

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: January 2, 3, 8, 9, 10, 13, and 14, 2014</p> <p>Facility number: 000513 Provider number: 155426 AIM number: 100275360</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN January 2, 3, and 8, 2014 Laura Brashear RN Karen Hartman RN</p> <p>Census bed type: SNF/NF: 141 Total: 141</p> <p>Census payor type: Medicare: 22 Medicaid: 103 Other: 16 Total: 141</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 01/22/2014 by Brenda Marshall, RN.</p>	F000000	We are requesting a desk review.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all residents seated at the same dining table were served their meals at the same time for 4 of 20 residents in random observations. (Residents #44, #175, #179, and #202.) This deficient practice had the potential to affect all 20 residents of the closed unit.</p> <p>Findings include:</p> <p>1. On 1/9/14 at 11:45 a.m. the noon meal service was observed on the secure unit. Four long tables were observed each with four or five residents. At 11:45 a.m. LPN #2 and CNA #3 started serving trays. All 20 residents of the unit required opening and applying condiments, opening packages, and some required having their meat cut. The trays were randomly served. Residents at the same tables were not served before beginning service</p>	F000241	<p>I. All residents seated at the same dining table will be served their meals at the same time. This will include residents # 44, #175, #179, and # 202.II. All residents in the dining room have the potential to be affected by the same deficient practice. All residents seated at the dining table will be served their meals at the same time. III. A dining table seating chart has been updated and provided to dietary services. The seating chart includes numbered tables in the order of independent diners first followed by diners needing to be cued and/or fed by staff. The food cart will be loaded in an order that will allow staff members to obtain trays from the cart in an order of the tables numbered 1-10, and in the order of providing trays to each resident at the table before providing a tray to a resident at the next table. Adjustments to the seating chart will be made by the charge nurse as the needs of the resident population changes. Dietary services will be notified immediately by the charge nurse of any necessary changes. Staff</p>	01/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>at another table. At 12:25 p.m. meals had been served to residents at each of the four long tables. One of the four long tables had been completely served.</p> <p>At 11:45 a.m., Table #1 was observed with Resident #105 eating meal. Trays were served to other tables before returning with a tray for table #1. Residents #179, #202, #170, and #44 were also at the table. Residents #179 and #202 were eating slices of bread given to them by Resident #105 from his meal. The two staff serving, continued delivering meals to the three other long tables, in random order. At 12:05 p.m. Resident #44 was served, the last person at the table #1, 20 minutes after Resident #105 was served.</p> <p>At 12:25 p.m. staff were still delivering meals to residents. None of the other three long tables had completely been served, all had been partially served.</p> <p>2. On 1/13/14 at 11:42 a.m. LPN #2 and CNA #3 were observed preparing for meal service. Four long tables and two short tables were observed with four to five residents at each of the long tables.</p>		<p>members will not take brakes during resident meal times. There will always be at least 3-5 staff members available during meal service to serve meals to the current 20 residents. The dining room will never exceed 24 residents. There are currently 4 of 20 residents requiring cueing with 1 of the 4 occasionally requiring physical assistance. The charge nurses will be responsible to contact the Unit Manager if the needs of the residents change. The Activity Assistant and the Unit Manager will assist the charge nurse and 2 CNAs in the dining room during meal times when on duty. An inservice will be provided to ensure there is a clear understanding of the systemic changes.IV. A monitoring tool has been developed that will include: 1) the number of residents in the dining room 2) the number of residents requiring cueing 3) the number of residents requiring physical assistance to eat/drink 4) the number of employees assisting from start to finish of the meal service 5) the time the first meal tray was served 6) the time the last meal tray was served 7) validation that the trays were served starting with table 1-10 8) validation that each resident at the table was served prior to serving at the next table. The monitoring tools will be completed by the Unit Manager or his/her</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>Service was started with table #2.</p> <p>Resident #175 had been observed at table #3 at 11:45 a.m. At 12:25 p.m. Resident #175 was served after waiting since 11:50 a.m. All other residents at table #3 had previously been served.