitting up there (at the meetings) hollering about it, the same residents who complained about it last month."</p> <p>With the permission of the Resident Council President, the Resident Council meeting minutes were reviewed on 10/06/2015 at 2:34 P.M. The minutes were dated between 01/08/2015 and 10/01/2015 and indicated the following:</p> <p>Meeting minutes dated 01/08/2015 indicated, "...Nurses still aren't answering call lights, wait for CNAs (Certified Nursing Assistant) to do it & verbalize this to residents ..."</p> <p>Meeting minutes dated 02/12/2015 indicated under old business, "...Nursing did not resolve last meeting issue..." and under new business "...Nursing: Not answering call lights in a timely manner..."</p> <p>Meeting minutes dated 03/12/2015 indicated, "...1. Nurses aren't answering call lights or helping residents to restroom..."</p> <p>Meeting minutes dated 04/09/2015 indicated, "...Nurses don't 'take over' when CNAs all go to lunch..."</p> <p>Meeting minutes dated 05/14/2015</p>		<p>Enrichment and the Executive Director re- educated the Director of life enrichment of the campus on the policy and procedure for Resident Council Meetings and the regulatory guidelines in regard to resident council on 10/16/2015 with emphasis being placed on follow up. The Executive Director of the campus and the Divisional Life Enrichment Support will attend the next 3 resident council meetings to provide oversight to insure the meetings are being conducted following proper procedure if approved by residents prior to meeting. The Resident Council meeting minutes will be reviewed and appropriate action plans developed after each monthly meeting. The Executive Director and Divisional Life Enrichment Support will attend the resident council meetings , unannounced and randomly x 6 months to insure ongoing compliance., This will be conducted by the Executive Director and Divisional Life Enrichment Support to insure proper process is being followed. The resident council minutes will be presented in the monthly QA&A meeting for review and further recommendations if indicated, this will be ongoing.</p>	

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	<p>indicated under old business, "...Nurses not toileting during CNA lunches..."</p> <p>Meeting minutes dated 09/10/2015 indicated, "Call light times seem to still feel long at times ..."</p> <p>During a confidential interview with Resident #152 on 10/06/2015 at 3:02 P.M., he/she indicated no one had ever come to follow up on any concerns voiced at a Resident Council meeting, including staffing concerns. Resident #152 further indicated he/she has to get him/herself up to the toilet unassisted, but "usually someone does come and help me off [of the toilet]". Resident #152 indicated he/she was not supposed to get up by his/herself but had diarrhea and, "it just won't wait". Resident #152 was observed to be in a wheelchair at the time of interview.</p> <p>During an interview with Resident #52, on 10/06/2015 at 3:13 P.M., he/she indicated the facility was short on staff a lot of the time. He/she further indicated, when a concern was voiced at a Resident Council meeting, "it just lays there," and no one ever follows up on the concern. Resident #52 indicated the Activities Director writes down the concern in a book, states the issue will be looked at, but "nothing ever happens".</p>			

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	<p>During an interview on 10/06/2015 at 2:41 P.M., AA (Activities Assistant) #6 indicated that following a resident council meeting, the standard procedure was to fill out a paper that had all the complaints for all departments. The Activities Department had another paper they filled out for each individual complaint and these were given to the Director of the individual departments. The Directors had to send the papers back indicating what they were going to do to correct the issue. AA #6 further indicated the resident who initially made the complaint was to be contacted by the Activities Department and informed of the plan to correct the issue. The Activities Department kept all the reports in a book and reports were reviewed at the next Resident Council meeting to determine if the issue had improved.</p> <p>The current "Resident Council Meeting Requirements" policy was provided by the Regional MDS (Minimum Data Set) Support staff on 10/07/2015 at 9:45 A.M. The policy indicated, "...The primary purpose of the resident council is to provide an organized meeting to determine and act on resident's needs and concerns in relation to their care and facility (campus) services ..."</p>			

