

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155104	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN 47710
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: 12/28, 29, 30, 2015, January 4, 6 and 7, 2016.</p> <p>Facility Number: 000043 Provider Number: 155104 AIMS Number: 100290960</p> <p>Census Bed Type: SNF:18 SNF/NF: 131 Total: 149</p> <p>Census Payor Type: Medicare: 23 Medicaid: 95 Other: 31 Total: 149</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on January 13, 2016.</p>	F 0000	F0000 This Plan of Correction is submitted under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The Submission of the Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Furthermore, we request this 2567 (Plan of Correction) serve as our credible allegation of compliance. We respectfully request paper compliance on the Plan of Correction.	

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 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review,</p>	F 0225	F225	02/06/2016	

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	<p>the facility failed to ensure prompt reporting of allegations of abuse to the administrator and the state survey agency for 2 of 5 allegations of abuse reviewed. (Resident #249, Resident #26, QMA #1, LPN #2)</p> <p>Findings include:</p> <p>1. On 12/30/15 at 10:59 a.m., the abuse reportable's were provided and reviewed. An allegation of abuse involving Resident #249 was reviewed. The reportable incident indicated QMA #1 had believed LPN #2 was rough and rude with Resident #249. The report indicated the incident had occurred on 5/31/15 at approximately 10:30 p.m. and QMA #1 had not reported it to the supervisor until 6/1/15 at 6:30 p.m.</p> <p>On 1/6/15 at 2:24 p.m., the DON and Administrator were interviewed. The DON indicated it had been approximately one day before QMA #1 reported the allegation to the supervisor.</p> <p>2. On 1/6/15 at 9:39 a.m., an allegation of abuse from 12/30/15 involving Resident #26 was reviewed. The report indicated the staff had been notified of an allegation of abuse on 12/30/15 at 11:30 a.m. The report indicated it had not been reported to the state survey agency until</p>		<p>Immediate Action – upon notification from ISDH Surveyor the IncidentReports for resident #26 and resident #249 was reviewed. These incidents occurred on 12/30/15 and 5/31/15respectively. Initial Reports weresubmitted to State Survey Agency on 12/31/15 AND 6/1/15. The Final Report was submitted at ISDHGateway on 1/4/16 and 6/5/15. Due todates of submission no correction may be made to these specific Incidents.</p> <p>Review of Residents – All incidents from last survey were reviewed andassessed for timeliness of reporting to Administrator/DON and State SurveyAgency. No residents were adversely affected by thisaction as it relates to F225.</p> <p>Corrective Action – The Policy and Procedure for Incidents/UnusualOccurrence Report and Investigation, and Abuse Prohibition, were revised toinclude ‘all allegations of abuse will be reported immediately to the Administrator/DONand the State Survey Agency.’ All staffwill receive in-service on the revised Policy and Procedure forIncidents/Unusual Occurrence Report and Investigation, and the AbuseProhibition P&P. The Reportable Loghas been revised to include ‘Date Reviewed by QA Team’ A minimum of 1 (one)member of the QA team will be notified</p>				

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F 0226 SS=D Bldg. 00	<p>12/31/15.</p> <p>On 1/6/15 at 2:24 p.m., the DON and Administrator were interviewed. The DON indicated the report was submitted together with another allegation the next day.</p> <p>On 1/6/15 at 1:35 p.m., the Abuse Prohibition policy was reviewed. The policy included, but was not limited to: Any team member with knowledge of an alleged abuse incident will report it immediately to the unit/charge nurse, supervisor, nursing administration, DON, or Administrator. Administrator and/or Administrative Nurse Designee will submit a written report to the appropriate state and local agencies...</p> <p>The policy did not indicate allegations of abuse should be reported immediately to the State Survey Agency.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement</p>		<p>immediately that an Incident/Unusual Occurrence has been reported/submitted. After reviewing the Incident/Unusual Occurrence the QA member will signoff on the Log to confirm that the Policy and Procedure has been followed, including the immediate reporting of allegation to Administrator/DON and immediate reporting of allegation to State Survey Agency.</p> <p>Monitoring – The QA Team will continue to review all Incidents/Unusual Occurrences at Quarterly QA Meetings. Reviewing timeliness of reporting by staff to Administrator/DON and timeliness of reporting to State Survey Agency will be added to the QA Process. This practice will continue a minimum of 12 months.</p> <p>Completed by February 6, 2016</p>	

