

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 23, 24, 25, 26, and 27, 2015.</p> <p>Facility number: 000116 Provider number: 155209 AIM number: 100266330</p> <p>Survey team: Gloria J. Reisert, MSW/TC Jenny Sartell, RN Trudy Lytle, RN Joshua Emily, RN</p> <p>Census bed type: SNF/NF: 94 Total: 94</p> <p>Census payor type: Medicare: 21 Medicaid: 53 Other: 20 Total: 94</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on April 2,</p>	F 000	<p>Based on the scope and severity of the findings on our annual survey dated 3/27/2015, the facility would like to respectfully request a desk review. We will be happy to submit any requested documentation to support the implementation of our plan of correction. Thank you in advance for your consideration.</p>	
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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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F 157 SS=D Bldg. 00	<p>2015, by Debra Holmes, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of</p>			

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	<p>the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to immediately notify the physician when a resident experienced a sudden decline in condition. This deficient practice affected 1 of 3 residents reviewed for physician notification. (Resident #154).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #154 on 3/25/15 at 10:00 a.m., indicated the resident was admitted from the hospital on 1/27/15 and subsequently passed away on 2/5/15 in the facility. Diagnoses included, but were not limited to, hepatic encephalopathy, ascites, edema, and cirrhosis.</p> <p>Nursing notes for 2/5/15 included the following entries:</p> <p>- "3:12 a.m. - Called to resident's room as resident was non-responsive and pupils fixed and dilated; o2 Sat (oxygen level in the blood) 89-90% fluctuating; upper and lower extrem (extremities) flaccid, sm (small) bleeding noted from nose and mouth. Lung sounds with coarse rales bilat. (bilaterally) 106/90 - 82 - Resp (Respirations) 24 and labored using accessory muscles for breathing." Family notified regarding current</p>	F 157	<ol style="list-style-type: none"> 1. Resident #154 is no longer a current resident. 2. An audit of 100% of residents charts with a current change of condition have been audited and all notifications have been made appropriately. 3. Nursing staff will be educated on the policies and procedures related to notification of the physician regarding a change of condition, criteria of a "change of condition" and the use of an SBAR by the DON and/or designee by 4/24/2015. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate. The IDT will utilize the 24 hour shift report and daily CQI process to ensure timely physician notification and appropriate follow during a change of condition. 4. The Director of Nursing and/or the designee will audit 3 charts of residents with a change of condition per week for 3 weeks then 2 charts per week for 2 weeks. Any negative findings discovered as the monitoring takes place will be addressed when found. The DON will bring results to the monthly QA meeting to determine need for ongoing auditing. The daily CQI 	04/25/2015

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	<p>condition.</p> <p>- "3:24 a.m. - Res unresponsive to verbal or tactile stimulus (touch stimulation), skin w/d (warm and dry) sm amt (amount) of blood noted from nose and mouth. Upper and lower extrem flaccid. Resp 24 and labored, Lung sounds coarse rales noted. Exhibiting s/s (signs/symptoms) dyspnea. Family aware."</p> <p>- "8:15 a.m. - Pt (Patient) with shallow respiration. o2 -sat 84% ORA (on room air). MD(physician) notified. N.O.(New Order) for o2 @ (at) 2L (liters) per n/c (nasal cannula). Family notified." This notification to the physician was 5 hours after the resident was found with the significant change in condition.</p> <p>In an interview with LPN #4 (Licensed Practical Nurse) on 3/26/15 at 11:40 a.m., she indicated, "I would immediately call 911 to send the resident out to the nearest hospital as that is a significant change in condition. I would then call the MD and family to let them know the resident was on their way to the hospital due to the change."</p> <p>In an interview with LPN #3 at 11:45 a.m. on 3/26/15, she indicated, "I would be calling 911 to send that resident out.</p>		<p>process will be ongoing followup to all changes of condition to see that timely notifications were made.</p> <p>5. The completion date is 4/25/2015.</p>				

