

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155468	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2013
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NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 325 W NORTHWOOD DR SULLIVAN, IN 47882
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 11-15, 2013</p> <p>Facility Number: 000525 Provider Number: 155468 AIM Number: 100267010</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicare: 4 Medicaid: 33 Other: 3 Total: 40</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 03/22/2013 by Brenda Nunan, RN.</p>	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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F000312 SS=D	<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. Based on observation and record review the facility failed to ensure good personal hygiene for 1 of 1 random observation of care provided to an incontinent [Resident #3].</p> <p>Finding includes:</p> <p>During interview of Resident #3 on 3/11/13 at 11:41 a.m., a urine odor was noted in the resident's room. The resident indicated "I wear briefs, I don't know when I'm going to go [urinate]."</p> <p>On 3/14/13 at 10:19 a.m., the resident was in bed with eyes closed. A urine odor was noted. On 3/14/13 at 10:35 a.m., Certified Nursing Assistants [CNAs] #1 and #2 transferred Resident #3 from the bed to a wheel chair then to the toilet. A cloth incontinence pad on the resident's bed was observed to be soiled with urine. After the transfer to the toilet a disposable incontinence brief was removed. The brief was observed to be saturated. The</p>	F000312	<p>The facility will ensure this requirement is met through the following corrective measures:1) Resident # 3 was provided peri care per the facility policy and procedure upon notification of the concern. Resident #3 incurred no negative outcome.2) All residents who require assistance with peri care have the potential to be affected.3) The facility's policy and procedure regarding peri care has been reviewed and no changes were made. (See Attachment 1) All nursing staff received re-education on the policy and procedure related to peri care. (See Attachment 2)4) The DON or her designee will monitor for the provision of peri care provided by 3 staff members on scheduled days of work daily for one month, two times a week for one month then weekly thereafter until compliance is maintained for six consecutive months. (See Attachment 3) Should concerns be observed, re-education will be provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	04/04/2013			

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	<p>resident urinated and had a bowel movement. CNA #2 used a single wipe to cleanse the rectal area only.</p> <p>A quarterly MDS [Minimum Data Set] assessment dated, 1/15/13, indicated the resident required extensive assist of two persons with toilet use and extensive assist of one person with personal hygiene.</p> <p>During interview of the DON [Director of Nursing] on 3/15/13 at 1:30 p.m., the DON indicated a resident with an incontinent episode should have the urine cleansed from their skin.</p> <p>3.1-38(a)(3)(A)</p>				

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F000315 SS=D	<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 and record review, the facility failed to ensure residents with indwelling catheters received appropriate services to prevent urinary tract infections i.e. maintaining catheter drainage bags off of floor for 2 of 3 random observations of residents with indwelling catheters and a history of urinary tract infections (Resident #36, Resident # 43).</p> <p>Findings include:</p> <p>1. Resident #36's foley catheter bag was observed to be touching and/or dragging on the floor on 3/11/13 at 11:30 a.m., 3/13/13 at 10:15 a.m., and on 3/14/13 at 10:09 a.m. On 3/13/13 at 10:15 a.m., the resident was observed to propel self down the hallway with the catheter bag dragging on the floor.</p>	F000315	<p>The facility will ensure this requirement is met through the following corrective measures: 1) Resident #36 or Resident #43 Foley catheters were observed upon notification of the concern to ensure they were not in contact with an undesirable surface. Resident #36 or Resident #43 incurred no negative outcomes.2) All residents who have Foley catheters have the potential to be affected. All residents who have Foley catheters have been observed to ensure of proper placement of the tubing as well as the drainage bag.3) The policy and procedure for Foley catheters has been reviewed and no changes were made. (See Attachment 4) All nursing staff received re-education related to Foley catheter care/maintenance. (See Attachment 5)4) The DON or her designee will observe all residents who have Foley catheters to ensure the tubing and the drainage bag are</p>	04/04/2013			