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	<p>written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the abuse policy was followed and the abuse policy included a provision for the immediate reporting of allegations of abuse to the state survey agency. (Resident #249, Resident #26, QMA #1, LPN #2)</p> <p>Findings include:</p> <p>1. On 12/30/15 at 10:59 a.m., the abuse reportables were provided and reviewed. An allegation of abuse, involving Resident #249, was reviewed. The reportable incident indicated QMA #1 had believed LPN #2 was rough and rude with Resident #249. The report indicated the incident had occurred on 5/31/15 at approximately 10:30 p.m. and QMA #1 had not reported it to the supervisor until 6/1/15 at 6:30 p.m.</p> <p>On 1/6/15 at 2:24 p.m., the DON and Administrator were interviewed. The DON indicated it had been approximately one day before QMA #1 reported the allegation to the supervisor.</p> <p>2. On 1/6/15 at 9:39 a.m., an allegation of abuse from 12/30/15 involving Resident #26 was reviewed. The report indicated the staff had been notified of an</p>	F 0226	<p>F226</p> <p>Immediate Action – upon notification from ISDH Surveyor the IncidentReports for resident #26 and resident #249 was reviewed. These incidents occurred on 12/30/15 and 5/31/15respectively. Initial Reports weresubmitted to State Survey Agency on 12/31/15 AND 6/1/15. The Final Report was submitted at ISDHGateway on 1/4/16 and 6/5/15. Due todates of submission no correction may be made to these specific Incidents.</p> <p>Review of Residents – All incidents from last survey were reviewed andassessed for timeliness of reporting to Administrator/DON and State SurveyAgency. No residents were adverselyaffected by this action as it relates to F226.</p> <p>Corrective Action – The Policy and Procedure for Incidents/UnusualOccurrence Report and Investigation, and Abuse Prohibition, were revised toinclude ‘all allegations of abuse will be reported immediately to the Administrator/DONand the State Survey Agency.’ All staffwill receive in-service on the revised Policy and Procedure forIncidents/Unusual Occurrence Report and Investigation, and the</p>	02/06/2016

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F 0272 SS=D	<p>allegation of abuse on 12/30/15 at 11:30 a.m. The report indicated it had not been reported to the state survey agency until 12/31/15.</p> <p>On 1/6/15 at 2:24 p.m., the DON and Administrator were interviewed. The DON indicated the report was submitted together with another allegation the next day.</p> <p>3. On 1/6/15 at 1:35 p.m., the Abuse Prohibition policy was reviewed. The policy included, but was not limited to: Any team member with knowledge of an alleged abuse incident will report it immediately to the unit/charge nurse, supervisor, nursing administration, DON, or Administrator. Administrator and/or Administrative Nurse Designee will submit a written report to the appropriate state and local agencies...</p> <p>The policy did not indicate allegations of abuse should be reported immediately to the State Survey Agency.</p> <p>3.1-28(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p>		<p>AbuseProhibition P&P. The Reportable Loghas been revised to include 'Date Reviewed by QA Team' A minimum of 1 (one)member of the QA team will be notified immediately that an Incident/UnusualOccurrence has been reported/submitted. After reviewing the Incident/Unusual Occurrence the QA member will signoff on the Log to confirm that the Policy and Procedure has been followed,including the immediate reporting of allegation to Administrator/DON andimmediate reporting of allegation to State Survey Agency. Monitoring – The QA Team will continue to review all Incidents/UnusualOccurrences at Quarterly QA Meetings. Reviewing timeliness of reporting by staff to Administrator/DON andtimeliness of reporting to State Survey Agency will be added to the QAProcess. This practice will continue aminimum of 12 months. Completed by February 6, 2016</p>	

