

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2012
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NAME OF PROVIDER OR SUPPLIER  MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00109770.</p> <p>Complaint IN00109770- Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: June 25, 26, 27, 28 and 29, 2012</p> <p>Facility number: 000343 Provider number: 155486 AIM number: 100289600</p> <p>Survey team: Sharon Lasher, RN, TC Angel Tomlinson, RN Barbara Gray, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 4 Medicaid: 18 Other: 5 Total: 27</p>	F0000	<p>This plan of correction is submitted to serve as a Credible Allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission of agreement by the provider or conclusions set facts on the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by State and Federal laws.</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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 5, 2012 by Bev Faulkner, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the 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 physician's orders after each incontinent stool for a resident with a large amount of excoriation for 1 of 4 residents observed for peri care. (Resident #3).</p> <p>Findings include:</p> <p>The record of Resident #3 was reviewed on 6/27/12 at 9:45 a.m. Resident #3's diagnoses included but were not limited to C-diff (Clostridium difficile, a bacteria with symptoms including diarrhea) and diarrhea.</p> <p>Resident #3's MDS (Minimum Data Set), assessment, dated 5/18/12, indicated the following:</p> <ul style="list-style-type: none"> <li>- BIMS (Brief Interview for Mental Status), scored 2, with a score of 0-7 indicating severe impairment</li> <li>- bed mobility, total dependence, with one person physical assist</li> <li>- transfer, total dependence, with one person physical assist</li> <li>- urinary continence, always incontinent</li> </ul>	F0282	<p>1. It is now on CNA's assignment sheets to notify the nurse when changing resident #3 brief after each incontinent episode and wait with the resident until the nurse comes to apply the treatment.2. All doctors orders have been audited and resident #3 it the only residnet with such specific orders to be done after each incontinent episode.3. If this type order is received nurse getting order will add it to the CNA's assignment sheet and the charge nurse will verbally tell the CNA's of the new treatment.4. Director of Nurses will check all new orders daily for 30 days then 2 times per week for 30 days then monthly there after and check CNA assignment sheets to make sure appropriate orders have been added to assignment sheets and carried out by CNA's and Nurses.5. This will be done with attached audit paper for new orders. Audits and assignment sheets will be reviewed at Quality Assurance meetings and forms revised as necessary during Quality Assurance meetings. This will be monitored by the Director of Nurses.Respectfully requesting paper compliance for F282</p>	07/23/2012	

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	<p>- bowel continence, always incontinent</p> <p>Resident #3's physician's order, dated 6/19/12 at 2:00 p.m., indicated "A &amp; D ointment. Apply to bilateral inner thighs, inner gluteals and bilateral buttocks every shift and after each incontinent episode PRN (as needed) until healed."</p> <p>During an observation on 6/27/12 at 11:12 a.m., CNA #1 and CNA #2 transferred Resident #3 from her wheelchair to her bed. Resident #3 was incontinent of a large amount of loose, light brown, foul smelling stool. Resident #3's thighs, inner gluteals, coccyx, bilateral buttocks and entire peri area were red and excoriated. CNA #1 and CNA #2 cleaned the stool from Resident #3 with soap and water. Resident #3 groaned and moaned with the care, but denied needing pain medication. CNA #1 and CNA #2 put a clean brief on Resident #3 and transferred her back to her wheelchair and transported her to the dining room for lunch.</p> <p>During an interview on 6/27/12 at 11:30 a.m., CNA #1 and CNA #2, both indicated they never put the ointment on Resident #3.</p>			

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	<p>During an observation on 6/29/12 at 9:28 a.m., CNA #1 and CNA #2 transferred Resident #3 from her wheelchair to her bed. Resident #3 was incontinent of a large amount of watery, light brown, loose and foul smelling stool. The stool was on Resident #3's slacks and from her coccyx, inner legs and entire peri area. After cleansing with soap and water, Resident #3 was left in bed on her right side with no brief on and no medication was applied to Resident #3's excoriated areas.</p> <p>During an interview with RN #3 on 6/29/12 at 10:05 a.m., the nurse indicated staff should put the A &amp; D ointment on Resident #3's excoriated areas every shift and after each incontinent episode.</p> <p>3.1-35(g)(1)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure thorough assessments and ordered treatment was provided for 1 of 4 residents observed for peri care. Resident # 3 had large areas of excoriation that had not been measured to ensure progress with healing and was not always provided the ordered treatment to promote healing. (Resident #3)</p> <p>Findings include:</p> <p>The record of Resident #3 was reviewed on 6/27/12 at 9:45 a.m. Resident #3's diagnoses included but were not limited to C-diff (Clostridium difficile, a bacteria with symptoms including diarrhea) and diarrhea.</p> <p>Resident #3's MDS (Minimum Data Set) assessment, dated 5/18/12, indicated the following: - BIMS (Brief Interview for Mental Status), scored 2, with a score of 0-7</p>	F0309	<p>1. It is now on CNA's assignment sheet to notify the nurse when changing resident #3 brief after each incontinent episode and wait with the resident until the nurse comes to apply the treatment. Resident #3 treatment was changed on 7/3/2012 to Riley Butt Cream and is healing. This area was last measured on 7/16/2012 and has decreased in size substantially and is light pink in color now. 2. All doctors orders have been audited and resident #3 is the only resident with such specific orders to be done after each incontinent episode. We have no other residents at this time with excoriation. 3. If this type order is received nurse getting the order will add to the CNA's assignment sheet and the charge nurse will verbally tell the CNA's of the new treatment. A new policy is written for nurses to measure areas of excoriation when first noted, notify the doctor and report measurements, initiate the treatment, and areas will be measured at least weekly to ensure progress with healing. 4. Director of Nurses will check all</p>	07/23/2012