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	<p>Upon review of the clinical record of Resident #36 on 3/15/13 at 11:30 a.m., documentation was noted of the resident having the diagnoses which included, but were not limited to, renal failure, sepsis, benign prostate hypertrophy (BPH), and history of urinary tract infections. Documentation was noted of the resident being readmitted to the facility on 1/7/13 with diagnoses of sepsis and urinary tract infection. The most recent Minimum Data Set (MDS) assessment, dated 2/7/13, identified the resident with use of indwelling catheter and urinary tract infection in the last 30 days. The resident's current plan of care addressed the of use of Foley catheter due to BPH dated 2/15/13. The approaches included, but were not limited to, position catheter tubing and drainage bag in such a way to avoid contact with the floor.</p> <p>2. On 3/11/12 at 1:55 p.m., Resident #43 was observed in a low bed. The resident's urinary drainage bag was laying on the floor. On 3/12/13 at 2 p.m., the resident was in bed with the urinary drainage bag laying partially on the floor and partially on a mat beside the bed.</p>		<p>positioned appropriately daily on scheduled days of work for one month, two times a week for one month then weekly thereafter until compliance is maintained for 6 consecutive months. (See Attachment 6) Should concerns be observed, re-education will be provided. Results of siad observation will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>	

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	<p>During review of the resident's clinical record on 3/15/13 at 1:25 p.m. a nurses note dated 3/13/13 at 4 p.m., indicated "[Hospital name] called to report resident has been admitted to hospital with 'Acute Polynephritis et [and] altered mental status' Sponsor aware."</p> <p>A Plan of Care, dated 1/17/13, identified a "Problem" of "Neurogenic Bladder" with an approach of, but not limited to, "Position catheter tubing and drainage bag in such a way to avoid contact with the floor."</p> <p>An undated Facility policy and procedure titled "Foley Catheter Maintenance Procedure" was received on 3/15/12 at 3:51 p.m. Documentation was noted of, but not limited to, "Ensure bag or tubing is not touching the floor."</p> <p>3.1-41(a)(2)</p>			

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F000323 SS=E	<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 and record review, the facility failed to ensure the residents' environment was free of accident hazards and/or assistance devices were used according to manufacturer's recommendations for 6 of 6 residents in a random sample who utilized toilet attached assistive devices and/or utilized a mechanical lift during physical transfers. [Resident #2, #9, #16, #24, #37, and #42].</p> <p>Findings include;</p> <p>1. During environmental tour on 3/15/13 at 2:52 p.m., with the maintenance person, toilet attachments to assist the resident to stand were loose in two bathrooms that were utilized for residents' room numbers 101, 103, and 208.</p> <p>During interview of the DON (Director of Nursing) on 3/15/13 at 2:52 p.m., the DON indicated Resident #24, #16, #37 and #42 utilized the toilet in those bathrooms.</p>	F000323	<p>The facility will ensure this requirement is met through the following corrective measures:1) Resident #16, #24, #37, and #42 incurred no negative outcomes related to teh assistive devices attached to their toilets. All resident toilets that have attached assistive devices were inspected as soon as the concern was brought to our attention with repairs/replacements being completed at that time, as warranted. Resident #2 and Resident # 9 incurred no negative outcome related to being transfered in the Hoyer lift.2) All residents who utilize assistive devices attached to their toilets have the potential to be affected. All residents who are transfered with the assistance of the Hoyer lift have th potential to be affected. All resident toilets have been inspected to ensure any assistive devices attached to the toilet is secure.3) The policy and procedure for Hoyer lift transfers was reviewed and no changes were made. (See Attachment 7) All nursing staff have been re-educated on the Hoyer lift transfer policy and procedure (See Attachment 8) All staff have</p>	04/04/2013	