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Bldg. 00	<p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive assessment was accurate for 1 of 29 residents reviewed as a resident's MDS (Minimum Data Set) assessment was incorrectly entered.</p>	F 0272	<p>F272</p> <p>Immediate Action – Upon notification by the ISDH the resident's MDS was reviewed. It was determined that the assessment</p>	02/06/2016

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	<p>(Resident #181)</p> <p>Findings include:</p> <p>During an observation on 1/4/16 at 10:32 a.m., Resident #181 was observed to be sitting in the lounge in a wheelchair. Resident #181 had a tracheostomy tube in place which was capped.</p> <p>The clinical record of Resident #181 was reviewed on 1/4/16 at 11:17 a.m. The clinical record indicated Resident #181 had been admitted to the facility on 9/9/14, with a tracheostomy. A quarterly MDS assessment, dated 12/18/15, indicated Resident #181 had a BIMS (Brief Interview for Mental Status) score of 13, which indicated slight mental impairment. The MDS indicated the resident did not have a tracheostomy while a resident at the facility.</p> <p>During an interview on 1/6/16 at 3:58 p.m., Resident #181's spouse indicated the physician had wanted to remove the tracheostomy in October, 2015, but the resident was unable to tolerate it and the tracheostomy was left in place.</p> <p>During an interview on 1/6/16 at 2:38 p.m., MDS Coordinator #1 indicated Resident #181 had the tracheostomy in place when the MDS was completed and</p>		<p>wassigned off and it was complete in the 14day requirement as of 12/31/2015.</p> <p>We checkedsupportive documentation to be sure that the tracheostomy care was actuallydone and that we indeed should have marked this on the MDS, we did havesupportive documentation. The MDS was transmittedwith the error since it was already signed as being complete. Once validated asbeing accepted into the CMS system, the MDS was then "Modified". Asper guidelines of CMS RAI Version 3.0 Manual Chapter 5: Submission andCorrection of the MDS Assessments, if a mistake is made in coding of an MDS weare allowed to complete a correction by submitting a "Modification request" andsend to the QIES ASAP system. We have up to 3 years to make modification/correctionsto the MDS. The Modification request asa "data entry error" was entered and as was the appropriate correction on theMDS—now marking tracheostomy care. It will not affect our reimbursement. Allhas been transmitted to the QIES ASAP system as of 1/7/16.</p> <p>Review ofResident – All residents MDS were reviewed to check for accuracy. No residents were adversely affected by thisaction as it relates to F272 CorrectiveAction – a 'MDS Transmission Log' has been created. Once the MDS assessment is</p>		

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F 0329 SS=D Bldg. 00	<p>signed on 12/18/15. MDS Coordinator #1 indicated the facility would need to send a correction for the incorrect MDS assessment.</p> <p>The facility lacked documentation of a policy for MDS assessments.</p> <p>3.1-31(c)(6)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse</p>		<p>completed, and prior to transmission, the MDS assessment will be reviewed by another MDS nurse. The initial check for accuracy of the MDS will be made by the nurse creating the MDS. The second check will be done by another MDS nurse. This information will be documented on the MDS Transmission Log. A policy for MDS Assessment Process was created. All MDS Nurses will be educated on use of MDS Transmission Log, and new Assessment Process MDS Policy/Procedure.</p> <p>Monitoring – Prior to transmission the Director of Health Services Utilization CMI/MDS Nurse will review the MDS. Also, the current RUG score and the previous RUG score will be compared; this will be documented on the MDS Transmission Log. This will allow another check for accuracy.</p> <p>This practice will continue a minimum of 12 months.</p> <p>Completed by February 6, 2016</p>	

