

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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F 0000 Bldg. 00	<p>This visit was for Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00202272.</p> <p>Survey dates: June 9, 10, 13, 14, 15, and 16, 2016</p> <p>Facility number: 000109 Provider number: 155202 AIM number: 100266290</p> <p>Census bed type: SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 28 Total: 81</p> <p>Sample: 5</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 06/21/2016 by 29479</p>	F 0000	<p>Preparations and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility respectfully requests paper compliance for this citation.</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 0164 SS=D Bldg. 00	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents' rights for personal privacy</p>	F 0164	It is the policy of the facility to ensure that personal privacy is provided for the residents during	07/05/2016

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	<p>for 3 of 6 residents reviewed for privacy during blood glucose monitoring and medication administration (Resident #63, #68, and #89).</p> <p>Findings include:</p> <p>1. On 6/10/16 at 11:06 a.m., RN (Registered Nurse) #3 performed a finger stick to obtain a sample of resident #89's blood to test his blood sugar. The resident was seated in his motorized chair by the nurses' station on the Misty Lane east unit. There were several staff and residents observed in the hallway while the nurse performed the finger stick.</p> <p>On 6/16/16 at 2:15 p.m., review of the resident's Annual Minimum Data Set (MDS) assessment, dated 3/19/16, indicated the resident had no cognitive deficit.</p> <p>2. On 6/14/16 at 7:58 a.m., LPN (Licensed Practical Nurse) #4 administered insulin to Resident #63. With the resident sitting up on the side of her bed and facing the hallway, the nurse administered the insulin injection into the resident's right upper arm. The door to the resident's room was open and staff and residents were observed in the hallway.</p>		<p>care or during activities that are of a private nature. Residents #89 and #68 have their glucose finger stick testing done in a private setting. Resident #63 has their insulin injection administered in a private setting. Any resident who resides in the facility and receives care of a private nature has the potential to be affected by this finding. An audit was conducted to identify a list of residents who receive finger stick glucose testing for blood sugars and/or who receive insulin injections. The DON/Designee will make rounds daily 5 days weekly on various shifts and including some weekend days. On these rounds, 5 residents who receive finger stick glucose testing for blood sugars and/or who receive insulin injections will be observed to ensure that they are provided with privacy during these care tasks. Any potential breach will not be allowed to take place and 1 on 1 education will be performed at that time. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, 5 residents will be observed weekly for privacy during these care tasks for a period of not less than 6 months to ensure ongoing compliance. Then, random monitoring will occur. At an all staff in-service held 6/29/16 the requirement of upholding Resident Rights with emphasis on privacy and dignity</p>				

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	<p>On 6/14/16 at 2:18 p.m., review of the Resident #63's Quarterly Minimum Data Set (MDS) assessment, dated 5/27/16, indicated the resident had no cognitive deficit.</p> <p>3. On 6/14/16 at 11:05 a.m., LPN # 5 performed a finger stick to obtain a sample of Resident #68's blood to test his blood sugar. The resident was seated in a recliner in his room while the nurse performed the finger stick. The door to the resident's room was open and residents were observed in the hallway.</p> <p>On 6/14/16 at 2:25 p.m., review of the Resident #68's Quarterly Minimum Data Set (MDS) assessment, dated 6/7/16, indicated the resident had no cognitive deficit.</p> <p>During an interview on 6/15/16 at 2:35 p.m., LPN #1 indicated a residents finger stick or insulin injection should be performed in the residents room with the door closed or the privacy curtain pulled. She further indicated neither should be performed in the hallway.</p> <p>A current policy titled, "Resident Rights," provided by the Administrator on 6/15/16 at 2:38 p.m., indicated, "...Privacy: Your privacy will include: personal care, medical treatments, telephone use, visits,</p>		<p>was reviewed with emphasis on privacy during invasive procedures such as a finger stick or an injection. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as necessary. At the monthly Q. A. meetings the results of the monitoring by the DON/Designee will be reviewed. Any patterns will be identified, however any concerns will have been addressed as discovered and prior to any breach in policy. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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F 0282 SS=D Bldg. 00	<p>letters, and meetings of family and residents groups...."</p> <p>3.1-3(p)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure medications and incontinence interventions were in accordance with physician orders for 1 of 1 resident reviewed for following plan of care (Resident C)</p> <p>Findings include:</p> <p>The clinical record was reviewed for Resident C on 6/13/16 at 10:53 a.m. Diagnosis included but were not limited to, infection and inflammatory reaction due to right knee prosthesis and enlarged prostate without lower urinary tract symptoms.</p> <p>A care plan, dated 6/3/16, indicated,</p>	F 0282	<p>It is the policy of the facility to ensure that medication and incontinence interventions are in accordance with the physician's order as well as per the individual plan of care. Resident C no longer resides in the facility. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was conducted to ensure that any resident in the facility who had a catheter had an order for the catheter and had the catheter assessed for medical necessity (supporting diagnosis) and all associated orders for catheter care and management as per policy. Further, facility wide skin assessments were done to identify any resident with a skin issue (these are done weekly as</p>	07/05/2016