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	<p>There are some serious issues going on with that resident. After calling 911, then the Physician would be called, along with the family, telling them that I just sent the resident out to the hospital."</p> <p>On 3/25/15 at 2:15 p.m., the Administrator presented a copy of the facility current policy titled, "Physician Notification of Resident Change in Condition". Review of this policy included, but was not limited to: "Guideline: It is the intent of the facility for the attending physician to be notified of a change in a resident's condition by licensed personnel as warranted...Procedure:1. Physician notification is to include but is not limited to:...Significant change in/or unstable vital signs...Change in level of consciousness...2. Make an entry into Nurse's notes regarding condition/physician notification and change in physician's orders."</p> <p>3.1-5(a)(2)</p>			

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F 309 SS=D Bldg. 00	<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 record review and interview, the facility failed to assess for causative factors when a resident had a sudden, significant decline in physical condition and failed to provide necessary services and ongoing monitoring to ensure resident comfort. This deficient practice affected 1 of 3 residents reviewed for death(Resident #154).</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #154 on 3/25/15 at 10:00 a.m., indicated the resident was admitted from the hospital on 1/27/15 and subsequently passed away on 2/5/15 in the facility. Diagnoses included, but were not limited to: hepatic encephalopathy, ascites, edema, and cirrhosis.</p> <p>Nurses Notes for 2/5/15 indicated the following entries:</p>	F 309	<ol style="list-style-type: none"> Resident #154 is no longer a current resident. An audit of 100% of residents with current change of conditions has been completed to ensure appropriate and timely assessments. No negative findings have been found. Nursing staff will be educated on the Resident Assessment policies and procedures and resident/family wishes as well as the SBAR and PCC assessments and tools. The inservice will be completed by the DON and/or designee by 4/24/2015. Any staff who fail to follow the points of the inservice will be further educated and/or progressively disciplined as appropriate. The IDT team will review the 24 hour shift report and CQI follow up will include review of assessments related to changes in condition. The Director of Nursing 	04/25/2015

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	<p>- "3:12 a.m. - Called to resident's room as resident was non-responsive and pupils fixed and dilated; o2 Sat (oxygen level in the blood) 89-90% fluctuating; upper and lower extrem (extremities) flaccid, sm (small) bleeding noted from nose and mouth. Lung sounds with coarse rales bilat. (bilaterally) 106/90 - 82 - Resp (Respirations) 24 and labored using accessory muscles for breathing." Family notified regarding current condition.</p> <p>- "3:24 a.m. - Res unresponsive to verbal or tactile stimulus (touch sensation), skin w/d (warm and dry) sm amt (amount) of blood noted from nose and mouth. Upper and lower extrem flaccid. Resp 24 and labored, Lung sounds coarse rales noted. Exhibiting s/s (signs/symptoms) dyspnea. Family aware."</p> <p>- "8:15 a.m. - Pt with shallow respiration. o2 -sat 84% ORA (on room air). MD (physician) notified. N.O. (new order) for o2 @ 2L (Liters) per n/c (nasal cannula). Family notified." This entry was made 5 hours after the the resident was found to be unresponsive and before the physician was notified and an order for O2 was then obtained. No additional assessments of the resident's condition were recorded between entries.</p>		<p>and/or designee will audit 3 changes of condition per week for 3 weeks then 2 changes of condition per week for 2 weeks to ensure all assessments are completed appropriately. Any negative findings will be addressed at that time. The Director of Nursing will report all findings to the QAA committee monthly and the committee will determine need for further followup.</p> <p>5. The completion date is 4/25/2015.</p>				

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	<p>- "8:41 a.m. - Res noted with shallow respirations, using accessory muscles. SpO2 84% on RA (room air). Oxygen applied per nurse per order. Eyes open, not responsive to verbal stimuli. Call placed to family. Spoke with family regarding plans for care. Both agree resident is not to be sent out to the hospital at this time and would prefer for him to remain at facility and be kept comfortable as possible. Call placed to Physician. New order received for Roxinal (for pain) 20mg/ml (milligrams/milliliters) - give 0.25 ml every hour PRN (as needed) for mild pain or SOA, give 0.5 ml PRN every hour for severe pain or SOA (shortness of air)...Will continue to observe for increased pain or SOA".</p> <p>- "12:08 p.m. - Resp 26/min (minute) using accessory muscles. Oxygen on per order. Turned and repositioned every 2 hours and PRN." This entry was made 4 hours later with no additional assessments of the resident's condition recorded between entries.</p> <p>- "17:00 (5:00 p.m.) - Pt (patient) reported to have passed away. Checked apical pulse and no HB (heartbeat). Family notified." This entry was made 5 hours later with no additional assessments of the resident's condition</p>			

