STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN 47042

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F0000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 28, 2012. This visit included the PSR to the Investigation of Complaint IN00109777 completed on June 28, 2012. Complaint IN00109777 - Corrected Survey date: August 22, 2012 Facility number: 000483 Provider number: 15E657 AIM number: 100273470 Survey team: Jill Ross, RN, TC Cheryl Fielden, RN Census bed type: NF: 20 Total: 20 Census payor type: Medicaid: 19 Other: 1 Total: 20 Sample: 3 These deficiencies reflect state findings	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2. Quality review completed on August 24, 2012 by Bev Faulkner, RN			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation and interview, the facility failed to maintain a resident's dignity in that Resident #11 was sitting at a table with no food while the other residents at the table were eating. This affected 1 out of 7 residents observed in the dining room. Findings include: During observation of breakfast in the dining room on 8/22/12 at 8:00 a.m., three residents were sitting at one table with two of the residents being served their food. They were assisted as was needed and began to eat their food. The third resident (Resident #11) had not received his tray at 8:10 a.m.. There were 4 other residents in the dining room eating at different tables. On 8/22/12 at 8:10 a.m., interview with the Charge Nurse indicated this resident should not have been brought out to the dining room until staff was ready to feed him. She went to find someone to feed him. In the mean time she moved the	F0241	The facility has reviewed and revised the Policy and Procedure for Dining. Social Service Designee conducted an in-service for all nursing staff on Dignity and the facilities dining policy. CNA's and Activity staff is responsible to serve all residents sitting at a table on after the other and not to bring residents which are totally dependent with eating to the dining room table until ready to assist them. The charge nurse is responsible to ensure dignity is provided to all residents. The administrator, director of nursing and SSD will randomly visually monitor that dignity is provided at all times while in the facility. CQI will monitor the monitor compliance with the Dining policy, no less than quarterly, the observation sheets provided by the director of nursing and social service designee.	08/31/2012

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	resident over to the TV room. At 8:12 a.m., on 8/22/12, the DON (Director of Nursing) went to the kitchen and got Resident #11's breakfast tray. She positioned this resident at a different table and began to feed him. Resident #11 became agitated and refused to eat. The DON took this resident to his room and said she would try to feed him there. During interview on 8/22/12 at 3:50 p.m., with the Administrator, DON, and the Charge Nurse, they indicated each resident at a table is to be served before serving another table. This resident should not have been taken to the dining room until staff was ready to feed him. 3.1-3(t)			

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F0371 SS=F	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, record review and interview, the facility failed to maintain	F0371	On August 22, 2012, the dietary aid was removed from the dietary department until further retraining. The dietary supervisor took over dietary responsibilities until the evening cooked arrived. The dietary manager reviewed and revised the facilities policy and procedures for: Filling the 3 compartment sink and Cleaning the 3 compartment sink to ensure all three sinks are cleaned and filled at the same time. The administrator reviewed and approved the revisions to the policy and procedures. All dietary staff were trained on the revised policy and procedures and assessed for competency of the policies. The dietary manager will be responsible to visually assess the policies and procedures are followed accurately, no less than 5 days per week and continue to complete the dietary observation sheet. The administrator will review the dietary observation sheets weekly. CQI will monitor the dietary supervisors finding, no less than quarterly.	08/31/2012

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	sanitization of the dishes in dietary in that the sanitizer in the 3-compartment sink was not at the correct level for bleach to sanitize the dishes. This had the potential to affect all 20 residents. Findings include: During kitchen observation on 8/22/12 at 10:30 a.m., the sanitizer (chlorine) in the 3-compartment sink was registered at only 10 ppm (parts per million). The water was emptied and re-made and tested again. The ppm was 100. This was all completed by the Dietary Aide. There were dishes in the wash sink, but none in the sanitizing sink. During interview with the Dietary Manager (D.M.) on 8/22/12 at 10:35 a.m., the D.M. indicated the water should have been changed when the water was changed in the other two sinks. She indicated she would need to retrain her staff. Review of the policy titled, "Sanitize Dishes and Utensils" received on 8/22/12 at 10:44 a.m., from the Dietary Manager stated, "...Procedure...3...Proper concentrations of sanitizers for dishwashing are: Chlorine 50 - 100 ppm..."			

