

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/18/2014
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NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN 47429
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction to the Investigation of Complaint IN00145855.</p> <p>Survey Dates: March 10, 11, 12, 13, 14, 17, & 18, 2014</p> <p>Facility number: 000558 Provider number: 155523 AIM number: 100267550</p> <p>Survey team: Diana McDonald, RN-TC Melissa Gillis, RN (3/10, 3/11, 3/12, 3/13, 3/17, 3/18, 2014) Cheryl Mabry, RN (3/12, 3/13, 3/14, 2014) Angela Patterson, RN Susan Worsham, RN (3/18/2014)</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 16 Medicaid: 45</p>	F000000		

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>Other: 13 Total: 74</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on March 26, 2014; by Kimberly Perigo, RN.</p>				

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview, and record review, the facility failed to meet professional standards as indicated by their policy and procedure in that a nurse failed to check placement of a g-tube (stomach tube) before administering scheduled medication. (Resident #70, RN #2)</p> <p>Findings include:</p> <p>On 3/13/14 at 5:30 a.m., observed RN #2 administering Resident #70's medication through a g-tube [gastrostomy/stomach tube]. RN #2 checked for residual and no stomach contents were obtained. RN #2 was not observed to check g-tube placement. RN #2 poured 30cc's of water into the tube followed by crushed pain pill, then poured 30cc in tube, then administered crushed antianxiety pill, then 30 cc's of water, and then 140cc's of water.</p> <p>On 3/13/14 at 5:58 a.m., interview with RN #3 when asked protocol for giving medication through a g-tube indicated, "Check placement, air</p>	F000281	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p> <p>Plan of Compliance is effective April 4, 2014</p> <p>F 281 Services provided meet professional standards</p> <p>Corrective action for affected resident:</p> <p>RN #2 and RN #3 were re-inserviced on facility's Enteral Medication Administration Policy and Procedure. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) provided education with each nurse completing return demonstration of enteral medication administration. Resident #70 was assessed with no findings.</p> <p>Identification of others at risk:</p>	04/04/2014
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	<p>bolus, clamp tube, turn off machine, and give crushed medication."</p> <p>On 3/13/14 at 6:25 a.m., interview with RN #2 indicated when asked what is the protocol for administering medication through a g-tube, "Flush the tube, check for placement." When asked had she done that indicated, "No, but the order says only to verify placement if feeding has been interrupted."</p> <p>On 3/17/14 at 3:15 p.m. the DoN provided a current copy of their policy titled, "Enteral Medication Administration Clinical Performance Evaluation Checklist" dated June of 2007. Review of the policy indicated, "Verify tube placement: Insert a small amount of air into the tube and listen to stomach with stethoscope for gurgling sound or aspirate stomach contents with syringe."</p> <p>3.1-35(g)(1)</p>		<p>Current residents with gastrostomy tubes were assessed with no findings.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>On March 19, 2014 licensed nursing staff were re-in-serviced on facility protocol regarding Enteral Medication Administration Policy and Procedures. March 19 thru March 21 the DON or ADON observed a return demonstration with each nurse to ensure understanding and competency. Monitoring of enteral medication administration will be ongoing through the scheduled Medication Administration Quality Assurance program. Enteral Medication Administration will be reviewed with licensed nurses during new hire orientation and with annual nursing competency assessment.</p> <p>Monitoring of corrective action:</p> <p>The Director of Nursing and/or designee will monitor to ensure adherence to the protocol for Enteral Medication Administration. The DON or designee will monitor enteral medication administration 5 times weekly for 2 weeks, 3 times weekly for one month, weekly times one month, then ongoing twice a month as part of the facility Medication Administration Quality</p>	
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			<p>Assurance program. The result of this monitoring will be reviewed by the Health Facility Administrator, reported and reviewed by the interdisciplinary team monthly and reported through the Quality Assurance Committee quarterly for further review and recommendations.</p> <p>Plan of Correction date: 4/4/14</p>	