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	<p>were recorded between entries.</p> <p>In an interview with LPN #4 (Licensed Practical Nurse) on 3/26/15 at 11:40 a.m., she indicated, "While calling 911 immediately, we would try to do as much of an assessment of the resident while waiting to send the resident out to the nearest hospital as that is a significant change in condition and the resident needed to go out. You need to also try to figure out where that bleeding was coming from to try to prevent it from getting worse."</p> <p>In an interview with LPN #3 on 3/26/15 at 11:45 a.m., she indicated, "The resident has some serious issues going on that need to be assessed as quickly as possible before the ambulance gets there. The hospital needs as much information as they can get in order to treat him properly."</p> <p>LPN #4 and LPN #3 also indicated that if for some reason the family did not want the resident sent to the hospital, then there should be frequent assessments of the condition, especially since there was noted bleeding from the nose and mouth.</p> <p>The 2/3/15 5-day Minimum Data Set Assessment indicated the resident did not have a chronic disease/condition that</p>			

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F 315 SS=D Bldg. 00	<p>might result in life expectancy of less than 6 months. No physician order for comfort measures other than a "Do Not Resuscitate" order could be located.</p> <p>During the final exit meeting with the Department heads on 3/17/15 at 3:15 p.m., the Administrator indicated that she thought the reason the resident was not sent to the hospital was because he was supposed to be "Comfort Measures Only" when the resident returned for this last Nursing Home Stay.</p> <p>3.1-37(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to provide appropriate incontinent care for 1 of 3 resident's reviewed for urinary incontinence. (Resident #53)</p>	F 315	<p>1. Resident #53 is no longer a resident at the facility.</p> <p>2. Residents who require incontinence/peri care have the</p>	04/25/2015

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	<p>Finding includes:</p> <p>The Clinical Record for Resident #53 was reviewed on 3/25/15 at 10:05 a.m. Diagnoses include, but were not limited to, dementia and urinary tract infection. The Minimum Data Set (MDS), dated 1/16/15, indicated Resident #53 was an extensive assist of 2 staff with toileting and always incontinent.</p> <p>During incontinent care on 3/25/15 at 10:26 a.m., the following was observed:</p> <p>CNA (Certified Nursing Assistant) #2 entered Resident #53's room with 2 wash cloths and 1 towel to provide incontinent care. CNA #2 entered the bathroom and wet both wash cloths. CNA #2 draped the first wash cloth on her left hand and, using her right hand, sprayed the wash cloth with peri wash. Using different areas of the wash cloth, CNA #2 washed the left and right creases of the peri area in a downward motion. CNA #2 then washed the left side, right side and center of labia using a down ward motion and placed the soilded wash cloth in a bag. Using the second wash cloth, CNA #2 rinsed the peri area and placed it in the same bag. Using the towel, CNA #2 patted the peri area dry. CNA #2 rolled Resident #53 to the resident's left side to</p>		<p>potential to be affected by this finding. The DON and/or designee will monitor 5 residents weekly for 2 weeks then 3 residents weekly for 2 weeks as these residents receive peri care. This monitoring will take place on various shifts. Any concerns with technique including all aspects of proper and appropriate handwashing policy requirements, will be corrected prior to a contamination taking place. Afterwards, random weekly monitoring will continue ongoing as part of the ongoing Quality Assurance.</p> <p>3. All nursing staff were educated and mock procedure completed during inservice using the Perineal Care procedure from the CNA state training manual by the Nursing Administration by 4/24/2015. Any staff who fail to comply with the points of inservice will be further educated and/or progressively disciplined as appropriate.</p> <p>4. Results of the monitoring will be reviewed at the monthly QA meeting to ensure that any patterns of concerns have been identified and addressed. Any need for further education will be identified and implemented.</p> <p>5. The completion date is 4/25/2015.</p>	