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	This deficiency was cited on June 28.2012. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure	F0441	The charge nurse that did not clean the glucometers was	09/02/2012

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	glucometers were disinfected. This affected 2 of 3 residents reviewed for blood sugar testing. This had the potential to affect 5 out of 5 residents receiving blood sugar testing on a daily basis. Findings include: During observation of blood sugar testing on 8/22/12 at 11:15 a.m., LPN #1 did not disinfect the glucometers before and/or after use. Each resident had their own glucometer. The glucometers were stored in the medication cart in their own open case. The case was not closed. The glucometers had no resident identification. LPN took the glucometer from the case and gathered all supplies. She then went into the room and completed the blood sugar test. When done the glucometer was placed back in the open case. There was no cleaning or disinfection done of the glucometer. LPN #1 was pulled from the floor for more training. Observation done on 8/22/12 at 1:45 p.m., LPN #1 wiped down all 5 glucomters in the cart with alcohol and placed them back in their appropriate cases per directions from the Director of Nursing (DON).		removed from her nursing responsiblities and retrained on the cleaning of glucometers. The facility reviewed and revised the policy and procedure for cleaning the glucometers. The facility hypodermic cart was thorughly cleaned and individual blood glucose testing devises were cleaned with 1:10 bleach solution and labled with the residents name. The director of nursing will evaluate by observation of demonstration, each licensed nurse knowledge of standard precaucations, guidelines and proficiency when obtaining finger stick for blood glucose testing to ensure the glucometers and lancing devices are cleaned according to facility police. The director of nursing will be responsible to monitor that the blood glucose devices are properly stored and labled individually weekly. The director of nursing will be responsible to visually assess adhearance to infection control recommendations for fingersticks of the glucose monitoring (such as hand washing, earing and changing gloves between resident) by observing random licensed staff performing this procedure, no less than weekly. Nursing staff were in-serviced on the cleaning of blood glucose device and Infection control. On September 8, 2012, CQI will review with DR. Willage, each resident that recieves blood	

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	During interview with the Charge Nurse on 8/22/12 at 1:17 p.m., she indicated the glucometers were to wiped down with alcohol before and after use. During interview on 8/22/12 at 1:25 p.m., with the DON, she indicated the glucometer is to be wiped off before and after each use with alcohol. During interview on 8/22/12 at 1:32 p.m., with LPN #1, she indicated she should have wiped the glucometers down before she used them and after she was done, before she placed the glucometer back in the case. Interview with the DON on 8/22/12 at 1:50 p.m., she indicated they would go through the entire cart and do a very thorough cleaning of all the glucometers and all the cases. "They would just clean the entire cart." During interview on 8/22/12 at 3:50 p.m., with the Administrator, DON and Charge Nurse, they indicated they were confused on the policies they have on cleaning glucometers and would go to the CDC website and follow their procedure when they rewrite their policy. Review of a policy titled, "Glucose Monitor and Cleaning" received on		glucose monitoring for any trends with infection control.	

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	8/22/12 at 2:13 p.m., from the DON, states, "...Aftercare: Clean the Blood Glucose Meter between patient tests." Review of a an orientation checklist for all nurses received on 8/22/12 at 2:22 p.m., from the Charge Nurse, did not list glucometer cleaning as one of the items for compliancy before starting to work. Review of another policy subtitled, "Cleaning" received on 8/22/12 at 2:33 p.m., from the DON, states, "...To clean the outside of your blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol (70% - 85%). To disinfect the meter, dilute 1 ml (milliliters) of household bleach (5% - 6% sodium hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution (final concentration of 0.5% - 0.6% sodium hypochlorite). Review of another policy titled, "Recommendations for Cleaning and Disinfection of Glucometers" received on 8/22/12 at 2:44 p.m., from the Administrator, states, "...Recommendations: ...2. If no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA-registered detergent/germicide with a tuberculocidal			

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	or HBV/HIV label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration. Review of another policy titled, "Policy and Procedure for Optium EZ Blood Monitoring Device and Test Strips" received on 8/22/12 at 2:53 p.m., from the Charge Nurse, states, "...Procedure:...You may clean it with a damp cloth and mild soap, and cleaning solutions include 10% bleach, 70% alcohol or 10% Amonia..." This deficiency was cited June 28,2012. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)(4)			