</p> <p>The Director of Nursing Services (DNS) was interviewed on 1/13/14 at 2:50 p.m. The DNS indicated she could not find a written policy to address meal service but it was the policy of the facility to serve residents seated together at dining tables to all be served before moving on to another table.</p> <p>3.1-3(t)</p>		<p>designee beginning 2/01/14. The monitoring tools will be submitted to the DON daily. The monitoring tools will be reviewed by the nursing management team during daily clinical meetings. The monitoring tools will be reviewed and reported to the Quality Assurance Committee for a period of at least 3 months sustained compliance.V. The systemic changes will be completed by 1/31/14.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staffing to ensure residents seated at the same table were served meals together and/or provided cues or supervision of the meal for 2 of 2 observations of meal service for 5 of 20 residents residing on a secure unit. [Residents #44, #175, #179, #202, and #59]. This deficient practice had the potential to affect all 20 residents of the unit.</p>	F000353	<p>I. The facility will provide sufficient staffing to ensure residents seated at the same table are served meals together and/or provided cues or supervision of the meal. This will include residents #44, #175, #179, #202, and #59. II. All residents in the dining room have the potential to be affected by the same deficient practice. All residents seated at the same table will be served meals together and will be provided cues or assistance as necessary. III. The following systemic changes have been put</p>	01/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>Findings include:</p> <p>1. On 1/9/14 at 11:45 a.m. the noon meal service was observed on the secure unit. Four long tables were observed each with four or five residents. At 11:45 a.m. LPN #2 and CNA #3 started serving trays. All 20 residents of the unit required opening and applying condiments, opening packages, and some required having their meat cut. The trays were randomly served. Residents at the same tables were not served before beginning service at another table. At 12:25 p.m. meals had been served to residents at each of the four long tables. One of the four long tables had been completely served.</p> <p>At 11:45 a.m., Table #1 was observed with Resident #105 eating meal. Trays were served to other tables before returning with a tray for table #1. Residents #179, #202, #170, and #44 were also at the table. Residents #179 and #202 were eating slices of bread given to them by Resident #105 from his meal. The two staff serving, continued delivering meals to the three other long tables, in random order. At 12:05 p.m. Resident #44 was served, the last person at the</p>		<p>into place to provide meals to our residents in a consistent and orderly fashion, serving all residents at the same table prior to serving the next table, in the least amount of time possible, allowing staff members to sit down with residents requiring cueing/supervision and physical assistance at the end of the serving time: a) A dining table seating chart has been updated and provided to dietary services. The seating chart includes numbered tables in the order of independent diners first followed by diners needing to be cued and/or fed by staff. The food cart will be loaded in an order that will allow staff members to obtain trays from the cart in order of the tables numbered 1-10, and in the order of providing trays to each resident at the table before providing a tray to a resident at the next table. Adjustments to the seating chart will be made as the needs of the resident population changes. Dietary services will be notified immediately by the charge nurse of any necessary changes. b) Staff members will not take brakes during resident meal times. There will always be at least 3-5 staff members available during meal service to serve meals to the current 20 residents. The dining room will never exceed 24 residents. There are currently 4 of 20 residents requiring cueing with 1</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>table #1, 20 minutes after Resident #105 was served.</p> <p>At 12:25 p.m. staff were still delivering meals to residents. None of the other three long tables had completely been served all had been partially served.</p> <p>2. On 1/13/14 at 11:42 a.m. LPN #2 and CNA #3 were observed preparing for meal service. Four long tables and two short tables were observed with four to five residents at each of the long tables. Service was started with table #2. At noon, Resident #202 at table #1, approached surveyor at the nurses' desk and asked where she was to go. She was directed back to her seat at table #1. The resident responded that is where she had been. The resident then indicated she was hungry and went back to her table. At 12:06 p.m. Resident #202 left the table and approached CNA #6, who had just returned to unit from a break, and asked for something to eat. At 12:10 p.m. the resident was served a tray. At 12:20 p.m. all residents at table #1 had been served.