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	<p>provide incontinent care. CNA #2 reached in the bag and retrieved one of the soiled wash cloths, draped it across her left hand and sprayed it with peri wash. CNA #2 cleansed the perineal area and in between both buttocks outward. CNA #2 then flipped the wash cloth and cleaned the left and right buttocks. CNA #2 placed the wash cloth back into the bag and retrieved the other wash cloth and rinsed the perineal area, left buttock and right buttock. CNA #2 placed the wash cloth back in the bag, and using the same towel, patted the perineal area and the left and right buttocks dry.</p> <p>During an interview with CNA #2 on 3/27/15 at 10:10 a.m., she indicated she had provided incontinent care that way before while being observed and no one ever said anything to her about it.</p> <p>The procedure for Perineal Care was provided by the Administrator on 3/25/15 at 2:15 p.m. and indicated as current. It included, but was not limited to, the following: "Procedure #33: Bed Bath/Perineal Care...Perineal Care: Step 21. Wet and soap folded washcloth. Step 23. Wipe from front to back and from center of perineum to thighs. If washcloth is visibly soiled, change cloths. For Females: Separate labia. Wash urethral area first. Wash between and outside</p>			

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F 329 SS=D Bldg. 00	<p>labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke. 24. ...Wash hands and change gloves. With a clean washcloth, rinse area thoroughly in the same direction as when washing. 26. Assist resident to lateral position, away from you. 27. Wet and soap washcloth. 28 Clean anal area front to back. Rinse and pat dry thoroughly...."</p> <p>3.1-41(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic</p>			

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	<p>drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to follow a pharmacy recommendation for a gradual dose reduction on Klonopin (anti-convulsant) for 1 of 6 resident's reviewed for unnecessary medications. (Resident #69)</p> <p>Finding includes:</p> <p>The Clinical Record for Resident #69 was reviewed on 3/27/15 at 8:30 a.m. Diagnosis included, but was not limited to, anxiety. The Minimum Data Set, dated 1/16/2015, indicated Resident #69 had behavioral symptoms not directed towards others 1-3 days.</p> <p>The March, 2015 Medication Administration Record (MAR) indicated Resident #69 was receiving Clonazepam (generic for Klonopin) 0.5 mg twice daily.</p> <p>Review of the document titled, "Note To Attending Physician/Prescriber ", included, but was not limited to, the following: "[Resident Name]...This</p>	F 329	<ol style="list-style-type: none"> 1. Resident #69 GDR request was readdressed by the Physician on 4/13/2015. Care plan reviewed to reflect the resident's needs. 2. All behavior logs and 24 hour shift report were reviewed in April. All GDR requests were audited and addressed and no residents with negative outcomes. 3. Behavior meeting to be held April 13, 2015 with psych ARNP in attendance. The IDT team will review all residents with new and known behaviors, review behavior logs, PCC 72 hour shift report, and current medications. Residents with new behaviors will be assessed and care planned and added to the appropriate logs and monitoring tools. All residents with a quarterly assessment due the month of the behavior monitoring meeting will be assessed for a possibility of a GDR whenever possible. The request for GDRs will be followed up at these monthly meetings to ensure accurate documentation and physician followup. Social Services 	04/25/2015