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	<p>Resident #24's Minimum Data Set [MDS] assessment, dated 12/11/12, coded the resident as requiring extensive assistance of one for transfers and toileting. The resident utilized a wheelchair.</p> <p>Resident #16's MDS assessment, dated 11/28/12, coded the resident with extensive assistance of two for transfers and toilet use and indicated the resident utilized a wheelchair.</p> <p>Resident #37's MDS assessment, dated 11/14/12, coded the resident as requiring limited assistance of one for transfer and supervision only for toileting. The resident utilized a walker.</p> <p>Resident #42's MDS assessment, dated 1/13/13, coded the resident as independent with transfers and toileting. The record indicated no limited mobility.</p> <p>2. On 3/14/13 at 10:35 a.m., CNAs #4 and #5 transferred Resident #9 from the bed to a broda chair utilizing "Medline Lift". The legs of lift were shut during lifting of resident from the bed. During the transfer the resident was maintained in the lift pad in a high position.</p>		<p>been re-educated related to the proper fit of assistive toilet devices. (See Attachment 9)4) The Administrator or her designee will conduct facility rounds to ensure all resident toilets that have any assistive device attached to them are secure daily on scheduled days of work for one month, two times a week for one month and then weekly until compliance is maintained for six consecutive months. (See attachment 10) Should concerns be observed repairs/replacements will be completed. Results of said observation will be discussed at the facility's quarterly QA meeting and the plan adjusted accordingly, as warranted. The DON or her designee will observe three Hoyer lift transfers to ensure correct procedure is followed daily on scheduled days of work for one month, two times a week for one month then monthly until compliance is maintained for six consecutive months. (See Attachment 11) Should concerns be observed, re-education will be provided. Results of said observations will be discussed at the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.</p>				

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	<p>3. On 3/14/13 at 10:23 a.m., Resident #2 was observed to be transferred from the bed to the wheelchair utilizing the "MEDLINE" mechanical lift by CNAs #4, #6 and #11. The resident was lifted with the mechanical lift over the side rail. The side rail was noted to be in the up position. The resident was lifted to a high position (chest level of CNAs).</p> <p>Upon review of the clinical record of Resident # 2 on 3/14/13 at 4 p.m., documentation indicated of the most recent Minimum Data Set (MDS) assessment was completed 1/31/13. The assessment identified the resident as independent in cognitive decision making skills and totally dependent for transfers. The resident's current plan, dated 2/5/13, indicated the resident required assistance of two persons for transfers, with approaches that included, but were not limited to, Hoyer lift for transfers.</p> <p>Upon review of the manufacturer's guidelines for the "MEDLINE" mechanical lift dated 4/5/07, documentation was noted of the following: "...ALWAYS lower the patient to the lowest comfortable position before transfers...NEVER lift with the legs in the closed/transport</p>				

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	<p>position. The closed position is for storage and transport only...During lifting or lowering, whenever possible, always keep the base of the lift in the widest position with the casters unlocked..."</p> <p>3.1-45(a)(1)</p>			

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F000332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation and record review, the facility failed to ensure it was free from medication error rates of 5 percent or greater for 4 of 53 observations of medication administration, which resulted in a 7.55 percent error rate [Residents #3, #27, #52, and #7].</p> <p>Findings include:</p> <p>1. On, 3/14/13 at 11:50 a.m., LPN #14 was observed to administer Novolog [short acting insulin, (insulin aspart)] 8 units subcutaneously (under the skin) [sq] to Resident #27 in the left upper arm, utilizing a flex pen. The nurse inserted the needle, administered the insulin, and immediately withdrew the needle. A drop of liquid was observed coming from the injection site.</p> <p>On 3/14/13 at 12:20 p.m., Resident #27 was observed in the dining room waiting on lunch to be served, 30 minutes after the administration of the insulin.</p> <p>Documentation in "Davis' Drug Guide</p>	F000332	<p>The facility will ensure this requirement is met through the following corrective measures:1)Resident #33, #27, #52, and #7 incurred no negative outcomes.2) All residents who receive insulin injections have the potential to be affected. All residents who receive insulin injections were reviewed to ensure insulin administration was correct and within the appropriate timeframe related to meal service.3) The facility's policy and procedure for insulin administration has been reviewed and no changes were made (see Attachment 12A and 12B) All nurses have received re-education related to the proper guidelines related to insulin injections. (See Attachment 13)4) The DON or her designee will observe 3 nurses administer insulin injections to monitor for the correct administration as well as administration at the appropriate time related to meal service daily on scheduled days of work for one month, two times a week for one month and then monthly thereafter until compliance is maintained for six consecutive months. (See Attachment 14) Should concerns be observed, re-education will be</p>	04/04/2013

