

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/23/2014
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints # IN00151982 and # IN00152083.</p> <p>Complaint # IN00151982 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint # IN00152083 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 16, 17, 18, 21, 22 and 23, 2014.</p> <p>Facility Number: 000124 Provider Number: 155219 Aim Number: 100266730</p> <p>Survey Team: Sharon Ewing, RN - TC Julie Baumgartner, RN ( July 16, 17, 21, 22 and 23, 2014) Pam Williams, RN Shauna Carlson, RN</p> <p>Census Bed Type: SNF/NF: 92 Total: 92</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. <b>This facility requests a desk review for paper compliance for all.</b></p>	

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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F000225 SS=D	<p>Census Payor Type: Medicare: 11 Medicaid: 70 Other: 11 Total: 92</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on July 31, 2014, by Brenda Meredith, R.N.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>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 record review and interview, the facility failed to ensure 1 of 3 investigations reviewed regarding allegations of abuse were reported timely. (Resident # 61)</p> <p>Findings include:</p> <p>On 7/23/14 at 8:45 A.M., an allegation of abuse between Nurse # 30 and Resident #61 was reviewed. The alleged incident occurred on 4/17/14 at 8:30 A.M. The allegation was reported on 4/18/14 at 11:41 A.M. by the Director of Nurses over 24 hours after the incident occurred.</p> <p>On 7/23/14 at 9:50 A.M., an interview was conducted with the Administrator. The Administrator indicated he did not</p>	F000225	<b>F-225 I. All reports involving allegations of abuse will be reported timely per ISDH guidelines. No residents were directly affected by this alleged deficiency. II. All residents have the potential to be affected by this deficiency. All allegations of abuse will be investigated per facility policy, and reported timely per ISDH guidelines. III. Administrator and Director of Nursing in-service regarding abuse reporting. Administrator or Designee will ensure all reports/allegations of abuse are reported timely per ISDH guidelines. IV. Administrator or Designee will log all reportable allegations. Log will be reviewed during QAA</b>	08/22/2014			

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F000226 SS=D	<p>know why the incident that occurred on 4/17/14 at 8:30 A.M. was not reported within 24 hours and that his expectation was that the reporting guidelines would be followed for reporting all allegations of abuse.</p> <p>On 7/23/14 at 1:00 P.M., a policy provided by the Administrator and titled Abuse, Neglect and Misappropriation was reviewed. The policy indicated the following: "...Department: Clinical... Revised: 03.2013... Procedure VIII Follow up... A. All allegations are to be reported within the timeframe allotted by the state agency...."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of</p>		<p><b>meeting x 6 months to ensure compliance. V.Systemic changes will be completed by 8/22/14</b></p>		

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	<p>residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement their abuse policy regarding the timely reporting of an abuse allegation. This deficient practice affected 1 of 3 investigations reviewed for abuse allegations.</p> <p>Findings include:</p> <p>On 7/23/14 at 8:45 A.M., an allegation of abuse between Nurse # 30 and Resident #61 was reviewed. The alleged incident occurred on 4/17/14 at 8:30 A.M. The allegation was reported on 4/18/14 at 11:41 A.M. by the Director of Nurses over 24 hours after the incident occurred.</p> <p>On 7/23/14 at 9:50 A.M., an interview was conducted with the Administrator. The Administrator indicated he did not know why the incident that occurred on 4/17/14 at 8:30 A.M. was not reported within 24 hours and that his expectation was that the reporting guidelines would be followed for reporting all allegations of abuse.</p> <p>On 7/23/14 at 1:00 P.M., a policy provided by the Administrator and titled Abuse, Neglect and Misappropriation was reviewed. The policy indicated the</p>	F000226	<p><b>F-226 I. All reports involving allegations of abuse will be reported timely per ISDH guidelines. No residents were directly affected by this alleged deficiency. II. All residents have the potential to be affected by this deficiency. All allegations of abuse will be investigated per facility policy, and reported timely per ISDH guidelines. III. Administrator and Director of Nursing in-serviced regarding abuse reporting. Administrator or Designee will ensure all reports/allegations of abuse are reported timely per ISDH guidelines. IV. Administrator or Designee will log all reportable allegations. Log will be reviewed during QAA meeting x 6 months to ensure compliance. V. Systemic changes will be completed by 8/22/14</b></p>	08/22/2014