</p> <p>Resident #175 had been observed at table #3 at 11:45 a.m. At 12:25</p>		<p>of the 4 occasionally requiring physical assistance. The charge nurses will be responsible to contact the Unit Manager if the needs of the residents change. c) The Activity Assistant and the Unit Manager will assist the charge nurse and 2 CNAs in the dining room during meal times when on duty. d) An inservice will be provided to ensure there is a clear understanding of the systemic changes.IV. A monitoring tool has been developed that will include: 1) the number of residents in the dining room 2) the number of residents requiring cueing 3) the number of residents requiring physical assistance to eat/drink 4) the number of employees assisting from start to finish of the meal service 5) the time the first meal tray was served 6) the time the last meal tray was served 7) validation that the trays were served starting with table 1-10. 8) validation that each resident a the table was served prior to serving at the next table. The monitoring tools will be completed during random meals throughout the week by the Unit Manager or his/her designee. The monitoring tools will be submitted to the DON. The monitoring tools will be reviewed by the DON to ensure continued compliance and/or appropriate actions taken to regain compliance The monitoring tools will be reviewed with findings reported to the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>p.m. Resident #175 was served 40 minutes after start of meal service. All other residents at table #3 had previously been served.</p> <p>A list of residents on the unit, provided by Unit Manager #7 on 1/14/14 at 11:07 a.m., identified four residents who required cues at times for meals. Residents #44, and #59 were included. All residents required meal set up.</p> <p>The staffing coordinator was interviewed on 1/14/14 at 10:37 a.m. The coordinator provided the daily staffing sheets which reflected one nurse and two CNAs were staffed for the unit. The coordinator indicated the Activity assistant for the unit, and the Unit Manager were also available Monday through Friday. The coordinator indicated it was the normal staffing pattern and the Activity assistant should have assisted with meal service. This was not observed.</p> <p>Unit Manager #7 was interviewed on 1/13/14 at 2:00 p.m. The manager indicated staff were not to take lunch breaks during meal service. This had been observed both days of observation as CNA #6 returned to unit during meal service.</p>		Quality Assurance Committee for a period of at least 3 months of sustained compliance. V. The systemic changes will be completed by 1/31/14				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>LPN #1 was interviewed on 1/14/14 at 10:40 a.m. LPN #1, who usually works the unit, indicated the Activity assistant sometimes helps. The LPN indicated it was not uncommon for staff to have lunch breaks during meal service.</p> <p>Resident #59's family member was interviewed on 1/9/14. The family member indicated there is not always enough staff at meal time to serve the residents and she frequently came in to help pass trays at lunch time. Resident #59 was identified by the Unit Manager as one of the four residents on the unit who required cueing at times for meals. The resident had been observed with meal and no assistance during the meals. The Unit Manager indicated the resident had not eaten much and required cueing during meals.</p> <p>3.1-17(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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			
F000441 SS=E	<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>During the interview of RN #10 working on 400 hall on 1/13/14 at</p>	F000441	I. The nursing center will ensure sanitation precautions are	01/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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>1:09 p.m., the RN indicated two residents received blood glucose monitoring utilizing the "Assure" blood glucose meter. The RN indicated she cleansed the blood glucose meter with alcohol wipes between residents. The RN stated she used the bleach wipes to cleanse the blood glucose meter at the end of the shift.</p> <p>During the interview of LPN #9 working on the 300 hall on 1/13/14 at 1:12 p.m., the LPN indicated five residents received blood glucose monitoring utilizing the "Assure" blood glucose meter. The LPN indicated alcohol pads were utilized to cleanse the meter between residents. The LPN indicated bleach wipes were utilized one time a shift to cleanse the meters. Bleach wipes were observed not to be available in the 300 hall medication cart.</p> <p>During the interview of LPN #12 Unit Manager on 1/13/14 at 1:20 p.m., the LPN indicated the staff were trained to cleanse the blood glucose meters between residents with the bleach wipes.