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F 0323 SS=D Bldg. 00	<p>3.1-3(l)</p> <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 maintain an environment free of accident hazards, as evidenced by a resident fall with injuries, related to no grab bar on the left side of the toilet for balance/support for 1 of 4 residents reviewed for accidents. (Resident #153)</p> <p>Findings include:</p> <p>During an interview on 10/01/2015 at 12:32 P.M., Resident #153 indicated after waiting a long time, he/she lost balance and fell off the toilet and onto the floor in</p>	F 0323	F – 323 1) Resident # 153 was reassessed by therapist on 09/29/15 to evaluate for appropriate interventions for fall prevention. A Fall Risk reassessment was conducted by the licensed nurse on 09/29/15. A toilet safety frame was implemented for support on 9/29/15 in the residents bathroom to assist with fall prevention per therapy recommendations. The physician and family were notified of therapists recommendations and appropriate orders were obtained. In addition, an intervention for staff to remain in the bathroom with the resident while toileting has been added to	10/30/2015	

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	<p>the bathroom on 09/29/2015. The resident further indicated there was no grab bar on the left side and he/she had to reach across for the right side grab bar.</p> <p>During an interview on 10/01/2015 at 12:37 P.M., Resident #153's family member indicated there were no grab bars on the left side of the toilet prior to the fall. The family member further indicated the resident was left sitting on the toilet for long periods while waiting on staff assistance.</p> <p>During an interview on 10/01/2015 at 12:43 A.M., the DON (Director of Nursing) indicated Resident #153's bathroom is set up with grab bars only on the right side of the toilet.</p> <p>During an interview on 10/05/2015 at 1:21 P.M., CNA (Certified Nurse Assistant) #5 indicated Resident #153 was accidentally left on the toilet longer then requested and lost his/her balance, falling on the floor. CNA #5 further indicated the resident's call light was turned off by a nurse and the resident's need for help was not relayed to her, in order for the resident to get assistance in a timely manner.</p> <p>During an interview on 10/05/2015 at 2:15 P.M., TM (Therapy Manager)</p>		<p>the plan of care. Resident # 153 care plan has been updated to reflect all new interventions. 2) All residents were reviewed and those with identified hemiparesis, hemiplegia or impairments affecting support ability have been reassessed by therapy, Nursing and MDS Coordinator for further recommendations for interventions to assist with fall prevention. The recommendations will be communicated to the IDT members, residents, residents family, and physician, and orders will be obtained as indicated. Any newly identified equipment or treatment plans will be implemented by therapy department and or nursing department for those identified residents. The plan of care will be updated and revised with all new orders and interventions as indicated, this will be conducted by the MDS Coordinator. Newly admitted residents will be reviewed by therapy and nursing to assess the need for interventions for fall prevention. 3) All licensed staff were re-educated on falls policy and procedure with emphasis placed on identifying possible interventions to prevent falls. In addition all staff were re-educated on the call light guidelines to include that call lights cannot be turned off and the staff leave the resident without addressing the residents needs. Emphasis</p>	

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	<p>indicated Resident #153's occupational therapy ended on 08/26/2015. The resident was reassessed after the fall on 09/29/2015 and a toilet safety frame was implemented for support on the left side. The TM further indicated the resident had right hemiplegia and self care functional limitations.</p> <p>During an observation, on 10/01/2015 at 10:58 A.M., Resident #153 had functional mobility on the left side only. Resident #153's bathroom was observed with hand rails on the right side wall beside the toilet and a safety frame was over the toilet (which was implemented after the fall on 09/29/2015).</p> <p>Review of Resident #153's clinical record on 10/02/2015 at 1:42 P.M., indicated the following:</p> <p>The "Nurse's Notes", dated 09/29/2015 at 10:30 A.M., indicated Resident #153 was assisted to the toilet on 09/29/2015 at 8:45 A.M. At 8:50 A.M., the nurse indicated she was called away from Resident #153 to assist another resident. The nurse indicated she was called back to the resident at 9:00 A.M. due to the resident falling off the toilet onto the floor. The resident had a large hematoma (area of swelling) to the right forehead, redness to the right shoulder and a small</p>		<p>placed on leaving the call light on until the residents needs are addressed. The education sessions were conducted by Clinical Support Nurse, ADHS, and Executive Director. 4) Random unannounced audits of call lights will be conducted by nursing administration to observe for call lights being answered timely and not turned off until the residents need has been met. These audits will be conducted 3 x week for 8 weeks, then 2x per week for 8 weeks, then weekly x 8 weeks, then monthly x 3 months. Any staff member observed turning the call light off and exiting the residents room without addressing the residents need, will be immediately re-inserviced. Counseling and or disciplinary action may be initiated if appropriate. The results of the audits will be reported to the monthly QA&A meeting for review and further recommendations as indicated based on the audit findings. Newly admitted residents will be reviewed in the daily Clinical Care Meeting by the Interdisciplinary Team, including therapy, to ensure that those at fall risk have been identified and have appropriate interventions in place to assist with fall prevention.</p>	