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F000371 SS=F	<p>following: "...Department: Clinical... Revised: 03.2013... Procedure VIII Follow up... A. All allegations are to be reported within the timeframe allotted by the state agency...."</p> <p>3.1-28(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food and drinks were being served under sanitary conditions in 2 of 2 dining rooms. (Main dining room and Rehab dining room).</p> <p>Findings include:</p> <p>1. On 7/16/14 at 12:09 P.M., CNA #5 was observed in the Rehab dining room serving a resident a glass of milk by the</p>	F000371	<p><b>F-371 I. No residents were negatively impacted by this alleged deficiency. Staff members have received in-service training related to food storage, preparation, distribution, and service of food under sanitary conditions.</b></p> <p><b>II. All residents have the potential to be affected by this alleged deficiency. Staff members have received in-service training related to food storage, preparation,</b></p>	08/22/2014

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	<p>top rim.</p> <p>On 7/16/14 at 12:12 P.M., SDC (Staff Development Coordinator) was observed in the Rehab dining room serving a resident a glass of milk and a glass of lemonade by the rim of glass.</p> <p>On 7/16/14 at 12:15 P.M., Director of Staff Development #5 was observed in the Rehab dining room serving a resident a glass of milk and a glass of ice tea by the rim of the glass.</p> <p>On 7/16/14 at 12:26 P.M., LPN #8 was observed in the main dining room giving two residents their noon medications, then handing them a glass of water by the rim.</p> <p>On 7/16/14 at 12:40 P.M., LPN #9 was observed in the main dining room serving a resident a glass of juice by rim</p> <p>On 7/16/14 at 12:41 P.M., LPN #9 was observed in the main dining room serving a resident juice by rim of glass.</p> <p>On 7/16/14 at 12:38 P.M., CNA #10 was observed in the main dining room serving a resident a glass of milk by the rim of the glass.</p> <p>On 7/16/14 at 12:45 P.M., CNA #11 was</p>		<p><b>distribution, and service of food under sanitary conditions.</b></p> <p><b>III.Meal service audits will be completed 3 x weekly to ensure compliance withfacility policy and procedure. IV.Meal service audits will be reviewed monthly in QAA meeting x 6 months. V.Systemic changes will be completed by 8/22/14</b></p>	

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	<p>observed in the main dining room serving a resident a glass of chocolate milk by rim of the glass.</p> <p>On 7/16/14 at 12:43 P.M., CNA #12 was observed in the main dining room serving a resident a glass orange juice by the rim of the glass.</p> <p>An interview with the DM (Dietary Manager) on 7/23/14 at 9:29 A.M., indicated that when serving drinks to residents, glasses should be handled by the middle and not the rim.</p> <p>On 7/23/14 at 1:16 P.M., a review of the current policy, dated December 2012, "Preventing Foodborne Illness- Food Handling," provided by the ED (Executive Director), did not indicate how glasses should handled when passing liquids to residents.</p> <p>2. On 7-16-14 between 12:10 and 12:20 P.M., during lunch service in the rehab dining room, the following were observed:</p> <p>At 12:10 P.M., RN #7 (Case Manager) was observed to wash her hands for 4 seconds.</p> <p>At 12:12 P.M., RN #7 was observed to wash her hands for 6 seconds before serving orange juice to a resident.</p>			

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	<p>At 12:16 P.M., RN #7 was observed to wash her hands for 6 seconds before serving a resident meal tray.</p> <p>At 12:18 P.M., RN #7 was observed to wash her hands for 5 seconds before sitting down to assist Resident #136 with eating.</p> <p>On 7-23-14 at 10:10 A.M., interview with the SDC (Staff Development Coordinator) indicated hand washing should last "...at least 20 seconds...."</p> <p>On 7-23-14 at 10:46 A.M., review of the current "Handwashing/Hand Hygiene" policy, received from the Administrator at this time, indicated "...Employees must wash their hands for at least fifteen seconds using antimicrobial or non-microbial soap and water...."</p> <p>3. On 7-16-2014 at 12:20 P.M., an observation of a Dietary Aide Employee #14 serving drinks from a drink service cart with 4 pitchers of ice water and 2 pitchers of iced tea without lids. Interview at this time with Employee #14 indicated, "...they [the pitchers] are usually covered but it's hard for me to pour them, so I leave them off...."</p> <p>Observation at this time of Employee #14 with her thumb in the top of the pitcher as she is pouring drinks for the residents.</p>			

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F000431 SS=D	<p>On 7-23-2014 at 9:29 A.M., an interview with the Dietary Manager indicated "...yes, the pitchers should have a lid when they are on the cart in the dining room...."</p> <p>3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in</p>			