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	<p>patient is currently taking the following medications:...Klonopin 0.5 mg [milligrams] BID [twice daily]. Please consider a gradual dose reduction, if a reduction is not appropriate at this time, please ensure the chart contains the proper documentation to indicate that a GDR [gradual dose reduction] is contraindicated...Physician/Prescriber Response...Disagree [checked]...ongoing chronic mental illness..." The document was undated and printed on 2/4/15 with physician signature on 2/7/15.</p> <p>Review of the Behavior/Intervention Monthly Flow Record for November, 2014, December, 2014, January, 2015 and February, 2015 indicated Resident #69 had no behaviors.</p> <p>Review of the Nurses Notes from November 2014 through February 2015 indicated Resident #69 had behaviors 8/120 days.</p> <p>During an interview with the Social Services Director on 3/27/15 at 11:10 a.m., when asked why a GDR was not done, she indicated Resident #69 had behaviors. She indicated she goes through the nurses' shift report sheets which lets her know who has had behaviors. She indicated the nurses were not documenting on the Behavior</p>		<p>will educate nursing staff on use of behavior logs and other documentation related to behaviors to ensure it is an accurate reflection of the residents' actions.</p> <p>4. Social Services will review the daily behavior logs prior to daily CQI as well as the 24 hour shift report. Any inaccurate documentation on these logs will be brought to the attention of the IDT team during CQI. The GDR requests will be reviewed monthly in the behavior meeting then delivered to the physician for order requests. The administrator and/or designee will audit behavior logs and 24 hour documentation 3 times per week for 3 weeks then 2 times per week for 2 weeks. When a resident has a known behavior, the behavior log will be reviewed to ensure it is included on the care plan and the nurses are signing off on this behavior. Social Services and the administrator will discuss findings on these audits in the monthly QA meeting. The QA committee will determine the need for further review.</p> <p>5. The completion date is 4/25/2015.</p>	

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F 371	<p>Tracking sheets.</p> <p>The Policy and Procedure for Behavior Management was provided by the Administrator on 3/27/15 at 1:30 p.m. and indicated as current. It included, but was not limited to, the following: "Policy...Residents who receive antipsychotic, anti-depressant, sedative/hypnotic, or anti-anxiety medications are to be maintained at the safest, lowest dosage necessary to manage the resident's condition. Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs...5. Current residents receiving Sedatives/Hypnotics and Anxiolytics: ...b) For resident receiving anxiolytics, daily use will be less than four months unless an attempt at a GDR. For drugs in this category, a GDR should be attempted at least twice within one year before one can conclude that any further GDR in clinically contraindicated...."</p> <p>3.1-48(b)(2)</p> <p>483.35(i)</p>			
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SS=E Bldg. 00	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to serve lunch in a sanitary manner during 2 of 3 meal service observations. This deficient practice had the potential to affect 88 of 94 residents receiving bread with their meal.</p> <p>Findings include:</p> <p>During meal service observation on 3/23/15 at 12:07 p.m., the Housekeeping Director was observed to remove bread from the waxed paper sleeve with her bare fingers and place the bread in her left hand to butter the bread for Resident #65.</p> <p>During the observation of the 200/300 Hall lunch tray delivery on 03/23/15 between 11:58 a.m. and 12:20 p.m., CNA #1 (Certified Nursing Assistant) was observed to pull bread from the wax paper sleeve and placed it on the tray with her bare hands for Resident # 150 and again for Resident #21.</p> <p>In the Main Dining Room on 03/23/15 at</p>	F 371	<ol style="list-style-type: none"> Currently, residents receive assistance with tray delivery and meal set up by staff using safe food handling techniques. Any residents who require assistance with tray delivery and/or meal set up has the potential to be affected by this finding. All staff inserviced on the facility policy and procedures related to food handling by the Director of Nursing and Food Services Manager. The Department supervisors will monitor 5 meals per week alternating meals for 2 weeks then 3 meals per week for 2 weeks then 2 meals per week for 2 weeks. Any staff who fail to comply with the points of the inservice will be progressively disciplined up to and including termination. The Food Services Manager will review the monitoring of the food handling during tray service. The Food Service manager will review the All Hands on Deck audit tool completed by department managers during meal service. 	04/25/2015

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	<p>12:25 p.m., the following were observed:</p> <p>Staffing Coordinator #10 was observed pulling the bread out of the wax paper sleeve with her bare hand. She then buttered the bread, holding it by the wax paper for Resident #14.</p> <p>LPN #1 (Licensed Practical Nurse) took the bread out of the wax paper sleeve with her bare hands and placed it on the wax paper. She then held the bread at the corner with her bare fingers to apply butter for Resident #53.</p> <p>LPN #5 was observed to pull Resident #47's bread out of the wax paper sleeve with her bare hand and placed it on top of the wax paper sleeve to butter it before giving to the resident.</p> <p>During an observation in the Main Dining Room on 03/25/15 at 12:33 p.m., the Activities Assistant #2 pulled the bread out of the wax paper sleeve with her bare hand and laid it on the wax paper sleeve for Resident # 102.</p> <p>During the same observation the Activities Director #4, pulled a peanut butter sandwich out of the wax paper sleeve with her bare hands and handed it to Resident #49.</p>		<p>Results will be discussed in the monthly QA for determination of any ongoing monitoring.</p> <p>5. The completion date is 4/25/2015.</p>		