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	<p>abrasion and bruise to the right knee.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 08/05/2015, listed a BIMS (Brief Interview of Mental Status) score of 06, indicating Resident #153 was cognitively impaired. The MDS assessment further indicated that Resident #153 "...required extensive assistance - resident involved in activity, two person physical weight bearing support assistance ..." Diagnoses included, but were not limited to, CVA (cerebrovascular accident), heart failure, hypertension, depression and asthma.</p> <p>Resident #153's care plan with a revised date of 08/12/2014, indicated the resident was "...at risk for fall and fall related injury related to impaired balance, impaired ROM (range of motion), and weakness related to effects from CVA..." Resident #153's care plan interventions included, but were not limited to, "...use the bilateral mobility bars to assist with turning and repositioning in bed ..." An additional care plan revision, dated of 09/29/2015, indicated, "...toilet seat raiser [sic] in place".</p> <p>Resident #153's care plan for ADLs (Activities of Daily Living), with a revised date of 08/12/2014, indicated interventions included, but were not</p>			

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	<p>limited to, "...Encourage me to grasp the rails and displace my own weight as desired ...at present I require assist of one with transfers."</p> <p>Review of the "Occupational Therapy Plan of Care" , dated 09/23/2015, indicated the following:</p> <ul style="list-style-type: none"> -ADL Self Care, Toileting - resident required moderate assistance -Functional Transfers, Toileting - resident required maximum assistance -Balance, Dynamic Sitting - resident has difficulty crossing midline without balance loss -Balance, Fall Risk - high risk <p>The current facility policy titled, "Guidelines for Incident and Accident Tracking" and dated 11/2010, was provided by the Clinical Nurse Consultant on 10/07/2015 at 10:45 A.M. and reviewed at that time. The policy indicated, "...The campus shall maintain a system for evaluation and analysis to identify: a. specific hazards...c. need patterns such as toileting..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F 0353 SS=E Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure adequate staffing was provided in relation to call lights being answered in a timely manner and residents having to wait long periods for assistance for 6 of 25 residents interviewed, (Resident #150, #151, #152, #153, #154, and #53) 1 of 3</p>	F 0353	F-353 Resident # 150, # 151, #152, #153, #154, #53 and family member of resident # 155 have been interviewed by Executive Director, ADHS, and Social Services to verify their call lights are being answered timely in order to met their personal care needs, including their toileting needs. An emergent resident council meeting was held on	10/20/2015