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	<p>Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were stored in a locked cart while in the hallway for 1 of 6 medication carts and 2 of 4 treatment carts.</p> <p>Findings include:</p> <p>On 7-21-2014 at 9:50 P.M., a treatment cart was observed by the 200 hall nurses station, unlocked and unattended.</p> <p>On 7-21-2014 at 10:05 P.M., a treatment cart was observed outside of Room 126, unlocked and unattended. Interview at this time with LPN (Licensed Practical Nurse) #2 indicated, "...that is a treatment cart and yes, it should be locked...."</p> <p>On 7-21-2014 at 1:50 P.M., a medication cart was observed in the 200 hall outside of Room 200, unlocked and unattended. The Social Service Director (SSD) indicated, "...yes, this is a medication cart and it is unlocked...this is LPN #4's cart...."</p>	F000431	<p><b>F-431 I.No residents were negatively impacted by the alleged deficiency. II.All residents with some type of mobility are potentially affected by thisalleged deficiency. Licensed staff havereceived in-service training related to policy and procedure on safe storage ofmedications/biologicals. III.Audits will be completed 3x weekly of medication/biological storage to ensurecompliance. IV.DNS or designee will review audit tools weekly and process will be reviewedmonthly in QAA x 6 months to ensure compliance. V.Systemic changes will be in place by 8/22/14</b></p>	08/22/2014

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	<p>On 7-21-2014 at 1:53 P.M., an interview with SDC (Staff Development Coordinator) indicated, "...all treatment and medication carts should be locked when not attended...."</p> <p>On 7-22-2014 at 3:40 P.M., an interview with the DON (Director of Nursing) indicated, "...all treatment and medication carts should be locked when not attended...."</p> <p>On 7-22-2014 at 4:00 P.M., record review of the "Medication Administration-Storage of Medication" policy received from the SDC at this time, effective 12-2010, indicated "...2. Only licensed nurses...are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access...."</p> <p>3.1-25(m)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the</p>			

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	<p>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. Based on observation, record review and interview, the facility failed to ensure precautions were followed to prevent the spread of infection related to proper information signs on the doors and isolation bins for linen and trash. This deficient practice affected 2 of 2 rooms observed for isolation precautions. Room 206 and 219.</p> <p>Findings include:</p> <p>1. On 7/23/14 at 10:06 A.M., an observation was made of Room # 206. A sign outside of the door indicated Contact Isolation precautions were to be observed. Room #206 lacked isolation bins for linen and trash.</p> <p>On 7/23/14 at 10:08 A.M., an interview was conducted with Physical Therapist # 31. Physical Therapist #31 indicated there were no isolation bins she takes off her isolation gown and gloves and takes it to the biohazard room for disposal.</p>	F000441	<p><b>F-441 I. Resident # 206 has isolation bins in his room for linen and trash. II. All residents identified as requiring isolation precautions have the potential to be affected by the alleged deficiency. All residents identified as requiring isolation precautions have been provided with isolation bins for linen and trash, III. DNS or Designee will audit all residents identified as requiring isolation precautions to ensure that bins are provided for linen and trash. In services have been completed for staff regarding Isolation precautions. IV. DNS or Designee will review audit tools weekly to ensure compliance. Process will be reviewed in QAA monthly x 6 months to ensure compliance. V. Systemic changes will be in place by 8/22/14.</b></p>	08/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/23/2014
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
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	<p>On 7/23/14 at 10:12 A.M., an interview was conducted with the Staff Development Coordinator. The Staff Development Coordinator indicated a resident who requires isolation should have 2 bins in their room one for linen and one for trash.</p> <p>On 7/23/14 at 10:30 A.M., a policy provided by the Administrator titled Isolation - Initiating Transmission - Based Precautions was reviewed. "...Policy Interpretation and Implementation...5... C. Ensure that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room...."</p> <p>2. On 7-16-2014 at 10:45 A.M., an initial tour was conducted and Room 206 was observed to have an isolation cart sitting in the hall, outside the door, no isolation sign was observed.</p> <p>On 7-16-2014 at 10:49 A.M., Room 219 was observed to have an isolation cart sitting in the hall, outside the door, 2 signs were observed indicating "...Stop...Please see the nurse before entering...." and "...Contact isolation...wear gown and gloves before entering...."</p> <p>On 7-16-2014 at 11:07 A.M., interview</p>			

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	<p>with the RN #7 (Case Manager) indicated "...I don't know how it [the signs] should be...." RN #7 indicated that Room 206 is in contact isolation.</p> <p>On 7-23-2014 at 9:45 A.M., record review of the "Isolation-Categories of Transmission-Based Precautions...Contact Precautions...g. Signs-The facility will implement a system to alert staff to the type of precaution resident requires...."</p> <p>On 7-23-2014 at 10:02 A.M., interview with the SDC (Staff Development Coordinator) indicated that "...there should be a sign outside of isolation rooms that says to see the nurse before entering...."</p> <p>3.1-18(b)(2)</p>			