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	<p>for Nurses Tenth Edition", copyright 2007, included, "...Administer insulin aspart in the abdominal wall, thigh, or upper arm within 5-10 minutes before a meal...."</p> <p>Resident #27's clinical record was reviewed on 3/13/13 at 12:40 p.m. A physician's order, dated 8/24/12, was noted of Novolog 100 unit/ml vial Inject 8 units Sub-Q before lunch.</p> <p>Manufacturer's direction for use of the 'Flex-pen,' provided by the Director of Nursing [DON] on, 3/15/13 at 7:00 p.m., indicated, "...wait for a few seconds after medication has been completely discharged before withdrawing the pen from the injection site. Check after each injection according to your physician's and/or health care professional's instructions whether medication drips from the pen needle, pen, or injection site. If the medication drips, follow your physician's and/or health care professional's instructions regarding the handling of potential under-dosage."</p> <p>2. During medication observation on, 3/14/13, at 11:26 a.m., LPN #3 was observed to provide a subcutaneous injection of 6 units of Humalog [Hypoglycemic (insulin lispro)] to Resident #3. At 12:15 p.m. (30</p>		<p>provided. Results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly.</p>	

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	<p>minutes after the injection), Resident #3 had not received lunch.</p> <p>Resident #3's clinical record was reviewed on 3/11/13. A physician's order was noted for Humalog 6 units SQ before lunch.</p> <p>3. On 3/14/13 at 4:04 p.m., Resident # 7 was observed to receive Humalog (short-acting insulin) 16 units subcutaneously per LPN #13. At 4:45 p.m. on 3/14/13, the resident had not received her supper meal.</p> <p>Upon review of the clinical record of Resident #7 on 3/15/13 at 1:13 p.m., documentation of a physician's order, dated 11/27/12, indicated Humalog 16 units subcutaneously before meals for diagnosis of diabetes.</p> <p>4. On 3/14/13 at 4:20 p.m., Resident # 52 was observed to receive Humalog (short-acting insulin) 18 units subcutaneously per LPN #13. At 4:45 p.m. on 3/14/13, the resident had not received her supper meal.</p> <p>Upon review of the clinical record of Resident #52 on 3/15/13 at 2:15 p.m., documentation was noted of physician orders as follows: Novolog 18 units subcutaneously three times daily with meals for diagnosis of insulin dependent diabetes dated</p>				

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	<p>2/14/13 and may use Humalog from pharmacy EDK (emergency drug kit) until exhausted then resume Novolog dated 3/14/13.</p> <p>Documentation in "Davis's Drug Guide for Nurses Tenth Edition, copyright 2007" included, but was not limited to, "...administer insulin lispro within 15 minutes before a meal...."</p> <p>3.1-48(c)(1)</p>			

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F000371 SS=F	<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 store, prepare, distribute, and serve food under sanitary conditions for 3 of 3 kitchen observations in that 1) left over food was kept for use beyond established policy and procedure, 2) preparation, service, storage, and distribution areas were observed with accumulation of dust, dirt, and debris, and 3) the dish machine was observed to have wash temperature below manufacturer's recommendation while sanitizing dishes. This had the potential to affect 39 residents.</p> <p>Findings include:</p> <p>1. On 3/11/13 at 6:45 a.m., the following was observed stored in the reach in refrigerator and/or storage area during kitchen observation:</p> <p>a. Cooked noodles were labeled with use by date of 3/9/13.</p>	F000371	<p>The facility will ensure this requirement is met through the following corrective measures: 1) No residents were harmed. The outdated leftover items were disposed of from the reach-in refrigerator. The plastic sugar container was cleaned and the scoop was removed. All sugar in the container was discarded. Items identified as soiled were cleaned and sanitized including: shelving, clean dish area, 3 compartment sink, side of reach-in refrigerator, lunch bags, dish racks, metal box, knife rack, dish machine and all surrounding areas, bulletin board, walk-in cooler floor, metal handles and filing cabinet. Two of the shelves were ordered and will be replaced as well as several of the dish racks. 2) All residents have the potential to be affected. See below for corrective measures.3) Dietary staff were re-educated on the proper use of the dish machine, storage of leftovers, utensil/equipment handling, proper ware washing and dish washing procedures, proper drying techniques and overall kitchen sanitation (See</p>	04/04/2013			