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	<p>family members interviewed (Resident #155) and 2 of 3 staff interviewed (Staff #4 and Staff #5).</p> <p>Findings include:</p> <p>During confidential interviews, on 10/01/2015 at 10:01 A.M. and 10/05/2015 at 10:54 A.M., Resident #150 indicated the facility needed more staff. The resident further indicated he/she has had to wait a long time for help before and that staff would turn off his/her call light and say they will "be right back and it is half an hour later". Resident #150 indicated he/she had asked for assistance an hour ago and the CNA (Certified Nursing Assistant) had turned her light off and said she would come back, but had not returned yet.</p> <p>During confidential interviews, on 10/01/2015 at 1:26 P.M. and 10/05/2015 at 11:06 A.M., Resident #151 indicated he/she has had to wait 30 minutes at times for assistance and that he/she has had an incontinent episode because the staff did not respond quickly enough.</p> <p>During confidential interviews, on 9/30/2015 at 3:01 P.M., 10/05/2015 at 10:29 A.M. and 10/06/2015 at 3:02 P.M., Resident #152 indicated he/she has had to wait up to half an hour for assistance</p>		<p>10/20/15 with all campus resident council members to review the purpose and the expectations of the Resident Council. This meeting was conducted by the Executive Director after approval by residents , Divisional Life Enrichment Support and the campus Life Enrichment Director. All areas of concern were identified and documented for appropriate follow up and resolution. These identified concerns, interventions for correction and status will be reported in the next meeting for follow up and input by the residents to verify improvement and resolution of identified concerns. Daily staffing is reviewed everyday by the Executive Director and Nursing Administration to ensure coverage is adequate to meet the needs of the residents All residents have the potential to be affected by the practice. All remaining interviewable residents were interviewed in regard to call lights being answered timely and their needs being met appropriately. The campus has a specific call-in procedure and call offs are replaced on the daily schedule. If necessary nursing administration team leaders will provide additional staffing to insure the residents needed are being met. All Staff were re-educated on the guideline for answering call lights, guidelines for providing adl assistance and</p>	

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	<p>in the restroom and that it is a problem on every shift. The resident further indicated he/she has had frequent incontinent episodes due to having to wait for help in the restroom. Resident #152 indicated he/she would get him/herself up to the toilet unassisted even though he/she was not supposed to get up by him/herself.</p> <p>During confidential interviews, on 10/01/2015 at 10:41 A.M. and 10/05/2015 at 10:59 A.M., Resident #153 indicated he/she had to wait a long time for assistance in the restroom. He/she further indicated the facility was "...too short..." on staff and when the staff say they will be right back it takes a while.</p> <p>During a confidential interview on 10/05/2015 at 2:22 P.M., a family member of Resident #155 indicated the resident does not get morning care in a timely manner due to there not being enough staff, especially in the rush of the morning.</p> <p>During an interview on 10/06/2015 at 2:09 P.M., the Resident Council President (Resident #53), indicated the facility was not doing anything for staffing issues. He further indicted, "when other residents need help getting to the bathroom, staff sit at the nurse's station and don't go and help." He</p>		<p>emphasis placed on toileting. This was conducted by Clinical Support, ADHS, and Nursing team leaders. All remaining interviewable dependent residents in the campus were interviewed by Social Services, Life Enrichment, and ADHS to verify their needs are being met in regard to their call lights being answered timely, and their toileting needs are being met Review of Staffing, Call lights being answered timely, the residents needs being met with the light is answered, including toileting will be topics in resident council meetings to insure that issues are being identified, addressed and resolved in a timely manner. Divisional Life enrichment Support Director met with the campus Director of Life Enrichment on 10/16/15. Divisional Support of Life Enrichment and the Executive Director re- educated the Director of life enrichment of the campus on the policy and procedure for Resident Council Meetings and the regulatory guidelines in regard to resident council on 10/16/2015 with emphasis being placed on follow up. Based on approval from the residents, the Executive Director of the campus and the Divisional Life Enrichment Support will attend the next 3 resident council meetings to provide oversight to insure the meetings are being conducted following proper procedure. The</p>	

