

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2016
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NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 5, 6, 7, 8, and 11, 2016</p> <p>Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930</p> <p>Bed census type: SNF: 45 SNF/NF: 41 Total: 86</p> <p>Census payor type: Medicare: 12 Medicaid: 32 Other: 42 Total: 86</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on July 15, 2016.</p>	F 0000		
F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the</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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	<p>facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow the care plan for resident's who required honey thick liquids (HTL) for 1 of 2 resident's reviewed on honey thick liquids. (Resident #20)</p> <p>Findings include:</p> <p>Resident #20's clinical record was reviewed on 7/7/16 at 10:47 a.m. The resident had diagnoses including, but were not limited to muscle weakness, unspecified psychosis, insomnia, and unspecified dementia. The most recent quarterly MDS (Minimum Data Set) assessment, dated 06/06/2016, indicated Resident #20 had a BIMS (brief interview of mental status) of 05 which indicated the resident had a sever cognitive impairment.</p> <p>On 3/24/16, a care plan was developed for Resident #20 for "Diet - Regular with HTL [honey thick liquids] (NO MIXED CONSISTENCIES, NO FRUIT, NO ICE CREAM, NO SOUPS)".</p> <p>During a medication administration observation on 7/7/16 at 10:33 a.m., Registered Nurse (RN) #1 gave Resident</p>	F 0282	<ol style="list-style-type: none"> 1. Resident #20 was not harmed by deficient practice as evidenced by monitoring vital signs and lung sounds for severty-two hours and resident remained at baseline. RN #1 immediately gave correct liquid upon noticing the error. 2. All remaining residents with orders for thickened liquids were reviewed by the Director of Health Services (DHS) on July 22, 2016. All residents were provided thickened liquids per plan of care. All residents with physician orders for thickened liquids will have the order listed on administration notes to alert nursing staff. 3. All nursing staff were re-educated by the DHS on following the plan of care and physician orders for thickened liquids for each resident on 7/19 and 7/20, 2016. 4. The DHS/Assistant Director of Health Services (ADHS) will conduct medication pass audits to ensure nursing staff are following the plan of care and physician orders for thickened liquids. Ten residents / week for four weeks then five residents / week for eight weeks will be audited by DHS/ADHS. Results of audits will be reviewed at monthly Quality Assurance Committee, consisting of Executive Director, Director of Health Services, Assistant 	08/01/2016

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	<p>#20 regular water with her medications instead of HTL. Resident #20 at that time started coughing and making a gargling noise. RN # 1 then realized she had given Resident #20 regular water instead of HTL. RN # 1 threw the water away and acquired HTL for the resident to drink while taking the rest of her medication.</p> <p>During an interview on 7/7/16, at 10:45 a.m., RN #1 indicated she should have never given Resident #20 regular water. She indicated that it should have been in the consistency of the "honey thick liquids".</p> <p>During an interview on 7/11/16 at 10:00 a.m., the Director of Nursing (DON) indicated that if a resident had an ordered for HTL, then regular water should never be given to that resident.</p> <p>The policy and procedure dated, 5/11/2016, titled, "SOP [standard operating procedure] FOR THICKENED FLUIDS" was received from the Director of Nursing on 7/11/16 at 10:20 a.m. It included, but was not limited to the following: "...To assure residents receive the appropriate consistency of liquids, as recommended by the Speech Therapist</p>		<p>Director of Health Services, Medical Records and Social Services, and by the Medical Director at least quarterly, until team concludes compliance has been achieved.</p>	

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F 0371 SS=D Bldg. 00	<p>and ordered by the physician to prevent complications such as choking or aspiration... Honey thick: consistency of honey at room temperature, or a thick milkshake"</p> <p>3.1-35(g)(2)</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</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained related to food and drink service for residents observed in the Legacy Lane and Restorative Dining Rooms, during 2 of 2 meal observations. (Residents #16, 22, 56, 59, 61, 74, 75, 79, 84, 85, 91, 92, 98, 101, 114, 117, 121, and 122)</p> <p>Findings include:</p> <p>1. On 7/05/16 at 9:05 a.m., during the kitchen tour Dietary Assistant (DA) #1 and DA #2 were observed working in the kitchen without facial nets to cover their chin hair. The chin hair was observed to</p>	F 0371	<p>1. & 2. Dietary Aide #1 and Dietary Aide #2 are now wearing beard restraints per policy. All staff members entering the kitchen with facial hair are wearing required beard restraints. Residents # 121, 75, 56, 117, 22, 59 and 101 were not affected by the deficient practice. Resident # 16, 91, 84, 85, 114, 98, 122, 74, 61, 79, 92 were not listed on the sample resident list.</p> <p>3. All employees were re-educated on the guidelines for proper infection control to include wearing beard restraints and proper hand washing techniques to ensure food is being served in a sanitary manner on 7/19 and 7/20, 2016 by the DHS.</p> <p>4. The DHS/ADHS will conduct an audit of proper hand washing techniques during meal service.</p>	08/01/2016