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F 431 SS=E Bldg. 00	<p>During meal service on 3/25/15 at 12:37 p.m., LPN #5 was observed to remove bread from the waxed paper sleeve using her bare fingers. She placed the bread in her left hand and buttered the bread for Resident #14.</p> <p>During an interview with the Administrator on 3/26/15 at 10:32 a.m., she indicated she could not find a policy or procedure regarding meal service. She also indicated it was common sense not to touch a resident's food.</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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>			

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	<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>Based on observation, interview and record review, the facility failed to label medications properly, store the medications following the manufacturer, pharmacy, or supplier recommendations, store personal drinks in the appropriate locations, and store medications in the correct resident's labeled container. This deficient practice affected 3 of 4 medication carts and 1 of 2 medication storage rooms observed for medication storage. (Resident #113, Resident #27, Resident #12, Resident #103, and Resident #99)</p> <p>Findings include:</p> <p>During the medication storage observation on the Creek Hall medication</p>	F 431	<p>1. Currently all med carts contain only properly labeled meds as per the requirements in the F 431 regulation. No personal med storage boxes or drinks/food are stored in the med carts.</p> <p>2. Residents who have medications/biologicals stored in the med carts and/or med rooms have the potential to be affected by this finding. An audit of the med carts and med rooms was completed on 4/10/2015. Any discrepancies were addressed and any unlabeled meds were destroyed and reordered as needed. No residents were negatively impacted by this finding. Going forward the DON and/or designee will monitor all med carts and all med rooms weekly for 4 weeks. Afterwards, 2 med carts and</p>	04/25/2015

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	<p>cart, with the Qualified Medical Assistant #1 (QMA), on 3/25/15 at 10:00 a.m., the following was observed:</p> <ol style="list-style-type: none"> Observed in the top drawer of the cart was a personal home pill dispenser, with four different compartments. The pill dispenser was undated and unlabeled. The first compartment contained one purple capsule, two yellow round pills, one white round pill, and one round orange pill. The second compartment contained two oval white pills. The third compartment contained one yellow capsule and one white round pill. The fourth compartment contained one yellow oval pill, two oval white pills, two round yellow, one half of a pink round pill, one half white and half gray capsule, and one red round pill. Observed in the bottom drawer with the liquid medications for the residents, was a half empty, plastic, twenty ounce bottle of iced tea. During the observation, the Qualified Medial Assistant #1 (QMA), indicated the personal home pill dispenser located in the top drawer was from a new admit and indicated it should have been disposed of or labeled properly. The QMA #1 indicated the bottle of iced tea was from a staff member on a previous 		<p>2 med rooms will be audited weekly for 4 weeks. Then auditing will include 1 med cart and 1 med room weely for 4 weeks. Any discrepancies will be addressed as found.</p> <p>3. All nursing staff educated on medication storage policies and procedures by 4/24/2015 by DON and/or designee. Pharmacy to complete a medication audit quarterly per policy as well as nursing administration to clean medication carts and medication rooms twice a month ongoing. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as appropriate.</p> <p>4. The DON and/or designee will report findings of the audits to the QA committee monthly and QA committee will determine the need for further monitoring.</p> <p>5. The completion date is April 24, 2015.</p>	