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	<p>indicated staffing comes up at the meetings every month, the activities director tells him they will follow up on it and he never hears back from them, "and evidently they don't because the people (residents) are still sitting up there (at the meetings) hollering about it, the same residents who complained about it last month."</p> <p>During a confidential interview on 10/05/2015 at 11:09 A.M., Staff #4 indicated they felt the facility was very understaffed and that things do not get done in a timely manner. Staff #4 further indicated things feel rushed when staff is short and the staff do not get to take the proper amount of time doing things as they should. He/she indicated at times there is only one aide for both the 100 and 300 halls, which means it takes time to find someone to assist when a resident requires two-person assistance. Staff #4 indicated they have seen call lights go off for 15 to 20 minutes before when they were too busy to get to the lights.</p> <p>During an interview on 10/05/2015 at 1:21 P.M., Staff #5 indicated there was not enough staff and that Resident #153 had fallen off the toilet due to having to wait too long for staff to respond. He/she further indicated a nurse had turned the call light off without assisting the</p>		<p>staffing will be reviewed by the Executive Director and Director of Health Services daily. Sufficient staffing will be verified by administration daily ongoing. The campus will continue to have an on call to fill in when a staff member is unable to fulfill their work schedule. If the staffing level is determined to be insufficient the on call staff member will be notified. In the instance the on call employee is unavailable, nursing administration will be responsible to insure adequate staffing numbers to meet residents needs. The Resident Council meeting minutes will be reviewed and appropriate action plans developed after each monthly meeting. The Executive Director and Divisional Life Enrichment Support will attend the resident council meetings , unannounced and randomly x 6 months to insure ongoing compliance., This will be conducted by the Executive Director and Divisional Life Enrichment Support to insure proper process is being followed based on approval of residents. The resident council minutes will be presented in the monthly QA&A meeting for review and further recommendations if indicated, this will be ongoing. Random unannounced audits of call lights will be conducted by nursing administration to observe for call lights being answered timely and not turned off until</p>	

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	<p>resident.</p> <p>During an observation and confidential interview on 10/05/2015 at 2:09 P.M., Resident #154 was observed in the 200 hall main area near the nurse's station. Resident #154 called down the hall to a CNA asking for assistance to the restroom. One CNA was heard to respond to the resident, indicating it would be just a few minutes. The resident voiced a complaint that he/she had asked four staff for help and no one had helped him/her yet. When asked, Resident #154 indicated he/she had been waiting since 2:00 P.M. and staff kept saying it would be just a minute, but he/she wasn't sure they could wait that long. The resident indicated he/she had asked four different staff and no one had helped and having to wait long times was not an uncommon occurrence. During this observation, RN (Registered Nurse) #1, RN #2, and QMA (Qualified Medication Aide) #3 were at the nurse's station. QMA #3 and RN #1 proceeded to begin a narcotics count as Resident #154 sat in a wheelchair waiting for assistance. Resident #154 was taken to his/her room by a CNA at 2:16 P.M.</p> <p>On 10/06/2015 at 2:34 P.M., the Resident Council Meeting Minutes dated between 01/08/2015 through 10/01/2015 were reviewed with the permission of the</p>		<p>the residents need has been met. These audits will be conducted 3 x week for 8 weeks, then 2x per week for 8 weeks, then weekly x 8 weeks, then monthly x 3 months. Any staff member observed turning the call light off and exiting the residents room without addressing the residents need, will be immediately re-inserviced. Counseling and or disciplinary action may be initiated if appropriate. The results of the audits will be reported to the monthly QA&A meeting for review and further recommendations as indicated based on the audit findings. . Action plans will be developed and continue for any identified concerns until substantial compliance is achieved.</p>	

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	<p>Resident Council President and indicated the following:</p> <p>Meeting minutes dated 01/08/2015 indicated, "...Nurses still aren't answering call lights, wait for CNAs to do it & verbalize this to residents..."</p> <p>Meeting minutes dated 02/12/2015 indicated under old business, "...Nursing did not resolve last meeting issue..." and under new business "...Nursing: Not answering call lights in a timely manner..."</p> <p>Meeting minutes dated 03/12/2015 indicated, "...1. Nurses aren't answering call lights or helping residents to restroom..."</p> <p>Meeting minutes dated 04/09/2015 indicated, "...Nurses don't "take over" when CNAs all go to lunch..."</p> <p>Meeting minutes dated 05/14/2015 indicated under old business, "...Nurses not toileting during CNA lunches..."</p> <p>Meeting minutes dated 09/10/2015 indicated, "...Call light times seems to still feel long at times..."</p> <p>3.1-17(a)</p>			