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	<p>be longer than 1/8 of an inch on both staff.</p> <p>On 7/05/16 at 12:19 p.m., during lunch service, DA #1 and DA #2 were observed working in the kitchen without facial nets to cover their chin hair. The chin hair was observed to be longer than 1/8 of an inch on both staff.</p> <p>On 07/08/16 at 1:59 p.m., the Dietary Manager indicated facial hair nets must be used for beards longer than a quarter of an inch. He indicated Dietary Assistants #1 and #2 have longer beards and he tried to ensure staff knew to keep their beards shorter than the required length.</p> <p>On 07/11/16 at 11:40 a.m., the Administrator provided a copy of the Beard Restraints Policy which indicated, but was not limited to, the following:..cover all facial hair below the corner of the mouth..More than a day or two growth...More than 1/8 inch...Like hair covers, beard nets must be worn."</p> <p>2. On 7/05/16 between 11:30 a.m. and 12:18 p.m., 28 residents were observed in the Legacy Lane Unit Dining Room. During the meal service, the following was observed:</p>		<p>The Dining Services Director will audit the proper use of beard restraints. The audit will be 5x/week for 4 weeks then 3x/week for 8 weeks. Results of audits will be reviewed at monthly Quality Assurance Committee, consisting of Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Records and Social Services, and by the Medical Director at least quarterly, until team concludes compliance has been achieved.</p>	

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	<p>DA #1 applied gloves then pushed his glasses up using his gloved index finger on two occasions while plating food for the residents. DA #1 was not wearing a facial net net while serving food.</p> <p>CRCA (Certified Resident Care Assistant) #1 was observed touching the back of Resident #16 and then obtained the meal plates for Residents #91 and #84. CRCA #1 then turned off the alarm for Resident #101 then used Resident 84's & #16's knives to cut up and butter the sweet potatoes. CRCA #1 then touched the arm of Resident #85 and picked up a pitcher of milk and poured it into a cup for Resident #91. CRCA #1 then picked up a pitcher of water and poured it into a cup for Resident #114. No handwashing or application of hand sanitizer was observed during the whole observation.</p> <p>3. During the lunch observation in the Legacy Lane Dining Room, on 7/08/16 between 11:25 a.m. and 12:06 p.m., 24 residents were observed to be present. During this meal service, the following was observed:</p> <p>DA #1 was observed to done gloves and began serving the meals from the steam table. DA #1's beard was uncovered with no facial net or hair protector. During the</p>			

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	<p>meal service DA #1 was observed, multiple times, to use his gloved hand and pushed his glasses up on the bridge of his nose.</p> <p>CRCA #2 was observed touching/patting her pants and apron while waiting for the food to be plated. Without washing her hands or using hand gel CRCA #2 served Resident #114, #22 and #98 their plates. CRCA #2 then held her hands against her apron and after picking up the residents' menu slips she served Residents #122, #74, and #117 their plates. Then CRCA #2 picked up Resident #117's utensils and cut the resident's fish into smaller pieces. CRCA #2 then picked up Resident #122's utensils and placed them on the resident's plate. Next CRCA #2 served Residents #79's and #121's plate and then picked up Resident #121's utensils and cut up the residents food. CRCA #2 picked up Resident 79's utensils and cut the resident's fish into smaller pieces. After CRCA #2 touched Resident #75's hands, she adjusted the wheelchair for Resident #92. Next CRCA #2 obtained a plate of food and a cup for Resident #59 and used the resident's utensils to cut the resident's fish into smaller pieces. CRCA #2 was handed a used cup from Resident #56. After receiving the cup from Resident #56 CRCA patted the resident on the shoulder. No hand sanitizer or hand</p>			

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F 0431 SS=E Bldg. 00	<p>washing was observed during this observation.</p> <p>4. On 7/08/16 at 11:58 a.m., CRCA #3 was observed to rub a resident's back and then she placed her hand over her mouth. Using the hand that was over her mouth CRCA #3 began to assist residents #92 and #75 with consumption of their meal. No handwashing or hand gel was used during this observation.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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,</p>						

