

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155740	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF BRETHREN	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST NORTH MANCHESTER, IN 46962
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 27, 28, 29, & March 1, 2012</p> <p>Facility number: 000448 Provider number: 155740 AIM number: 100275140</p> <p>Survey team: Sue Brooker RD TC Rick Blain RN Diane Nilson RN Angie Strass RN Linn Mackey RN</p> <p>Census bed type: SNF/NF: 58 Residential: 156 Total: 214</p> <p>Census payor type: Medicare: 4 Medicaid: 30 Other: 179 Total: 214</p> <p>Stage 2 sample: 48 Residential sample: 12</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F0000		

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>IAC 16.2.</p> <p>Quality review completed 3/5/12 Cathy Emswiller RN</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation and record review, the facility failed to lock the medication cart when it was not in view, while passing medications. This had the potential to effect 1 resident (resident #41) who was observed walking up to the medication cart.</p> <p>Finding includes: On 2/29/12 at 11:30 a.m. observation of the medication pass on the Crestwood dementia unit indicated nurse #1 was passing medications to residents in the dining room.</p> <p>The nurse prepared medications for residents (#35, 38, 45, 48, 56, 61, 68 and 73) separately and walked to the residents at their dining table. Observation of nurse #1 while passing the medications indicated she did not lock the medication cart.</p> <p>Observation of resident #41, who had a diagnosis of dementia and a history of wandering throughout the unit, was</p>	F0323	<p>All staff responsible for the administration of medications in the Health Care and Crestwood (dementia) units will be re-inserviced on the proper procedures for medication passes. Special emphasis will be on the importance of medication carts being securely locked when not visible to the medication nurse or aide, and that no medications may be left on top of the cart while it is unattended. The efficacy of this corrective action will be monitored for three months by the Director of Nursing conducting at least five random observations of medication passes each month and documenting the same on the attached Medication Pass Check List. If by the third month not all observed medication passes are conducted without discrepancy from the procedure, they will be continued from month to month until a month with no observed errors is achieved. The results of the monitoring will be reported to the Clinical Quality Assurance Committee at each of their quarterly meetings until a full month with out a descriciancy has been achieved, documented and</p>	03/30/2012	

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	<p>observed to walk up to the medication cart and walk away 3 times while the nurse was away from the medication cart.</p> <p>Observation during the medication pass on 2/29/12 at 11:30 a.m. indicated the medication cart was up against the wall facing the kitchen area and was not visible on all sides by nurse #1, who was observed to have her back to the cart while passing medications</p> <p>On 3/1/12 at 9:30 a.m. the Director of Nursing was informed of the medication cart being left open and the facility policy was requested. On 3/1/12 at 9:40 a.m. review of the facility policy "Preparation and General Guidelines for Medication Administration" which was dated January 2007, indicated the following:</p> <p>During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.</p>		reported to the Committee.		

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	3.1-45(a)(1)			

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure 1</p>	F0441	All staff responsible for the administration of medications in	03/30/2012	

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	<p>of 3 nursing staff washed their hands and/or used sanitizing hand gel while passing medications to 8 residents (#35, 38, 45, 48, 56, 61, 68 and 73)</p> <p>Finding includes:</p> <p>On 2/29/12 at 11:30 a.m. observation of medication administration by nurse #1 indicated she was passing oral medications to 8 residents on the Crestwood locked unit. The residents were seated in the dining room waiting on the noon meal to be served.</p> <p>Nurse #1 prepared the medications for residents (#35, 38, 45, 48, 56, 61, 68 and 73) each separately, and took the medication to each resident. The nurse returned to the medication cart, and without washing her hands or using sanitizing gel, proceeded to prepare the medication for the next resident. Observation during the medication pass indicated the nurse was touching the residents' clothing, water glasses, walkers, medication cart, and medication cards.</p> <p>On 3/1/12 at 9:30 a.m. the Director of Nursing was informed of the concern and the facility policy was requested. Review of the facility policy for "Preparation and General Guidelines</p>		<p>the Health Care and Crestwood (dementia) units will be re-inserviced on the proper procedures for medication passes. Special emphasis will be on the importance of hands being cleansed by washing with soap and water or by the use of sanitizing hand gel between residents. The efficacy of this corrective action will be monitored for three months by the Director of Nursing conducting at least five random observations of medication passes each month and documenting the same on the attached Medication Pass Check List. If by the third month not all observed medication passes are conducted without discrepancy from the procedure, they will be continued from month to month until a month with no observed errors is achieved. The results of the monitoring will be reported to the Clinical Quality Assurance Committee at each of their quarterly meetings until a full month with out a descriciancy has been achieved, documented and reported to the Committee.</p>		

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	<p>for Medication Administration" indicated the following:</p> <p>Hands are washed with soap and water before and after administration of topical, ophthalmic, optic, parenteral, enteral, rectal, and vaginal medications. Alcohol gel may be used between patients when passing po (per mouth) meds. After 3 or 4 times of using alcohol gel, hands are washed with soap and water."</p> <p>3.1-18(l)</p>				