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	<p>shift.</p> <p>During the medication storage observation on the Canyon Short Hall medication cart, with the Registered Nurse #1 (RN), on 3/27/15 at 10:39 a.m., the following was observed:</p> <p>4. Observed in the top drawer of the Canyon Short Hall medication cart, was a Humalog Kwik Insulin Injection pen with no label identifying the residents name or the residents identifier.</p> <p>5. Observed in the Canyon Short Hall medication cart, were two packages of acetaminophen 325 mg tablets for Resident #113, both packages were expired and labeling on package indicated do not use after 11/30/2014. One package contained sixteen doses left, and the other package contained seventeen doses left. Resident #113 did not have any other package containing acetaminophen in the medication cart.</p> <p>6. At the time of the observation of the Canyon Short Hall medication cart, record review of the medication administration record indicated Resident #113 received a dose of acetaminophen 325 mg on 3/2/2015 at 7:30 p.m.</p> <p>7. Observed in the Canyon Short Hall</p>			

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	<p>medication cart, were unlabeled medications, which did not have a resident identifying label for the following medications: an opened bottle of acetaminophen 500 mg, an opened bottle of 81 mg aspirin, an opened bottle of Iron 65 mg pills, and a bottle of 100 mg Colace pills.</p> <p>8. Observed in the Canyon Short Hall medication cart, Resident #27's Epipen injection 2-pack for allergic reactions, the label indicated to discard after 12/17/2013.</p> <p>9. At the time of the observation of the Canyon Short Hall medication cart, record review indicated Resident #27 did not have an order for the Epipen injection 2-pack for allergic reactions in the medication administration record.</p> <p>During the medication storage observation on the Creek Hall medication cart, with the Qualified Medical Assistant #1 (QMA), on 3/27/15 at 11:00 a.m., the following was observed:</p> <p>10. Resident #12's Novolog Flex prefilled insulin syringe was located in Resident #103's bag. The outside of the bag indicated the medication inside was for Resident #103's Levemir injection flextouch insulin syringe, but inside the</p>			

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	<p>bag was Resident #12's Novolog Flex prefilled insulin syringe.</p> <p>11. Observed in the Creek Hall Medication cart, were Resident #99's unopened Levemir injection flextouch insulin syringe. Resident #99 had three Levemir Injection flextouch insulin syringes in one bag, one of three of the syringes were opened. The bag containing the medication indicated the medication should be refrigerated. The medication was not refrigerated and was located in the top drawer at room temperature.</p> <p>During the medication storage observation on the 100 Hall medication room, with the Registered Nurse #2 (RN), on 3/25/15 at 11:21 p.m., the following was observed:</p> <p>12. Stored in the refrigerator were one of three opened and undated turbeso injectable 5/0.1 ml vials.</p> <p>An interview on 3/27/2015 at 11:34 a.m., with the Director of Nursing (DON), confirmed all above issues. The DON indicated the pharmacist makes monthly checks on the medications carts and the nurses working the floor should check them as needed. The DON indicated all medications in the carts should be labeled</p>			

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	<p>with resident identifiers. The DON indicated all expired medications should not be the the cart. The DON indicated no personal staff drinks should be located in the medication carts. The DON indicated the medications should be stored and dated per manufacturer, pharmacy, or supplier recommendations.</p> <p>A policy, dated June 19, 2012 and titled, " 3.1: Medication Storage In The Facility, " was provided by the Administrator on 3/27/2014 at 12:00 p.m. and was identified as current. The policy indicated, medications are not to be transferred into different containers than what the medications were received in. Medications requiring "refrigeration" or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Outdated medications will be immediately withdrawn from the stock, and disposed of properly.</p> <p>3.1-25(j)(k)(l)(m)</p> <p>3.1-25(o)</p>			

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F 441 SS=D Bldg. 00	<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</p>			