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	<p>consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. An anti-anxiety medication had not been attempted to reduced. (Resident #128).</p> <p>Findings include:</p> <p>On 12/30/15 at 9:54 a.m., Resident #128 was observed sleeping in bed.</p> <p>On 12/30/15 at 3:15 p.m., Resident #128's clinical record was reviewed.</p> <p>The most recent signed physician's recapitulation orders, signed 12/18/15, included, but were not limited to: Buspar (an anti-anxiety medication), 10 mg (milligrams), take 1 (one) tablet by</p>	F 0329	<p>F329</p> <p>Immediate Action – Upon notification by the ISDH the Pharmacy Recommendations for res #128 were reviewed. No other issues were found. All recommendations meet GDR requirements for res #128.</p> <p>Review of Residents – All Pharmacy Recommendations were reviewed for Physician's response. Any follow up necessary for unacceptable responses from Physician was made.</p> <p>Corrective Action – The Pharmacy PI P&P has been revised to include 'Monthly Pharmacy Recommendation Review' Unit Directors will continue to</p>	02/06/2016

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	<p>mouth, two times daily. The orders indicated the initial medication order was 1/27/15.</p> <p>The Request for Psychoactive Medication Change, dated 3/31/15, indicated the pharmacist had requested a reduction in Resident #128's Buspar to 5 mg twice a day. The physician responded and disagreed with the reduction. The physician indicated the patient was doing good on the current dose.</p> <p>The Request for Psychoactive Medication Change, dated 10/21/15, indicated the pharmacist had requested a reduction in Resident #128's Buspar to 5 mg twice a day. The physician responded and disagreed with the reduction. In the area indicated for the reason for decline, the physician wrote, patient.</p> <p>The Nursing Progress Notes, dated 9/1/15 through 12/30/15 lacked any documented anxious behaviors.</p> <p>On 12/30/15 at 3:28 p.m., Resident #128 was observed sleeping in the television area.</p> <p>On 1/6/16 at 10:25 a.m., LPN #1 was interviewed. LPN #1 indicated the facility had requested a gradual dose reduction for Resident #128's Buspar</p>		<p>forward recommendations on GDR to Physicians. When Physician responds Unit Director will review response to ensure Physician has documented acceptable reason if they disagree with Consultant Pharmacist Recommendations. This will be tracked on the new form Monthly Pharmacy Recommendation Review. Unit Directors will receive additional instruction on acceptable/unacceptable responses from Physician's on GDR, revised Pharmacy PI Policy and Procedure, and use of Monthly Pharmacy Recommendation Review.</p> <p>Monitoring- During the monthly Pharmacy PI meeting the Unit Director will review the Monthly Pharmacy Recommendation log with Pharmacy PI committee. The Physician's Response to Consultant Pharmacist Recommendations will be checked again for acceptable rational when Physician disagrees. This practice will continue for a minimum of 12 months.</p> <p>Completed by February 6, 2016</p>	

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F 0441 SS=D Bldg. 00	<p>multiple times but the physician had denied the requests.</p> <p>On 1/7/15 at 2:20 p.m., the DON provided the Policy and Procedure for Psychoactive medications. The policy indicated gradual dose reductions would be reviewed.</p> <p>3.1-48(a)(1)</p> <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.</p>						

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	<p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 2 of 6 residents observed for care. A resident received inadequate catheter care (Resident #88) and isolation containers were located in a semi-private room for (Resident #100) and next to (Resident #126) who was not isolated. (Resident #88, Resident #100, Resident #126)</p> <p>Findings include:</p> <p>1. During an observation on 1/4/16 at 3:05 p.m., CNA #1 and CNA #2 were observed to assist Resident #88 to bed. Hand hygiene was performed and gloves were applied. After placing the resident in bed, CNA #1 was observed to remove the resident's slacks and brief. Resident #88 had an indwelling foley catheter. CNA #1 was observed to obtain a clean</p>	F 0441	<p>F441 Immediate Action – Upon notification from ISDH it was determined what staff member(s) had provided care to resident #88. This CNA who provided care received 1:1 education for cath care.</p> <p>Review of Residents – Residents who currently have a catheter were reviewed. 1 of 11 residents with foley catheter was being treated for UTI. On January 13, 2016 results of this residents repeat U/A was faxed to Physician. Physician did not continue antibiotic treatment, currently on no antibiotic for UTI</p> <p>Corrective Action – Marina Tieken LPN Staff Development was notified and Kandace Kolley CNA received instruction for perineal care, cath care. CNA Skills Check Off Perineal Care was reviewed. No revisions were required. All CNA/QMA will be inserviced on</p>	02/06/2016