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	<p>"Problem- Has DX (diagnosis): BPH with need for condom (external) catheter." Interventions included, but were not limited to: catheter care every shift and prn (as needed) and change per facility policy or MD order</p> <p>Admission MDS assessment, completed on 6/6/16, indicated Resident C was marked as having an external catheter.</p> <p>A nurse's note, dated 6/3/16 at 1:40 a.m., indicated Resident C's condom catheter was in place.</p> <p>A nurse's note, dated 6/6/16 at 11:49 p.m., indicated Resident C's condom catheter was due to immobility due to knee hardware removal due to infection.</p> <p>A nurse's note, dated 6/7/16 at 3:22 a.m., indicated Resident C's catheter was patent and draining to gravity with yellow urine.</p> <p>Resident C's record did not indicate a physician's order for the exdwelling catheter.</p> <p>The record indicated a physician order dated 6/13/16, for Nystatin Powder (antifungal to treat fungal infections) applied to groin topically two times a day for skin treatment.</p>		<p>a routine). These residents had their orders reviewed to be certain that an appropriate treatment was ordered and available and being administered to promote healing of the area. Additionally, the care plans as well as the medication administration sheets and the treatment sheets were reviewed to see that they were accurate in regards to catheters and skin issues. At the daily CQI meetings all orders will be reviewed. Any new residents will have their admission assessments reviewed to be sure that any device or condition they are admitted with such as a condom catheter or a skin issue is properly addressed with an appropriate order and then care planning. New orders for these issues will be reviewed as well for appropriate care planning. This process will be ongoing. The DON/Designee will monitor 10 residents weekly to see that the resident's devices are in place and that any skin issues are accurately identified, assessed and have orders and care planning in place as appropriate. Any concerns will be addressed as found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, monitoring will occur with 5 residents weekly for a period of not less than 6 months to ensure ongoing compliance. Afterwards, random monitoring</p>	