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F000362 SS=E	<p>483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL</p> <p>The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient support staff to ensure provided meal service at the at the posted meal times in the dinning room. This affected 47 out of 74 residents (Residents #14, #70, #102)</p> <p>Findings include:</p> <p>On 3/10/2014 at 12:00 p.m. in the main dinning room 47 residents where sitting at the dinning tables being served drinks and waiting for lunch to be served. The lunch meal is scheduled to be served at 12:00 p.m. The first resident received a lunch tray at 12:40 p.m.</p> <p>Observation of Resident #102 on 3/10/2014 at 12:34 p.m., indicated he was self propelling himself out of the dining room. A conversation between Resident #14 and Resident #102 indicated Resident #102 was leaving the dining room, because he was tired of waiting on lunch.</p> <p>Observation of dining room on</p>	F000362	<p>F 362: Sufficient Dietary Support Personnel Corrective action for affected resident: Residents #14, #70 and #102 were provided meals for lunch on March 10, 2014. Identification of others at risk: Residents received a lunch meal on March 10, 2014 with no findings observed. Measures to ensure this deficient practice does not recur: On March 17, 2014 dietary staff and nursing staff were re-in-serviced as to timely meal delivery and staff participation in assuring timely dining service. Upon review of the weekly food council meeting minutes no issues with timely delivery of meals have been noted. Monitoring measures are in place to ensure timely delivery of meals. Meal times are posted and staff education provided during new hire orientation regarding meal service.</p> <p>Monitoring of corrective action: The Director of Food Services and/or designee monitors and assists with ensuring that timely meal service is maintained. Monitoring of sufficient dietary and nursing staff available to perform timely meal service will include random monitoring of breakfast, lunch and dinner,</p>	04/04/2014
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	<p>3/10/2014 at 1:01 p.m., indicated there were still 5 residents who did not have trays and were sitting at tables with people who did have food or were being fed.</p> <p>Observation of the dining room on 3/10/2014 at 1:15 p.m., indicated Resident #70 received his tray at 1:15 p.m. A random observation of a Resident in a Geri chair indicated she was just now being fed. The last tray was served from the dining room at 1:15 p.m.</p> <p>Interview on 3/10/2014 at 12:24 p.m., with Resident #14 indicated that a lot of meals are being served very late. At that time, he indicated sometimes its as much as an 1 1/2 hour late. They (staff) are outside smoking instead of serving meals.</p> <p>Interview with Resident #70 on 3/10/2014 at 1:09 p.m., indicated he wanted to know when he was going to get his lunch. He indicated he has been waiting over an hour for lunch.</p> <p>Interview with ADM on 3/10/14 at 1:15 p.m., indicated the frozen chicken had not be pulled to thaw in time to be pan cooked. The facility went to the local store, got more fresh chicken, and that is why lunch was</p>		<p>weekdays and weekends. Monitoring will occur 5 times weekly for 2 weeks, 3 times weekly times one month, weekly times 4 weeks, then monthly times 3 months. The results of this monitoring will be reviewed by the Health Facility Administrator, and reported to and reviewed by the interdisciplinary team. Results of this monitor will be reviewed by the Quality Assurance Committee quarterly for further recommendations. Plan of Correction date: 4/4/14</p>		

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	<p>late.</p> <p>Record review on 3/12/14 at 3:45 p.m., of receipt for chicken purchased at the local food store indicated \$34.38 for chicken on 3/10/2014 at 10:26 a.m.</p> <p>3.1-20(h)</p>			
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F000371 SS=D	<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 employee's personal items were not stored in the kitchen and dry storage area.</p> <p>Findings include:</p> <p>Observation on 3/10/14 at 11:00 a.m., indicated there were 2 purses, one coat and a pair of gloves in the dry storage area on a shelf where dry cereal is stored.</p> <p>Observation on 3/13/14 at 5:45 a.m., indicated there was a coat and a purse in the dry storage area on a shelf where cereal is stored.</p> <p>Observation on 3/17/14 at 8:20 a.m., indicated there was a coat and a purse in the dry storage area on a shelf where the dry cereal is stored and a coat and a phone with a charger where bread is stored. When this was brought to the dietary manager's attention, he indicated,</p>	F000371	<p>F 371: Food Procure, Store/Prepare/Serve Sanitary</p> <p>Corrective action for affected resident:</p> <p>No residents were identified as affected. On March 17, 2014 all personal items identified were removed from the dry storage area. On March 17, 2014 the dietary staff were in-serviced as to the requirement of no personal items are to be present in the dry storage area.</p> <p>Identification of others at risk:</p> <p>March 17, 2014 staff education was provided, and dry storage area observation completed, to ensure storage conditions with no personal items in the dry storage area, thus no residents were at risk.</p> <p>Measures to ensure this deficient practice does not recur:</p>	04/04/2014			