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	<p>wipe. CNA #1 wiped the urethral area of Resident #88. Using the same wipe, CNA #1 was observed to wipe the bilateral groin areas of the resident and cleaned approximately 3-4 inches of the catheter tube. CNA #1 used the same wipe to wipe the inner middle labia again. The wipe was discarded and the resident was then repositioned in bed.</p> <p>During an interview on 1/4/16 at 3:16 p.m., CNA #1 indicated when performing catheter care, the urethral area should be wiped or washed first and then the two outer labias should be separated and wiped.</p> <p>A "CNA Skills Check Off - Perineal Care," obtained from the DON (Director of Nursing) on 1/7/15 at 12:40 p.m., indicated when doing perineal care on a female resident, the labia should be separated and the urethral area washed first. Secondly, the labia should be washed between and outside, alternating side to side and moving outward to the thighs.</p> <p>2. On 12/29/15 at 9:00 a.m., during Stage 1 interview and resident review, room 114 had two large boxes with isolation bags in them, in between the resident beds. Resident #100 was isolated for ESBL(extended spectrum beta</p>		<p>procedure on Perineal Care, Catheter Care.</p> <p>Monitoring – The Director of QAPI Nurse/Designee will conduct random weekly checks for Perineal Care, Catheter Care utilizing the RANDOM WEEKLY CHECKS PERINEAL/CATHETER CARE form. This practice will continue for a minimum of 12 months.</p> <p>Completed by February 6, 2016 F441</p> <p>Immediate Action – Upon notification from ISDH the Heritage staff moved resident #100 bed and isolation bins to correct the concern.</p> <p>Review of Residents – Heritage staff went to each resident's room that was on isolation to review placement of isolation bins. No violations were found. No residents were adversely affected.</p> <p>Corrective Action – The ISOLATION LOG/ISOLATION SET-UP LOG has been revised to include 'date of isolation set up/barrels placed appropriately. A Policy and Procedure for 'PROCEDURES FOR SETTING UP ISOLATION ROOM' was created. DON/ADON/UD/AUD/Infection Control Nurse will be in serviced on the revised ISOLATION LOG/ISOLATION SET-UP LOG. Nursing and</p>				

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	<p>lactamase), which was thought to be colonized in the her urine. The roommate was identified as Resident #126, who was not in isolation, but shared the room.</p> <p>On 12/30/15 at 2:00 p.m., room 114 had cardboard boxes with red isolation bags in them, located in the middle of room, between the two roommates. One box had dirty linens and clothes, the other had trash.</p> <p>On 01/06/16 11:27 a.m., the boxes remained in the middle of the room, the curtain was pulled between the two beds of Resident #100 and Resident #126.</p> <p>On 01/06/16 11:41 a.m., an interview with RN # 2 concerning the isolation containers with bags in the middle of the room next to the other roommates bed. RN #2 indicated the residents bed could be moved against the other wall, making room for the isolation boxes away from the roommate. Interview with Unit Manager for Harbor unit indicated the curtain was usually pulled between the residents, but the bed position could be changed to accommodate the isolation boxes, so they were not so close to the roommate.</p> <p>A policy was received from Director of</p>		<p>Housekeeping will be inserviced on 'PROCEDURES FOR SETTING UP ISOLATION ROOM'</p> <p>Monitor – Utilizing the ISOLATION LOG/ISOLATION SET-UPLOG the Infection Control Nurse/Designee will assess each resident's room whenan Isolation order is received. Afterisolation has been established the Infection Control Nurse/Designee will checkweekly to ensure the bins are placed appropriately in resident's room, thiswill be for duration of Isolation Precautions. This practice will continue fora minimum of 12 months.</p> <p>Completed by February 6, 2016</p>		

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	Nursing on 1/7/16 at 2:30 p.m., indicated Isolation Precautions that included ensure that the facility had adequate procedures for the routine care, cleaning and disinfection of environmental services; beds, bed rails, bedside equipment and other frequently touched surfaces and that these procedures are being followed. 3.1-18(b) 3.1-18(j)				