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	<p>permanently affixed compartments for storage of controlled drugs listed in 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 label medications properly, store the medications following the manufacturer, pharmacy, or supplier recommendations, store personal food in the appropriate locations, and store medications in the correct resident's labeled container. This deficient practice affected 5 of 7 medication carts and had the potential to affect all residents currently residing in the facility. (Resident #156 & #54)</p> <p>Findings include:</p> <p>1. During the medication storage observation on the Legacy Lane Medication Cart 1, with LPN (Licensed Practical Nurse) #1, on 7/07/16 at 12:44 p.m., the following was observed:</p> <p>Located in the bottom of the medication storage drawers were 17 loose unidentified medication tablets/capsules.</p> <p>Located in two drawers next to the residents medications, ensure, and</p>	F 0431	<p>1. The loose pills, powder, humalog kwikpen and insulin pen found in the medication carts were properly disposed. The sani-cloth bleach germicidal disposable wipes are now being stored properly away from medications. Resident # 156 and 54 were not affected by the deficient practice.</p> <p>2. All residents with physician orders for insulin pens were rechecked. All insulin pens were dated and stored properly as verified by the DHS on 7/12/2016.</p> <p>3. All nursing staff were re-educated by the DHS on 7/19 and 7/20, 2016 on ensuring medications are labeled and stored properly, drawers are free of loose pills and powder. Germicidal disposable wipes are stored per policy and procedure.</p> <p>4. The DHS/Assistant Director of Health Services (ADHS) will conduct an audit of the medication carts to ensure medications are labeled and stored properly, free of loose pills, powder and germicidal disposable wipes are stored per policy and procedure. All six medication carts will be audited each week by the DHS/ADHS for eight weeks then</p>	08/01/2016

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	<p>toothbrushes, there were two bottles of Sani-cloth bleach germicidal disposable wipes.</p> <p>2. During the medication storage observation on the Legacy Lane Cart 2, with LPN #2, on 7/07/16 at 1:05 p.m., the following was observed:</p> <p>Located in the bottom of the medication storage drawer were 7 loose unidentified medication tablets/capsules.</p> <p>Located in a drawer next to the residents nebulizer treatments, residents supplements, and residents shampoo was one bottle of Sani-cloth bleach germicidal disposable wipes.</p> <p>3. During the medication storage observation on the Cherry Hill Medication Cart 1, with LPN #3, on 7/07/16 at 1:20 p.m., the following was observed:</p> <p>Located in the top drawer was Resident # 156's Humalog Kwikpen. The pen had an open date of 6/15/16 and the bag it was stored in had an open date of 6/17/16.</p> <p>4. During the medication storage observation on the Harvest Place Cart 1, with RN (Registered Nurse) #2, on</p>		<p>three medication carts per week for four weeks. Results of audits will be reviewed at monthly Quality Assurance Committee, consisting of Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Records and Social Services, and by the Medical Director at least quarterly, until team concludes compliance has been achieved.</p>	

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	<p>7/07/16 at 1:31 p.m., the following was observed:</p> <p>Located in the bottom of the medication storage drawer were 7 loose unidentified medication tablets/capsules and white loose powder of the floor of the cart.</p> <p>Located in two drawers next to the residents medications, there were two bottles of Sani-cloth bleach germicidal disposable wipes.</p> <p>5. During the medication storage observation on the Harvest Place Medication Cart 2, with RN #1, on 7/07/16 at 2:05 p.m., the following was observed:</p> <p>Located in the bottom of the medication cart was loose yellow powder.</p> <p>Located in the top drawer at room temperature was Resident #54's unopened Toujeo Solostar Insulin pen. On the package of the Toujeo Solostar Insulin pen it stated, "Refrigerate until opened."</p> <p>Located in a drawer next to the residents nebulizer treatments, was one bottle of Sani-cloth bleach germicidal disposable wipes.</p> <p>During an interview on 7/07/16 at 2:07</p>			

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	<p>p.m., RN #1 indicated the unopened Toujeo Solostar insulin pen was in the drawer when she started work that morning. Resident #54 had another opened Toujeo Solostar insulin pen that was currently being used. RN #1 further indicated she did not know when the the pen was placed in the draw and since it had not been refrigerated or dated, the Toujeo Solostar insulin pen should be thrown away and a new one ordered.</p> <p>An interview on 7/11/2016 at 9:09 a.m., with the Director of Nursing (DON), confirmed all above issues. The DON indicated the pharmacist makes monthly checks on the medications carts and the nurses working the floor should check them as needed. The DON indicated chemicals should be stored away from the residents medications.</p> <p>A policy, dated 9/1/13 and titled, "MEDICATION STORAGE IN THE FACILITY" was provided by the DON on 7/11/2016 at 10:20 a.m. and was identified as current. This document included, but was not limited to, the following: "... G. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) are clearly identified and stored in a locked area separately from medications... J.</p>			