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	<p>The medication administration record lacked documentation of the Nystatin Powder being administered to Resident C prior to his discharge to the hospital on 6/13/16.</p> <p>A hospital social work progress note, dated June 13, 2016 at 8:56 a.m., indicated the hospital social worker spoke with the facility Director of Nursing (DON) and the DON indicated, "...pt [patient] was seen by medical director, [physician named] on Friday (6/10/16)...Per DON's review of chart...Ordered Nystantin for thrush on 6/10...There was also a one-time order for Nystantin powder for for (sic) the groin area; this has been ordered from the pharmacy but not yet received"</p> <p>An emergency department progress note, dated June 13, 2016 at 5:26 p.m., indicated Resident B had a skin rash described as, "rash in perineum however, no open areas noted." The record indicated the resident was not in acute distress and had "MULTIPLE ERYTHERMATOUS (abnormal redness of the skin) RASH, MOST LIKELY CANDIDIASIS (fungal infection related to yeast)."</p> <p>During an interview on 6/13/16 at 12:14</p>		<p>will occur. At a in-service held for nurses on 6/29/16, the following was reviewed: A.) Following Physician Orders—(catheter usage/skin issues/meds/treatments) B.) Administering ordered meds timely C.) What to do if a med is not available D.) Care planning E.) Documentation F.) Q & A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly Q A meetings the results of the monitoring by the DON/Designee will be reviewed. Any patterns will be identified, however any concerns will have been addressed as found. If needed, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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	<p>p.m., the Minimum Data Set (MDS) Coordinator indicated, Resident C had come to their facility with a condom (exdwelling) catheter in place from the hospital.</p> <p>During an interview on 6/13/16 at 1:31 p.m., the DON indicated she was made aware on the evening of 6/9/16 by Resident C's wife that he had a skin area of concern. The DON indicated she assessed Resident C's skin that evening. She indicated his bilateral groin area was "yeasty looking and wet." She also indicated his top layer of skin just "rolled off." The DON indicated the physician was notified on 6/10/16 about the skin area, and was unsure as to why the medication order was not placed into the computer system until 6/13/16.</p> <p>During an interview on 6/13/16 at 1:35 p.m., the DON indicated Resident C was admitted to their facility with an external catheter in place. She indicated she had spoken to a nurse at the hospital because she needed to make sure she had the correct size of catheters to take care of the resident when he arrived to the facility.</p> <p>During an interview on 6/16/16 at 2:05 p.m., the Medical Director and attending physician indicated, he was not aware</p>			

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	<p>Resident C had a condom (exdwelling) catheter upon admission to the facility.</p> <p>A facility policy dated 7/1/11, identified as current and titled, "Admission Orders," provided by the Administrator on 6/14/16 at 7:55 a.m., included but not limited to, "... 1. Orders are to be obtained on day of admission in one of the following was: a. Attending physician writes orders in person. b. Nurse receives admission orders via telephone, in which case "via telephone" is indicated by nurse signature...."</p> <p>A facility policy dated 2/2/15, identified as current and titled, "Physician Notification of Resident Change of Condition," provided by the Administrator on 6/14/16 at 7:55 a.m., included but not limited to, "...1. Physician notification is to included but is not limited to: Symptoms of any infectious process...."</p> <p>This federal tag relates to complaint IN00202272.</p> <p>3.1-35(g)(2)</p>			
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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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 ensure services were provided to prevent possible urinary tract infections for 1 of 1 random observation of a resident with a urinary catheter. (Resident #67)</p> <p>Finding includes:</p> <p>On 6/13/16 at 11:19 a.m., Resident #67's urinary catheter tubing was observed touching the floor. The resident urinary catheter tubing was again observed touching the floor on 6/13/16 at 12:25 p.m., and 2:43 p.m.</p> <p>The resident's medical record was reviewed on 6/15/16 at 10:13 a.m. The resident's diagnoses included, but were not limited to, chronic urinary retention secondary to Parkinson's disease, and</p>	F 0315	<p>It is the policy of the facility to see that services are provided to prevent the occurrence of a urinary tract infection for any resident. Resident #67's catheter tubing does not touch the floor.</p> <p>Any resident who has a catheter with tubing has the potential to be affected by this finding. A facility wide audit was conducted so as to compile a complete list of targeted residents who have catheters/catheter tubing. All were checked to see that they were properly draped and</p>	07/05/2016