</p> <p>Upon interview of the Director of Nursing Services (DNS) on 1/13/14 at 3:25 p.m., the DNS indicated the</p>		<p>maintained to include cleansing/disinfecting the blood glucose meters with 1:10 bleach wipes between residents. This practice includes residents numbered 28, 159, 114, 205, 139, 314, 109, 95, 104, 38, 146, 145, 36, 151, 12, 116, 49, 34, 120, 32, 33, 46, 31, 76, 52, 22, 43, 62. The nursing center will ensure infection control practices are followed to include removal of contaminated gloves followed by immediate hand washing prior to coming into contact with another surface. This practice includes residents #145 and #136.II. All residents have the potential to be affected by the same deficient practices who are receiving blood glucose monitoring with our in-house meters, and all residents receiving care that requires the use of gloves that can become contaminated during the use of the gloves.III. The following measures will be taken to ensure the same deficient practices do not continue: 1.a) Licensed nurses will be reeducated/inserviced regarding our policy to cleanse &amp; disinfect our blood glucose meters with 1:10 bleach wipes immediately after use. Current licensed nurses will be inserviced by 1/31/14 or before working another scheduled shift if not working prior to 1/31/14. 1.b) All newly hired licensed nurses will be educated/inserviced regarding our policy to cleanse &amp; disinfect</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>blood glucose meters should have been cleansed with the disinfectant bleach wipes between residents. The DNS indicated 29 residents received blood glucose monitoring in the facility and that none of the 29 residents had any blood borne diseases.</p> <p>Upon interview of the Assistant Director of Nursing Services (ADNS) on 1/13/14 at 3:30 p.m., the ADNS indicated LPN #6, LPN #9, and RN #10 work throughout the facility .</p> <p>The following residents' physician orders were reviewed on 1/13/14 at 3:15 p.m. and noted as follows:</p> <p>a. Resident #28- Accucheck before meals and at bedtime with Humulin R coverage dated 1/10/14</p> <p>b. Resident #159- Accucheck before meals and at bedtime with Humalog sliding scale coverage dated 10/17/13.</p> <p>c. Resident #114- Accucheck before meals and at bedtime dated 1/7/14.</p> <p>d. Resident #205- Accucheck before meals and at bedtime dated 11/18/13.</p> <p>e. Resident # 139- Accuchecks before meals and at bedtime dated 1/6/14.</p> <p>f. Resident #214- Accuchecks</p>		<p>our blood glucose meters with 1:10 bleach wipes immediately after use during orientation, prior to working on the nursing units. 2.a) Employees will be reeducated/inserviced regarding our policy to remove contaminated gloves and wash hands before coming into contact with another surface. Current employees will be inserviced by 1/31/14 or before working another scheduled shift if not working prior to 1/31/14. 2.b) All newly hired employees will be educated/inserviced regarding our policy to remove contaminated gloves and wash hands before coming into contact with another surface during orientation, prior to working.IV. A monitoring tool has been developed to ensure education was effective and to ensure sustained compliance of infection control practices in our nursing center. The monitoring tool will include the date, time, employee, hall, care activity (blood glucose meter sanitation or removal of contaminated gloves &amp; hand washing prior to coming into contact with another surface). The Unit Managers, or their designees, will complete the monitoring tool. Monitoring will be random and will occur during all shifts, 7 days a week, on all units 100-800. Monitoring tools will be submitted to the DON. Monitoring tools will be reviewed by the nursing management team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2014	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804			
(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>before meals and at bedtime dated 12/17/13.</p> <p>g. Resident #109- Accuchecks twice daily dated 4/6/13.</p> <p>h. Resident #95- Accuchecks daily at 6 a.m. dated 12/6/13.</p> <p>i. Resident #104- Accuchecks four times daily twice a week dated 10/30/13.</p> <p>j. Resident #38- Accuchecks twice a day once a week dated 10/17/13.</p> <p>k. Resident #146- Accuchecks twice daily dated 12/11/13.</p> <p>l. Resident #145- Accuchecks twice daily dated 9/6/13.</p> <p>m. Resident #36- Accuchecks four times a day three times a week dated 8/26/13.</p> <p>n. Resident #151- Accuchecks in the morning and at bedtime dated 7/30/13.</p> <p>o. Resident# 12- Accucheck once daily and as needed dated 11/5/13.</p> <p>p. Resident # 116- Accucheck daily and Lantus 10 units daily dated 8/23/13.</p> <p>q. Resident# 49- Accuchecks before meals and at bedtime with sliding scale coverage dated 10/4/13.</p> <p>r. Resident # 34- Accuchecks twice daily dated 7/1/13.</p> <p>s. Resident # 120- Fasting accuchecks daily 1/4/13.