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F 0441 SS=D Bldg. 00	<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</p>			

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	<p>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 infection control practices and standards were maintained related to hand washing for 2 of 2 observations during medication pass and 1 of 3 observations of personal care. (Resident #1, #13 and #83)</p> <p>Findings include:</p> <p>1. During an observation of medication pass on 10/05/2015 at 7:03 A.M., LPN (Licensed Practical Nurse) #3 donned gloves without first washing her hands, removed the glucometer from the top of the medication cart, entered Resident #83's room, checked his blood sugar with the glucometer, removed her gloves, washed her hands for five seconds, then used hand gel.</p> <p>On 10/05/2015 at 7:05 A.M., during an interview, LPN #3 indicated she should have washed her hands before putting her gloves on.</p> <p>2. During an observation of care with Resident #1 on 10/05/2015 at 7:12 A.M., LPN #2 donned gloves without</p>	F 0441	<p>F-441 Resident # 83 has been reassessed by the licensed nurse and has no signs or symptoms of infection. Resident 1# gastrostomy tube site was reassessed by the licensed nurse and there are no signs or symptoms of infection. Resident # 13 was reassessed by the Licensed Nurse and has no signs or symptoms of infection. All residents had the potential to be affected. ADHS immediately began inserving for all nursing employees, regarding infection control policy and procedure protocols specifically regarding handwashing. Inserving of all nursing team members will be completed by 11/01/15. The education will be conducted by the ADHS and nursing administrative team members. ADHS, nursing administrative team will conduct random handwashing observations of nursing staff during care delivery to insure ongoing compliance. The observations will be conducted 3 x week for 8 weeks, then 2x per week for 8 weeks, then weekly x 8 weeks, then monthly x 3 months. then quarterly thereafter to insure ongoing compliance. If concerns are identified during the</p>	11/01/2015

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	<p>performing handwashing. LPN #2 then hung a feeding tube bag, removed a soiled dressing from the g-tube (gastrostomy tube) site, removed her gloves, donned new gloves, and placed a clean gauze pad around the g-tube. LPN #2 checked placement of the g-tube, flushed the g-tube with water and connected the feeding tube. LPN #2 bagged the trash, removed her gloves, washed her hands for 10 seconds, and exited the resident's room.</p> <p>3. During an observation on 10/06/2015 3:58 P.M., CNA #7 and CNA #8 entered Resident #13's room and donned gloves. CNA #7 and CNA #8 did not wash their hands prior to donning gloves. CNA #7 rolled the soiled brief under Resident #13 and used moistened wipes to cleanse the resident's buttocks. CNA #7 then rolled the soiled brief and wipes together and placed them in a trash bag. CNA #8 assisted CNA #7 in placing a new brief under Resident #13 and the soiled linens were placed in a trash bag. CNA #7 and CNA #8 removed their gloves and washed their hands for 10 seconds each.</p> <p>On 10/06/2015 at 4:15 P.M., during an interview CNA #7 and CNA #8 indicated hands should be washed for 15 to 20 seconds while you sing the "Happy Birthday" song.</p>		<p>observations, re-education will be provided at the time of the occurrence and re-observation will be conducted. Results of the observations will be presented to the QA&A committee monthly for review and further recommendations as indicated. Action plans will be developed and continue for any identified concerns until substantial compliance is achieved.</p>	

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R 0000 Bldg. 00	<p>The "Guideline for Handwashing/Hand Hygiene" policy was provided by the Clinical Nurse Consultant on 10/05/2015 at 9:15 A.M. and identified as current. The policy indicated, "...Health Care Workers shall wash hands...Before/after having direct contact with residents...After removing gloves worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc. ...Wash well for 20 seconds (ABC or Happy Birthday song).</p> <p>3.1-18(I)</p>	R 0000		
	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential census: 31</p>			

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	<p>Sample: 7</p> <p>Aspen Place Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>				