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	<p>indicating severe impairment</p> <ul style="list-style-type: none"> <li>- bed mobility, total dependence, with one person physical assist</li> <li>- transfer, total dependence, with one person physical assist</li> <li>- urinary continence, always incontinent</li> <li>- bowel continence, always incontinent</li> </ul> <p>Resident #3's nursing notes, dated 6/19/12 at 11:30 a.m., "bilateral inner gluteus, inner thighs and buttocks excoriated, physician notified."</p> <p>Resident #3's physician's order, dated 6/19/12 at 2:00 p.m., indicated "A &amp; D ointment. Apply to bilateral inner thighs, inner gluteals and bilateral buttocks every shift and after each incontinent episode PRN until healed."</p> <p>During an interview with RN #3 on 6/29/12 at 1:40 p.m., RN # 3 indicated there was not an assessment completed on 6/19/12 except all excoriated areas were documented in the nursing notes.</p> <p>Resident #3's nursing notes where the excoriation was documented are as follows:</p> <ul style="list-style-type: none"> <li>- 6/19/12 at 2:05 p.m., diagnosis of C-diff with antibiotic therapy, vaginal</li> </ul>		<p>new orders daily for 30 days then 2 times per week for 30 days and check CNA's assignment sheet to make sure apporiate orders have been added to assingment sheets and carried out by CNA's and Nurses.Nurses notes will be checked weekly for measurments of any excoriated areas.5. This will be done with attached audit paper for new orders. Audits and assignment sheets will be reviewed at Quality Assurance meetings and forms revised as necessary during Quality Assurance meetings.All excoriated areas and measurments will be reported and review at all Quality Assurance meetings.This will be monitored by the Director of Nurses.Respectfully requesting paper compliance for F309</p>	

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	<p>area, peri area, inner thighs and gluteals excoriated. Treatment applied as per physician order - 6/23/12 at 3:00 a.m., treatment applied as per physician order incontinent (most of the time) of bowel and bladder. Peri care by staff per episode and PRN (as needed) - 6/25/12 at 12:00 a.m., skin warm and dry, excoriated inner thighs/peri/vaginal/gluteals. Treatment applied as per physician order - 6/26/12 at 2:00 a.m., skin warm and dry, excoriated areas bilateral inner thighs, peri area, vaginal/gluteal. Treatment applied as physician order - 6/26/12 at 11:30 a.m., right lateral ankle, bilateral inner thighs, inner gluteals, and bilateral buttocks observed and treatment completed - 6/28/12 at 1:30 a.m., skin warm and dry, excoriated groin/peri/gluteal. Treatment applied per incontinent episode and PRN.</p> <p>During an observation on 6/27/12 at 11:12 a.m., CNA #1 and CNA #2 transferred Resident #3 from her wheelchair to her bed. Resident #3 was incontinent of a large amount of loose, light brown, foul smelling stool. Resident #3's thighs, inner gluteals, coccyx, bilateral buttocks and entire peri area were red and excoriated.</p>			
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	<p>CNA #1 and CNA #2 cleaned the stool from Resident #3 with soap and water. Resident #3 groaned and moaned with the care but denied needing pain medication. CNA #1 and CNA #2 put a clean brief on Resident #3 and transferred her back to her wheelchair and to the dining room for lunch.</p> <p>During an interview on 6/27/12 at 11:30 a.m., CNA #1 and CNA #2 both indicated they never put the ointment on Resident #3.</p> <p>During an observation on 6/29/12 at 9:28 a.m., CNA #1 and CNA #2 transferred Resident #3 from her wheelchair to her bed. Resident #3 was incontinent of a large amount of watery, light brown, loose and foul smelling stool. The stool was on Resident #3's slacks and from her coccyx, inner legs and entire peri area. After cleansing with soap and water, Resident #3 was left in bed on her right side with no brief on and no medication was applied to Resident #3's excoriated areas.</p> <p>During an observation on 6/29/12 at 11:00 a.m., RN #3 measured Resident #3's excoriated areas.</p>			