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	<p>b. Sour cream was labeled with date opened of 12/8/12 with use by date of 1/22/13.</p> <p>c. Pork gravy was labeled with use by date of 3/9/13.</p> <p>d. Chili soup was labeled with use by date of 3/7/13.</p> <p>e. Grape drink (facility prepared) in pitcher was labeled with use by date of 3/4/13.</p> <p>f. Orange drink (facility prepared) in two pitchers were labeled with use by date of 3/6/13.</p> <p>g. Lemonade drink (facility prepared) in pitcher was labeled with use by date of 3/6/13.</p> <p>h. Lemonade drink (facility prepared) in pitcher was labeled with use by date of 3/9/13.</p> <p>i. Fruit punch drink (facility prepared) in pitcher was labeled with use by date of 3/9/13.</p> <p>j. The plastic sugar container in the dry storage area was observed to have accumulation of dust and debris on the top of lid. A blue plastic bowl used as scoop was noted to be lying</p>		<p>Attachment 15). The dietary manager or designee will complete sanitation rounds daily (M-F) for 4 weeks on different shifts (B, L, S) then twice weekly. The audits will be completed to ensure compliance with labeling and storage of food items, dishmachine sanitation, kitchen sanitation, 3 compartment sink sanitation, drying techniques and utensil handling (See attachment 16). The results of said observations will be discussed during the facility's quarterly QA meetings and the plan of action will be adjusted accordingly, as warranted.. Failure of staff to comply will result in corrective action and possible termination.</p>		

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	<p>in the sugar.</p> <p>Upon interview of dietary person #15 on 3/11/13 at 6:45 a.m., dietary person indicated the left overs and drinks in pitchers prepared by the facility were to be discarded by the use by date on the label. The dietary person indicated the leftovers not used within 3 days should have been discarded.</p> <p>Upon interview of the Food Service Supervisor (FSS) on 3/11/13 at 2:25 p.m., the FSS indicated the items should have been discarded by the labeled date and that the blue plastic bowl should not have been used as a scoop and should not have been stored in the sugar container.</p> <p>2. On 3/14/13 at 11:34 a.m., the following was observed during the kitchen observation:</p> <p>a. Dietary person #16 was observed to sanitize the food processor container three separate times in the dish machine. The food processor was observed to be used by dietary person #15 after each sanitation. The dish machine water temperature was observed to measure on the temperature dial as 100 degrees Fahrenheit, 110 degrees Fahrenheit,</p>						

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	<p>and 106 degrees Fahrenheit respectively.</p> <p>b. Dietary person #16 was observed to hold the sanitized food processor container against her clothing prior to dietary person #15 using it for pureeing food.</p> <p>c. Dietary person #16 was observed to towel dry the food processor container with a hand towel. The hand towel was observed to touch the uniform of the dietary person during the drying and then the towel was placed on the surface of the clean dish area by the dish machine.</p> <p>d. Documentation was noted on the dish machine of wash temperature requirements per manufacturer of 120 degrees Fahrenheit minimum and recommendation of 140 degrees Fahrenheit.</p> <p>Upon interview of the dietary person #16 on 3/14/13 at 11:40 a.m., the dietary person indicated the wash and rinse temperatures should be 120 degrees Fahrenheit and the she had checked it 2 hours ago and it was at proper temperature.</p> <p>Upon interview of the FSS on 3/14/13 at 11:42 a.m., the FSS indicated</p>			

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	<p>temperatures should be at a minimum of 120 degrees Fahrenheit. The FSS also indicated the machine should be ran 3-4 times before sanitizing dishes if the machine had not been used recently.</p> <p>3. On 3/14/13 at 12:05 p.m., the following was observed during the kitchen observation:</p> <p>a. The underside of the metal shelve located over the food preparation and service area was observed to have a heavy accumulation of debris and dried on splatters.</p> <p>b. The metal shelf over the clean dish area next to the dish machine was observed with peeling pieces of paint, rust, dust and debris. The plastic shelving liner on the metal shelf was observed to have heavy accumulation of dust.</p> <p>c. The clean dish area next to the dish machine was noted to have heavy accumulation of dried on white splatters and dust.</p> <p>d. The clean dish area of the 3 compartment sink was observed to have dried on white splatters and dust. The side of the reach in refrigerator next to the clean dish</p>			