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F 0441 SS=D Bldg. 00	<p>Medications requiring "refrigeration" are kept in a refrigerator with a thermometer to allow temperature monitoring...M. Medication storage area are kept clean, well-let, and free of clutter and extreme temperatures..."</p> <p>3.1-25(j)(k)(l)(m)(o)</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</p>			

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NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN 47150
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	<p>must isolate the resident.</p> <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 perform proper hand hygiene during 1 of 4 Medication Administration observations. This deficient practice affected 3 of 7 resident's receiving medication. (Residents #20, #29, and #37)</p> <p>Findings include:</p> <p>During a Medication Administration observation on 7/8/16 starting at 9:11 a.m., LPN (Licensed Practical Nurse) #4 entered Resident #37's room and retrieved Resident #37's TV remote out of the the trash can. LPN #4 then washed her hands for 3 seconds, donned gloves and administered Resident #37's eye drops. LPN #4 removed her gloves and without washing her hands, administered Resident #37's oral (by mouth)</p>	F 0441	<ol style="list-style-type: none"> 1. Resident # 20, 29 and 37 were not affected by the deficient practice. 2. Other residents that received medications passed by LPN #4 were not found to be affected by the deficient practice as audited by DHS on 7/12/2016. 3. All nursing staff were re-educated by the DHS on proper hand hygiene during medication pass on 7/19 and 7/20, 2016. 4. The DHS/Assistant Director of Health Services (ADHS) will conduct an audit to ensure nurses are performing proper hand hygiene during medication pass. Ten residents / week for four weeks then five residents / week for eight weeks will be audited by DHS/ADHS. Results of audits will be reviewed at monthly Quality Assurance Committee, consisting of Executive 	08/01/2016

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	<p>medication. LPN #4 exited the resident's room without washing her hands.</p> <p>LPN #4 then prepared Resident #29's medications without washing or using hand gel for hand hygiene. LPN #4 poured a cup of honey thick liquids to be taken with Resident #29's medications. LPN #4 administered Resident #29's medication by spoon with applesauce. LPN #4 then donned gloves and administered Resident #29's nasal spray. LPN #4 removed her gloves and without washing or hand gel exited Resident #29's room.</p> <p>LPN #4 then without washing or using hand gel LPN #4 prepared Resident #20's medications. LPN #4 walked into Resident 20's room and poured the cup of medications directly into Resident #20's mouth. LPN #4 periodically wiped Resident #20's mouth and clothing with a Kleenex, as some of the liquids were coming out of the residents mouth. LPN #4 was not observed to wash or gel her hands during any part of the medication pass observed with Resident #20.</p> <p>LPN #4 without washing her hands or using hand gel went into Resident #29's room with a can of Ensure. LPN #4 opened the can of Ensure with her bare hands for Resident #29's consumption.</p>		<p>Director, Director of Health Services, Assistant Director of Health Services, Medical Records and Social Services, and by the Medical Director at least quarterly, until team concludes compliance has been achieved.</p>	

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	<p>During an interview with LPN #4 on 7/8/16 at 11:52 a.m., she indicated hands should be washed for 20 seconds and should be washed before and after each resident contact when passing medications.</p> <p>During an interview with Registered Nurse (RN) #2 on 7/8/16 at 12:13 p.m., she indicated hands should be washed for 20 seconds and should be washed before and after each resident contact when passing medications.</p> <p>During an interview with RN #1 on 7/8/16 at 1:58 p.m., she indicated hands should be washed for 20 seconds and should be washed before and after each resident contact when passing medications.</p> <p>An interview on 7/11/2016 at 9:09 a.m., the Director of Nursing (DON), indicated hands should be washed for 20 seconds. She also indicated that nurses should wash their hands before and after contact with a resident when passing medications.</p> <p>An undated policy, titled, "Guideline for Handwashing/Hand Hygiene " was provided by the DON on 7/11/2016 at 10:20 a.m. and was identified as current.</p>			

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	<p>This document included, but was not limited to, the following:"... 8. Wash well for 20 seconds, using a rotary motion and friction..."</p> <p>A policy, dated 9/1/13 and titled, " PREPARTION AND GENERAL GUIDELINES" was provided by the DON on 7/11/2016 at 10:20 a.m. and was identified as current. This document included, but was not limited to, the following:"... 8) Hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications..."</p> <p>3.1-18(I)</p>			