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	<p>their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to follow policy and procedure to prevent the spread of infection during handwashing and incontinent care for 1 of 3 resident's reviewed for infection control. (Resident #53)</p> <p>Finding includes:</p> <p>The Clinical Record for Resident #53 was reviewed on 3/25/15 at 10:05 a.m. Diagnosis included, but was not limited to, urinary tract infection. The Minimum Data Set (MDS), dated 1/16/15, indicated Resident #53 was always incontinent.</p> <p>Review of the Infection Surveillance Report Forms dated 10/21/14, 11/7/14 and 12/9/14 indicated Resident #53 was positive for a urinary tract infection on each of the dates indicated.</p> <p>During incontinent care on 3/25/15 at 10:26 a.m., the following was observed:</p>	F 441	<ol style="list-style-type: none"> Resident #53 is no longer a resident at the facility. Residents who require incontinence/peri care have the potential to be affected by this finding. The DON and/or designee will monitor 5 residents weekly for 2 weeks then 3 residents weekly for 2 weeks as these residents receive peri care. This monitoring will take place on various shifts. Any concerns with technique including all aspects of proper and appropriate handwashing policy requirements, will be corrected prior to a contamination taking place. Afterwards, random weekly monitoring will continue ongoing as part of the ongoing Quality Assurance. All nursing staff will be educated and mock procedure using the Perineal Care guidelines from the CNA state training manual by the Nursing Administration by 4/24/2015. Any staff who fail to 	04/25/2015

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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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	CNA (Certified Nursing Assistant) #2 entered Resident #53's room with 2 wash cloths and 1 towel to provide incontinent care. She washed her hands for 15 seconds. CNA #2 donned gloves, entered the bathroom and wet both wash cloths. She draped the first wash cloth on her left hand and, using her right hand, sprayed the wash cloth with peri wash. Using different areas of the wash cloth, she washed the left and right creases of the peri area in a downward motion. She then washed the left side, right side center of labia using a down ward motion and placed the soiled wash cloth in a bag. Using the second wash cloth, CNA #2 rinsed the peri area and placed it in the same bag. Using the towel, CNA #2 patted the peri area dry. CNA #2 rolled Resident #53 to the resident's left side to provide incontinent care. She reached in the bag and retrieved one of the soiled wash cloths, draped it across her left hand and sprayed it with peri wash. She cleansed the perineal area and in between both buttocks outward. She then flipped the wash cloth and cleaned the left and right buttocks. She placed the wash cloth back into the bag and retrieved the other wash cloth and rinsed the perineal area, left buttock and right buttock. She placed the wash cloth back in the bag, and using a towel, patted the perineal area, left		<p>comply with the points of inservice will be further educated and/or progressively disciplined as appropriate.</p> <p>4. Results of the monitoring will be reviewed at the monthly QA meeting to ensure that any patterns of concerns have been identified and addressed. Any need for further education will be identified and implemented.</p> <p>5. The completion date is 4/25/2015.</p>	

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	<p>buttock and right buttock dry. She placed a clean brief on Resident #53. She removed her gloves and washed her hands for 12 seconds.</p> <p>During an interview on 3/27/15 at 10:10 am., CNA #2 indicated using the same wash cloths could be an infection control issue.</p> <p>Review of the Infection Control Inservice dated 1/23/15 and provided by the Assistant Director of Nursing on 3/27/15 at 2:00 p.m. indicated CNA #2 was in attendance of this inservice.</p> <p>The procedure for Perineal Care was provided by the Administrator on 3/25/15 at 2:15 p.m. and indicated as current. It included, but was not limited to, the following: "Procedure #33: Bed Bath/Perineal Care...Perineal Care: Step 21. Wet and soap folded washcloth. Rationale 21. Folding creates separate areas on cloth to reduce contamination. Step 23. ...For Females: Separate labia. Wash urethral area first. Wash between and outside labia in downward strokes, alternating from side to side and moving outward to thighs. Use different part of washcloth for each stroke. Rationale 23. Prevents spread of infection. 24. ...Wash hands and change gloves. 28. Clean anal area front to back...Rationale 28.</p>			

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	<p>Prevents spread of infection...."</p> <p>On 3/25/15 at 11:00 a.m., the Administrator provided a copy of the document titled "Quality Review, LLC, Resident Care Manual, Section: Infection Control", dated 7/1/11 and indicated as current. It included, but was not limited to, the following: "Responsibility: All facility staff Procedure: I. Standard Precautions...a. Handwashing b. Gloves...A. Handwashing 1. ...It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites...B. Gloves...Change gloves between tasks and procedures on same patient after contact with material that may contain a high concentration of microorganisms..." The CDC (Centers for Disease Control and Prevention) guidelines recommend handwashing for 20 seconds.</p> <p>3.1-18(l)</p>			