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	<p>area was noted with heavy accumulation of dried on splatters and substances.</p> <p>e. Two thermal lunch bags utilized for residents were observed stored as clean in the dirty dish area of the 3 compartment sink.</p> <p>f. A metal shelf above the clean dish area and sanitizing compartment of the 3 compartment sink was observed with heavy accumulation of peeling paint, rust, dust and debris.</p> <p>g. 7 plastic dish racks, utilized for clean dishes, were observed with heavy accumulation of brown scaly substance.</p> <p>h. The base of the electrical/fire metal box was observed with heavy accumulation of brown loose debris and dirt. A clean knife rack, with knives and cutting utensils, was stored under the fire box.</p> <p>i. The back edge of the 3 compartment sink was observed with heavy accumulation of dust, dirt and debris. The 3 compartment sink was utilized for sanitation. The water hoses and sanitizing hoses were observed with heavy accumulation of dust and dirt.</p>			

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	<p>j. The dish machine area was observed with accumulation of dust and dirt on the machine, under the machine, and along the floor on the base coving.</p> <p>k. The bulletin board, located over a food preparation area, was observed with heavy accumulation of dust and dirt.</p> <p>l. The dry storage metal shelves were observed with marring and loose dirt and debris.</p> <p>m. The floor of the walk in refrigerator was observed with loose dirt on the floor along edges. A large dried white spill was observed under the shelving unit. Food was noted stored on the shelving units.</p> <p>n. 1 of 2 metal handles of the steam table covers were observed to be rusted.</p> <p>o. A filing cabinet next to the reach in refrigerator was observed with heavy accumulation of dust and splatters.</p> <p>Upon interview of the FSS on 3/14/13 at 12:20 p.m., the FSS indicated the underneath of the shelves over the service, preparation, and clean dish</p>			

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	<p>storage had been included in the cleaning schedule. The FSS indicated the areas in the clean dish area, preparation areas, service and distribution areas should have been cleaned.</p> <p>3.1-21(h)(3)</p>			

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	The facility will ensure this requirement is met through the	04/04/2013			

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	<p>ensure a sanitary environment to prevent the spread of infection for 2 of 4 random observations of blood glucose testing, 1 of 4 random observations of insulin administration, 1 of 1 random observation of administering medications through a gastrostomy [g-tube,] and 1 of 1 random observation of incontinence care [Residents #27, #32, #3].</p> <p>Findings include:</p> <p>1. On 3/14/13 at 11:54 a.m., LPN #14 was observed to perform a blood sugar test on Resident #27. The nurse assembled the supplies, placed a paper towel barrier on the resident's bedside table and placed the meter on the towel. The nurse inserted a test strip into the meter, put on gloves, swabbed the resident's finger with an alcohol swab, performed the finger stick, placed a drop of blood on the test strip inserted in the meter, swabbed the stick site, picked up the supplies, removed gloves, exited the room and placed the meter on top of the medication cart without utilizing a barrier surface. The nurse then removed a single package of the cleaning and disinfectant product "Gluco-Chlor." The nurse wiped the exterior surface of the meter, opened a drawer of the medication cart and</p>		<p>following corrective measures:1) Resident #27, # 32 and #3 incurred no negative outcomes.2) All residents who receive blood glucose monitoring via the glucometer have the potential to be affected. All residents who receive blood glucose monitoring via the glucometer were observed to ensure proper infection control was maintained. All residents who receive insulin injections have the potential to be affected. All residents who receive insulin injections have been observed to ensure proper infection control was maintained. All residents who are assisted with peri care have the potential to be affected. All residents who receive treatment via g-tube have the potential to be affected. All residents who receive treatment via g-tube have been observed to ensure proper infection control is maintained during and after the care provided to the resident.3) The facility's policy and procedure for cleaning the glucometer has been reviewed and no changes were made. (See Attachment 17) The facility's policy and procedure for insulin injections has been reviewed and no changes were made. (See Attachment 12A, 12B and 12C) The facility's policy and procedure for hand washing has been reviewed and no changes were made. (See Attachment 18A and 18B) All nursing staff have received re-education regarding</p>				