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	<p>"Yes, we have told them that. We are working on it."</p> <p>On 3/18/14 at 9:28 a.m., the Administrator provided the "Dry Storage Area" policy, dated 2/5/12. The policy indicated, "...C. Shelves are kept clean."</p> <p>Review of the "Retail Food Establishment Sanitation Requirement Manual" on 3/18/14 at 12:07 p.m., indicated "...Food Storage; prohibited areas, Sec. 178. (a) Food may not be stored as follows: (1) In the following: (A) Locker rooms ... (C) Dressing rooms ...(E) Mechanical rooms, when contamination is likely to occur (2) Under the following ...(D) Other sources of contamination."</p> <p>3.1-21(i)(3)</p>		<p>Dietary staff were re-in-serviced on facility protocol regarding personal items not being stored in the dietary dry storage area. Dietary Staff orientation and annual education will include proper storage of food items and appropriate storage of personal items.</p> <p>Monitoring of corrective action:</p> <p>The Director of Food Services and/or designee will monitor to ensure no personal items are kept in the kitchen or dry storage area. Monitoring will occur 5 times weekly for two weeks, 3 times weekly times four weeks, weekly times four weeks, and continue monthly as part of the Dietary Quality Assurance process. The results of this monitoring will be reviewed by the Health Facility Administrator, reported and reviewed by the interdisciplinary team and Quality Assurance Committee for further review and recommendations.</p> <p>Plan of Correction date: 4/4/14</p>	
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F000431 SS=D	<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, 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>A. Based on observation, interview, and record review the facility failed to ensure that excess medication in a single dose vial which was no longer</p>	F000431	<p>F 431: Proper Drug storage, Labeling, Security of Medications</p> <p>Corrective action for affected</p>	04/04/2014	

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	<p>needed was removed from the medication cart and discarded properly according to current facility policy. (Resident #119) (LPN #2/Unit Clerk)</p> <p>B. Based on observation, interview, and record review, the facility failed to accurately reconcile and account for all controlled medications according to current facility policy in 1 out of 4 medication carts. (Resident #2, Resident #11, Resident #54, Resident #73, Resident #78, Resident #104) (LPN #3) (Cart 200 hall)</p> <p>C. Based on observation, interview, and record review the facility failed to ensure that all expired medication was discarded according to current facility policy.</p> <p>Findings include:</p> <p>A. Resident #119's clinical record was reviewed on 3/14/14. Diagnoses include but not limited to hypertension, diabetes, and anxiety.</p> <p>The current MDS (minimum data set) assessment dated 2/12/14 indicated a BIMS score (brief interview mental status) of 14, when 8-15 is interviewable.</p>		<p>resident:</p> <p>Residents #2, #11, #54, #73, #78, #104 and #119 were assessed with no findings. On March 14, 2014, Nurse #3 received education regarding documenting narcotic sign out at the time of medication administration. Controlled medications are accounted for.</p> <p>The remaining Depo Testosteronemedication and vial were disposed of. The one time use vial information was noted on the MAR to promote ongoing nursing staff communication.</p> <p>On March 18, 2014, medication storage areas were checked by a representative of Omnicare Pharmacy and/or facility nursing staff to assure disposal of expired medications.</p> <p>Identification of others at risk:</p> <p>The Director of Nurses and Assistant Director of Nurses checked Medication Administration Records, narcotic sign out sheets, and medication carts/storage areas with no findings.</p> <p>Measures to ensure this deficient</p>		

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	<p>On 3/14/14 at 10:00 a.m., during observation of the 400 hall medication cart Resident #119's Depo-Testosterone (hormonal) 200 mg/ml injection 0.2 ml IM (intramuscular) every other week without any markings that indicated the amount of medication inside of the vial. The dispense date was 2/24/14. The narcotic book indicated 0.8 ml were left in the vial after removing 0.2 ml on 3/9/14. Interview with LPN #2/Unit Clerk when asked how do you know how much medication was left in the vial in order to accurately document on the narcotic sheet indicated, "I don't know the answer. I guess they subtract from what was previously written. I don't pass meds [medication]." LPN #2/Unit Clerk was observed to call the Pharmacist at that time. LPN #2/Unit Clerk indicated, "The medication should have been wasted after the first dose was given, because it was a single use vial." Obtained Pharmacist contact information from LPN #2/Unit/Clerk.</p> <p>The physician's order on the current MAR (Medication Administration Record) dated 3/2014 indicated "Testosterone 200mg/ml *Give 0.2ml IM q (every) 2 wks -supplement"</p>		<p>practice does not recur:</p> <p>On March 18, 2014, medications were rechecked for expiration dates, proper disposal, and documentation of dosing on the narcotic count sheet. March 20 through 21, nursing staff education was provided regarding proper medication disposal and documentation. Documentation of descending narcotic count after administration and medication storage and disposal are reviewed during licensed nursing staff orientation with ongoing monthly monitoring and education through the facility Quality Assurance program.</p> <p>Monitoring of corrective action:</p> <p>The Director of Nursing and/or designee monitors to ensure proper documentation, labeling, storage, and disposal of expired and controlled substance medications. Monitoring to ensure proper narcotic documentation, labeling, storage and disposal of medications will occur 3 times weekly for 2 weeks, 2 times weekly for one month, then ongoing monthly as part of Medication Administration and Storage Quality Assurance process. The result of this monitoring will be reviewed by the Health Facility Administrator, interdisciplinary team and reported</p>		