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	<p>Resident #3's nursing notes, dated 6/29/12 at 11:00 a.m., included "resident gluteals, inner thighs and inner gluteals observed and measured at this time, left gluteal starting at the coccyx and down to the proximal (near to the point of attachment) thigh measures 19.8 cm (centimeters) X 7.1 cm. Right gluteal starting at the coccyx and down to the proximal thigh measures 21.0 cm X 12.8 cm. Left inner thigh measures 20.1 cm X 6.5 cm. Right inner thigh measures 17.2 cm X 7.3 cm. Left posterior (toward the hind part of the body) thigh measures 10.9 cm X 9.1 cm. Right posterior thigh measures 12.9 cm X 9.3 cm. Areas remain excoriated/intact. Treatment applied at this time."</p> <p>During an interview with RN #3 on 6/29/12 at 10:05 a.m., indicated the nurses should put the A &amp; D ointment on Resident #3's excoriated areas every shift and after each incontinent episode. She also indicated the excoriated areas had not been measured because they were not open area and that was the protocol for excoriations in the facility.</p> <p>3.1-37(a)</p>			

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F0441 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 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>	F0441	1. Resident #3 is now in contact isolation. A sign is now on the	07/23/2012			

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	<p>place a sign for contact isolation on the door of 1 resident with a diagnosis of C-diff (Clostridium difficile, a bacteria with symptoms including diarrhea), and to wear gowns for 1 resident reviewed with a need for contact isolation. (Resident #3).</p> <p>Findings include:</p> <p>The record of Resident #3 was reviewed on 6/27/12 at 9:45 a.m. Resident #3's diagnoses included but were not limited to C-diff (Clostridium difficile, a bacteria with symptoms including diarrhea) and diarrhea.</p> <p>During an observation on 6/27/12 at 11:12 a.m., CNA #1 and CNA #2 transferred Resident #4 from her wheelchair to her bed. Resident #3 was incontinent of a large amount of loose, light brown, foul smelling stool. CNA #1 and CNA #2 cleaned the stool from Resident #3 with soap and water and CNA #1 and CNA #2 did not wear gowns. During the observation of Resident #3's incontinence care, a sign for contact isolation or a sign to check with the nurse before entering Resident #3's room was not on Resident #3's door to her room.</p> <p>During an interview with RN #3 on</p>		<p>door of resident #3's private room stating to check at nurses station before entering room. Staff has been inserviced on Contact Isolation Procedures (see attachment #1) and are being followed for resident #3.2. There are no other residents in the facility that have C-DIFF Infection or any other diagnoses requiring any isolation procedures.3. Guideline for caring for residents with C-DIFF Infection have been written. (see attachment #2) And will be followed for any residents having this diagnosis in the future.4. All infections are reviewed during Quality Assurance meetings. Residents requiring any isolation precautions will be reviewed with the infection control report at all Quality Assurance meetings.5. This is being monitored by the Director of Nurses and the Asst. Director of Nurses. Respectfully requesting paper compliance for F441</p>		

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	<p>6/29/12 at 11:30 a.m., RN # 3 indicated signs on the door of residents with infectious diseases were not put on resident's doors because of privacy for the residents. She also indicated Resident #3 had C-diff and would be tested again on 7/7/12 to see if she still tested positive for C-diff.</p> <p>During an observation on 6/29/12 at 9:28 a.m., CNA #1 and CNA #2 did not have on gowns and cleansed a large amount of watery, light brown, loose and foul smelling stool from Resident # 3. The stool was on Resident #3's slacks and from her coccyx to her peri area. There was no gowns available for the staff to wear.</p> <p>Resident #3's care plan, dated 6/12/12, indicated "Possible C-diff. Goal, resident will receive medication for C-diff as ordered and then on 7/9/12 will have C-diff retested. Interventions, Vancomycin (antibiotic) as ordered, amoxicillin (antibiotic) as ordered, test for C-diff 7/9/12, observe for signs/symptoms of C-diff, contact physician as needed, keep loose stool contained in brief, private room and room to be cleaned with bleach daily per housekeeping."</p> <p>A document provided by the DON on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2012
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NAME OF PROVIDER OR SUPPLIER  MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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	<p>6/29/12 at 12:50 p.m., titled, "Contact Precautions consist of:" included but was not limited to, wearing a gown when entering the room if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or items in the patient's room, of if the patient is incontinent, or has diarrhea...."</p> <p>"2007 Guideline for Isolation Precautions from the Centers of Disease Control and Prevention" indicated "C-diff and incontinence, contact precautions and isolation: - gloves and gowns required for direct contact and contact with environment - discontinuation of isolation when diarrhea resolves"</p> <p>3.1-18(b)(2)</p>			

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