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	<p>placed the meter in a plastic basket, on top of lancets stored in the basket.</p> <p>2. On 3/14/13 at 11:14 a.m., LPN #3 performed a blood sugar test on Resident #3. After the blood sugar test, the LPN cleansed the accucheck with a sanitizing wipe, and immediately placed the wipe in a small plastic basket housing other articles in a bottom drawer of the medication cart, and shut the drawer.</p> <p>Manufacturer's direction on the exterior of the Gluco-Chlor product included, but was not limited to, "...Apply towelette and wipe desired surface to be disinfected. Allow treated surface to remain wet for 5 minutes. Allow surface to air dry and discard used towelette..."</p> <p>The Director of Nursing [DON] was interviewed on 3/14/13 at 3:00 p.m. The DON indicated the facility did not have a policy for use of the disinfectant wipes but had trained staff on use. The DON provided a summary of training [no date] on 3/14/13 at 3:00 p.m. The documentation was "Cleaning the Glucometer: 1. Place a barrier such as a paper towel on the surface of the table or medication cart. 2. Obtain cleansing wipe. 3. Open package</p>		<p>glucometer cleaning and hand washing. (See Attachments 13 and 19)4) The DON or her designee will observe 3 nurses daily on scheduled days of work to ensure proper infection control is maintained during the cleaning of the glucometer for one month, twice a week for one month and then monthly until compliance is maintained for six consecutive months. (See Attachment 20) The DON or her designee will observe 3 nurses administer insulin injections daily to ensure proper infection control is maintained on scheduled days of work for one month, twice a week for one month then monthly until compliance is maintained for six consecutive months. (See Attachment 14) The DON or her designee will observe 3 staff members provide peri care to ensure infection control is maintained on scheduled days of work for one month, twice a week for one month then weekly until compliance is maintained for six consecutive months. (See Attachment 3) The DON or her designee will observe 2 nurses provide treatment via g-tube daily to ensure proper infection control is maintained on scheduled days of work for one month, twice a week for one month then monthly until compliance is maintained for six consecutive months. (See Attachment 21) Should concerns related to any of the aforementioned audits be noted</p>		

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	<p>and clean machine per manufactures guidelines. 4. Place the glucometer machine on the barrier and allow to air dry for 5 minutes."</p> <p>3. On 3/14/13 at 10:35 a.m., Certified Nursing Assistants [CNAs] #1 and #2 transferred Resident #3 from a wheel chair to the toilet. The resident urinated and had a bowel movement. CNA #2 while wearing gloves, used a wet wipe to cleanse the rectal area. While wearing the same gloves, the CNA assisted the resident, utilizing a gait belt, from the toilet to the wheelchair. Prior to removing the soiled gloves, the CNA removed the trash bag from the trash can and tied the bag.</p> <p>4. During medication observation on, 3/14/13, at 11:26 a.m., LPN #3 was observed to provide a subcutaneous injection of 6 units of Humalog [Hypoglycemic] to Resident #3. Prior to the injection, the LPN washed her hands, but did not wear gloves during the injection. The LPN left the room, removed keys from her uniform pocket and opened the medication cart to remove hand gel. The LPN utilized the hand gel to cleanse her hands.</p> <p>5. On, 3/14/13 at 11:34 a.m., LPN</p>		re-education will be provided. The results of said observations will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly, as warranted.		

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NAME OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 325 W NORTHWOOD DR SULLIVAN, IN 47882		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#14 was observed to administer medication to Resident #32 through a gastrostomy tube. While wearing gloves, the nurse utilized a syringe to check tube placement, flushed the tube, administered the medication, flushed the tube again, and capped the tube. After completion of the procedure while wearing the same gloves, the nurse reattached the resident's call light to the blanket covering her, opened the bathroom door, turned on the sink faucet, rinsed the syringe, then removed the gloves and washed her hands.</p> <p>During review of an undated facility policy, titled "HANDWASHING PROCEDURE," received from the DON (Director of Nursing) on 3/15/13 at 3:29 p.m., documentation was noted of, "...Specific times hands must be washed...2. Before and after direct resident contact..."</p> <p>3.1-18(l)</p>				