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	<p>On 3/14/14 at 1:1:43 p.m., received Policy " ... General Dose Preparation and Medication Administration" from the DON with a Revision date of 01/01/13 indicated, "... 6.2 Dispose of unused medication portions in accordance with Facility policy; ... "</p> <p>On 3/16/14 at 4:30 p.m., spoke with a Pharmacist at 800-772-7096 option #1 who indicated, "Depo Testosterone 200 mg/ml vial is intended to be a single use vial due to the amount of medication in the vial."</p> <p>B. On 3/14/14 at 10:40 a.m., observation of medication carts with the DON (Director of Nursing) of the 200 Hall indicated the following narcotics reconciliation sheets did not match:</p> <p>Resident #11's hydrocodone-app 7.5/325 mg give orally 2 time a day. The count indicated 31 pills, but the control substance sheet indicated 32 pills.</p> <p>Resident #104's hydrocodone-apa 5-325 mg give 1 tablet 2 times a day and 1 tablet every 4 hours for pain. The count indicated 58 pills, but the control sheet indicated 59 pills.</p>		<p>to the Quality Assurance Committee for further review and recommendations monthly.</p> <p>Plan of Correction date: 4/4/14</p>	

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	<p>Resident #54's hydrocodone-apa 10-325 mg give 1 tablet orally 2 times a day 9 AM/9 PM. Give 1 tablet orally every 6 hours as needed for pain. The count indicated 20 pills, but the control sheet indicated 21 pills.</p> <p>Resident #2's diazepam 2 mg give 1 tablet orally every morning. Give 2 tablets at bedtime. The count indicated 85 pills, but the control sheet indicated 86 pills.</p> <p>Resident #73's Lyrica 25 mg give 1 capsule orally 2 times a day. The count indicated 29 pills, but the control sheet indicated 30 pills, modafinil 200 mg tablets give 1 tablet orally every morning. The count indicated 2 pills but the control sheet indicated 3 pills.</p> <p>Resident #78's hydrocodone 7.5-325 mg give 1 tablet orally 4 times a day. The count indicated 71 pills, but the control sheet indicated 72 pills</p> <p>On 3/14/14 at 11:00 a.m., interview with LPN #3 indicated "Oh I guess I didn't sign out any of my 9:00 narc's [narcotics]."</p> <p>On 3/14/14 at 1:ppm., received Policy</p>			

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	<p>" ... General Dose Preparation and Medication Administration" from the DON (Director of Nursing) the Revision date 01/01/13. "...5. During medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: ... 5.5 Document the administration of controlled substances in accordance with Applicable Law; ... 6.1 Document necessary medication administration ... (... when medications are opened, when medications are given) on appropriate forms;..."</p> <p>C. On 3/14/14 at 11:40 a.m., observation with the DON (Director of Nursing) of the medication storage room for the 300 and 400 hall indicated latanoprost (treatment for glaucoma) eye drops was observed to be in the medication refrigerator with an expiration date of 2/25/14. The snack room on for the 100 and 200 hall indicated 2 cartons of boost (nutritional drink) expired on 3/8/14. There were several over the counter facility medications with February expiration dates. Interview with the DON indicated, "We don't even have anyone on boost at this time and we just got these medications in [the over the counter]."</p>						