</p> <p>t. Resident # 32- Fasting</p>		<p>during daily clinical meetings. Opportunities will be addressed at the time of observation/monitoring along with follow-up by a nursing manager to ensure reeducation was effective. The DON will report findings to the Quality Assurance Committee for a period of at least 3 months of sustained compliance.V. The systemic changes will be completed by 1/31/14.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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>accuchecks twice a week dated 6/12/12.</p> <p>u. Resident #33- Accuchecks daily with meals dated 7/1/13.</p> <p>v. Resident # 46- Accuchecks twice daily with Humalog coverage dated 6/21/12.</p> <p>w. Resident #31- Accuchecks before meals and at bedtime dated 11/6/13.</p> <p>x. Resident #76- Accuchecks at 6 a.m. and 8 p.m. daily dated 9/2/11.</p> <p>y. Resident# 52- Accucheck daily dated 10/9/13.</p> <p>z. Resident # 22- Accuchecks as needed for low or high blood sugars dated 11/13/13.</p> <p>aa. Resident# 43- Accuchecks before meals and at bedtime dated 7/4/13.</p> <p>bb. Resident# 62- Accuchecks before meals and at bedtime dated 11/20/13.</p> <p>Upon review of the facility's current policy and procedure titled "MAINTENANCE-Cleaning and Disinfecting Guidelines [no date]" on 1/13/14 at 2:05 p.m., documentation was noted of "Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning the meter between</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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>patient use...Option 2: To clean the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%); To disinfect the meter, dilute 1 mL (milliliter) of household bleach...to achieve a 1:10 dilution. The solution can then be used to dampen a paper towel (do not saturate the towel). Then use the dampened paper towel to thoroughly wipe down the meter. Please note that there are commercially available 1:10 bleach wipes from a variety of manufacturers..."</p> <p>B1. On 1-13-14 at 11:45 a.m. LPN #6 was observed administrating medication through a G-tube (Gastronomy Tube or Gastric feeding tube). During this observation the nurse had bilateral gloves on and when the administration of the medication was completed, the gloves were not removed and the Enteral Feeding Pump was turned on with dirty gloves.</p> <p>B2. On 1/13/14 at 9 a.m., RN #10 with gloves on administered eye drops to resident # 136. The RN, without removing the contaminated gloves, turned on the television and opened the resident's room door</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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>before removing the contaminated gloves.</p> <p>Upon review of the facility's current policy and procedure titled "Handwashing/Hand Hygiene" dated August 2012 on 1/13/14 at 4:39 p.m., documentation was noted of "...5. Employees must wash their hand for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);..."</p> <p>3.1-18(a)</p> <p>A. Based on observation, interview, and record review the facility failed to ensure sanitation precautions were maintained for cleansing of contaminated reusable equipment for 4 of 8 medication carts containing four blood glucose meters utilized for 14 residents. (Residents' #116, # 46, #120, #34, #49, #151, #22, #214, #211, #139, #205, #114, #28, #159). This had the potential to affect an additional 15 residents due to the 3 licensed nurses identified improperly sanitizing the blood glucose meters</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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>floated throughout the facility. (Residents' #12, #76, #31, #43, #62, #52, #33, #32, #36, #145, #146, #38, #104, #95, and #109).</p> <p>B. Based on observation, interview, and record review the facility failed to ensure a sanitary environment i.e. staff did not remove contaminated gloves according policy during resident care for 2 of 3 licensed nurses observed administering medications to residents #145 and #136. (LPN #6, RN #10).</p> <p>Findings include:</p> <p>A1. On 1-13-14 at 11:25 a.m., RN # 5 was observed checking resident # 211's blood sugar. During this observation the RN cleaned the glucometer with alcohol wipes, then preceded to resident # 211's room to perform a blood sugar. The RN #5 preformed the blood sugar and then went back to the cart and cleaned the glucometer with alcohol wipes, and proceeded down the hall to continue her med pass.</p> <p>RN #5 was interviewed on 1-13-14 at 11:30 a.m. The nurse indicated alcohol wipes used to clean the glucometers. RN stated "we are not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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>suppose to use the Dispatch wipes (bleach wipes)on the glucometers, because it ruins the face. We only use those wipes to clean our med carts."</p> <p>Resident #211's physicians orders were reviewed on 1-13-14 at 3:15 p.m. the order dated 12-24-13 was to check blood sugar levels before meals and at bedtime.</p>			