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	<p>On 3/14/14 at 1:36 p.m., received Policy "... Disposal/Destruction of Expired or Discontinued Medication" from the DON the revision dated 01/01/13. "... This Policy 8.2 sets forth procedures relating to medication disposal and destruction. ...1. Facility staff should destroy and dispose of medications in accordance with Facility policy and Applicable Law, and applicable environmental regulations. ... 4. Facility should place all discontinues or out-dated medications in a designated, secure location whish is solely for discontinued medications, ..."</p> <p>3.1-25(n) 3.1-25(o)</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 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>1. Based on observation, interview, and record review, the facility failed to</p>	F000441	F 441: Hand washing and glove use Corrective action for	04/04/2014
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	<p>ensure infection control practices were followed related to hand washing while administering a residents injection and cleaning the glucometer after resident use as indicated by the facility policy. This deficient practice had to potential to affect 1 randomly observed resident during medication administration. (Resident #22) (RN #3)</p> <p>2. Based on observation, interview, and record review, the facility failed to ensure infection control standards were used related to handwashing by facility staff in that staff was observed not to wash their hands before entering and leaving a randomly observed isolation room. (LPN #1).</p> <p>Findings include:</p> <p>1. On 3/13/14 at 6:10 a.m., Observed RN #3 enter Resident #22's room to administer medication. No handwashing observed. RN #3 was observed to put on gloves and check Resident #22's blood sugar, via finger stick. RN #3 left out the room to retrieve insulin. No handwashing observed nor cleansing of the glucometer. RN #3 entered the room, no handwashing observed, put on gloves, and gave Resident #22 an insulin injection. RN #3 indicated</p>		<p>affected resident: Residents #22 and #127 were assessed with no findings. RN# 3 and LPN # 1 were educated on proper hand hygiene. Identification of others at risk: Current residents were observed with no findings. On March 18, 2014, Hand Hygiene education and monitoring of hand washing and glove use was implemented with no findings. Measures to ensure this deficient practice does not recur: Staff were re in-serviced from March 18 through March 21, 2014, on proper hand washing and glove procedures. Starting on March 18, the DON or ADON provided education with return demonstrations preformed by staff and observed resident care procedures and work tasks, observing each step to ensure proper hand washing/ hand hygiene and glove usage. Staff were encouraged to ask questions during the return demonstrations to ensure that the policy was understood completely. Monitoring of corrective action: The Director of Nursing and/or designee monitors to ensure hand hygiene practices comply with the facility protocol for hand hygiene, hand washing, and glove use. Monitoring of hand hygiene, hand washing and glove use will nclude random monitoring on each shift, weekdays and weekends. Monitoring will occur</p>		

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	<p>when asked when should you handwash or use sanitizer, "When you enter a room, after you put on gloves, whenever you touch something." Did you do that? "No."</p> <p>When asked what should be done after using the glucometer. "Clean it." Was that done. "No." RN #3 was then observed to clean the glucometer.</p>		<p>3 times weekly for 2 weeks, 2 times weekly for one month, weekly times one month, then monthly for one year. Results of this monitoring will be reviewed by the Health Facility Administrator, interdisciplinary team and reported to the Quality Assurance Committee for further review and recommendations monthly. Plan of Correction date: 4/4/14</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 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>2. Observation on 3/10/14 at 10:00</p>	F000441	F 441: Hand washing and glove use Corrective action for	04/04/2014	

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	<p>a.m., indicated LPN #1 walked in Resident #127's room, which was an isolation room for MRSA (Methicillin-resistant Staphylococcus aureus), and was not observed to wash his hands. LPN #1 then went to an Intravenous therapy (IV) pump, beside the resident's bed and turned the IV off. He then walked out of the room and was observed not to wash his hands. When asked what the sign on the door meant, LPN #1 indicated, "The resident is on isolation for MRSA. He has a wound on his back."</p> <p>On 3/10/14 at 11:31 a.m., the Administration provided the "Isolation Precautions" policy, undated, and indicated the policy was the one currently used by the facility. The policy indicated, "Policy for Isolation Precautions. It is the policy of this facility to, when necessary, prevent the transmission of infections within the facility through the use of Isolation Precautions ...Standard Precautions consist of group of infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status ...These include hand hygiene; use of glove, gown, mask ...The transmission-based categories are the following: ...contact ...Procedure</p>		<p>affected resident: Residents #22 and #127 were assessed with no findings. RN# 3 and LPN # 1 were educated on proper hand hygiene. Identification of others at risk: Current residents were observed with no findings. On March 18, 2014, Hand Hygiene education and monitoring of hand washing and glove use was implemented with no findings. Measures to ensure this deficient practice does not recur: Staff were re in-serviced from March 18 through March 21, 2014, on proper hand washing and glove procedures. Starting on March 18, the DON or ADON provided education with return demonstrations performed by staff and observed resident care procedures and work tasks, observing each step to ensure proper hand washing/ hand hygiene and glove usage. Staff were encouraged to ask questions during the return demonstrations to ensure that the policy was understood completely. Monitoring of corrective action: The Director of Nursing and/or designee monitors to ensure hand hygiene practices comply with the facility protocol for hand hygiene, hand washing, and glove use. Monitoring of hand hygiene, hand washing and glove use will include random monitoring on each shift, weekdays and weekends. Monitoring will occur</p>				

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	<p>for Isolation: Initiation of Isolation Precautions ...A ...Use Standard Precautions when giving care for all residents regardless of diagnoses or presumed infection status. This includes barrier protections for healthcare workers such as gloves, gowns, masks, and goggles ...3. Contact Precautions: In addition to Standard Precautions, use contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items ...Points to remember: Handwashing (hand hygiene) is the single most important precaution to prevent transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belongings and equipment. Alcohol-based hand rub may be used if hands are not visibly soiled ...Contact Precautions ...Wear clean gloves when entering the resident ' s room or unit ...remove gown carefully before leaving the room and wash hands ...wash hands immediately with soap and water or alcohol-based rub ..."</p>		<p>3 times weekly for 2 weeks, 2 times weekly for one month, weekly times one month, then monthly for one year. Results of this monitoring will be reviewed by the Health Facility Administrator, interdisciplinary team and reported to the Quality Assurance Committee for further review and recommendations monthly. Plan of Correction date: 4/4/14</p>	

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure that a sanitary environment was provided for all residents as evidenced by dead bugs in the lighting fixtures on the 400 hall. This had the potential to effect 8 out of 8 residents who had rooms on the 400 hall. (Room 401, Room 402, Room 403, Room 404, Room 405, Room 406, Room 407, and Room 408)</p> <p>Findings include:</p> <p>On 3/12/14 at 3:30 p.m., the two ceiling lights by room 408 were observed to have dead bugs in it.</p> <p>On 3/13/14 at 3:00 a.m., interview with the ADM (Administrator) when asked who is responsible for cleaning the hallways indicated, "Maintenance and housekeeping. Housekeeping does the floors weekly and maintenance follows with the big floor machine." Who does the lighting? "Maintenance checks and cleans the lights every Friday."</p> <p>On 3/14/14 at 7:45 a.m., during the</p>	F000465	<p>F 465: Safe, Functional, Sanitary and Comfortable Environment</p> <p>Corrective action for affected resident:</p> <p>Residents in rooms 401, 402, 403, 404, 405, 406, 407 and 408 were observed with no findings.</p> <p>This facility strives to ensure provision of a safe, comfortable, sanitary and homelike environment. On March 12, 2014, the Maintenance Assistant cleaned and then re-checked all other light fixtures to assure their cleanliness. The facility maintenance staff were re-educated to assure light fixtures are free from any dust or other debris weekly during lighting rounds as per facility policy.</p> <p>Identification of others at risk:</p> <p>The light fixture was cleaned and other light fixtures checked with no findings of debris requiring cleaning and no residents were at risk.</p> <p>Measures to ensure this deficient practice does not</p>	04/04/2014
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	<p>environmental tour with the ADM and Maintenance assistant, the ADM indicated that maintenance changed light bulbs and cleaned lighting on a weekly schedule. The ADM indicated when asked what was in the light fixture above her head on the 400 hall, "Well it looks like those little beetles." The Maintenance Assistant was told to clean the light fixture at that time.</p> <p>3.1-19(f)(5)</p>		<p>recur:</p> <p>Environmental and maintenance staff werere-inserviced as to facility protocol on weekly lighting rounds and cleanliness of light fixtures. Resident room and Housekeeping Quality Assurance rounding checks were reviewed with the environmental and maintenance staff to ensure understanding of the process. On March 14, 2014, weekly lighting rounds monitoring was completed which includes ensuring cleanliness of corridor lighting fixtures. Maintenance staff will be oriented upon hire regarding weekly rounds and the Administrator will review to assure logs are completed and accurate.</p> <p>Monitoring of corrective action:</p> <p>The Maintenance Director and/or designee monitors and assists with ensuring the facility maintains a clean, safe, sanitary and homelike atmosphere. Monitoring will occur 3 times weekly for 2 weeks, 2 times weekly for one month, then monthly for one year. Results of this monitoring will be reviewed by the Health Facility Administrator, interdisciplinary team and reported to the Quality Assurance Committee for further review and recommendations monthly.</p>	
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