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	<p>hemiplegia/hemiparesis following nontraumatic subarachnoid hemorrhage. The resident's quarterly MDS (minimum data set) assessment dated 5/13/16, indicated the resident had moderate cognitive deficits.</p> <p>During an interview on 6/15/16 at 10:57 a.m., CNA #6 (Certified Nursing Assistant) indicated urinary catheter tubing should never touch the floor. She indicated it was an infection control risk.</p> <p>During an interview on 6/15/16 at 11:01 a.m., CNA #7 indicated urinary catheter tubing should never touch the floor.</p> <p>During an interview on 6/15/16 at 3:12 p.m., the DON (Director of Nursing) indicated it was never okay for urinary catheter tubing to be in contact with the floor.</p> <p>On 6/15/16 at 3:45 p.m., the DON provided a copy of the Lippincott Nursing Manual, ninth edition, identified as a current policy, titled, "Maintaining a closed drainage system." The policy indicated, "...2c. Keep the bag off the floor...3c. Avoid letting the bag touch the floor...."</p> <p>3.1-41(a)(2)</p>		<p>anchored so as to flow with gravity and so no tubing was in contact with the floor. The DON/Designee will make rounds 5 days (to include some weekend days) weekly on different shifts to ensure that catheter tubing on residents who have catheters is properly placed, anchored and draped to the flow of gravity and so as not to touch the floor. Any concerns will be remedied immediately if found. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, these residents will be monitored 3 days weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur.</p> <p>At an in-service held for all staff 6/29/16, the following was reviewed:</p> <p>A.) Infection Control (as related to catheter tubing and</p>	

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			<p>the floor)</p> <p>B.) Nursing staff's role in catheter tubing (placement, anchor, draping, care)</p> <p>C.) What should a non-nursing staff member do if they see a catheter tubing on or near the floor?</p> <p>D.) Care planning catheters/care</p> <p>E.) Q and A</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly Q. A. meetings the results of the monitoring by the DON/Designee will be reviewed, however any concerns will have been addressed as found. If needed, an Action Plan will be written by the committee. Any Action Plan will be</p>	

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F 0371 SS=E Bldg. 00	<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</p> <p>Based on observation, interview, and record review, the facility failed to ensure a sanitary kitchen environment, proper food storage and preparation, and adequate hand washing or hair restraint for 2 of 2 kitchen observations. This had the potential to affect 81 of 81 residents who received food that was prepared in kitchen.</p> <p>Findings include:</p> <p>1. During an initial kitchen tour with the DM (Dietary Manager) on 6/9/16 at 10:04 a.m., the following were observed:</p> <p>a) The floors around the baseboard throughout the kitchen and dry storage room were observed to have dried food particles, fresh food items and small pieces of paper debris, including paper</p>	F 0371	<p>followed up on weekly by the Administrator until resolved.</p> <p>It is the policy of the facility to maintain a sanitary kitchen environment where food is properly stored and prepared and adequate hand washing and hair covering is practiced. All floors and baseboards throughout the kitchen including the dry storage room as well as the walk-in refrigerator and walk-in freezer have been thoroughly cleaned and placed on the cleaning schedule for routine as well as deep cleaning on a regular basis. All food to be served is labeled and dated as per policy and requirement. This includes trays of food on countertops or in the refrigerator or freezer or the dry storage room. The steam table compartments have been emptied and thoroughly cleaned. They have fresh water placed in the compartments as per policy. The steam table has been placed on a cleaning schedule for routine</p>	07/05/2016

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NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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	<p>straw wrappers and paper towel pieces were observed on the soiled and dingy kitchen and dry-storage room floors around the coves.</p> <p>b) Four undated trays of brownies were observed on the kitchen counter.</p> <p>c) Heavy lime buildup was observed in the five wells of the steam table. The steam table was turned on with water heating in the wells. Large pieces of lime scale, buildup were observed floating in the water and the water had an odor of chicken both. The DM indicated at that time that the water did have a strange odor and needed fresh water.</p> <p>d) A sugar canister was observed with a paper cup scoop inside the container.</p> <p>e) The floors in the walk-in freezer and walk-in refrigerator were soiled and dingy with food debris and spillage.</p> <p>f) An undated and unmarked, tray with five, plastic cups of ice cream, was in the walk-in freezer.</p> <p>g) The walk-in refrigerator had an undated tray of eighteen cups of juice.</p> <p>h) A dry storage room shelf contained an undated container of 10-ounce parsley</p>		<p>as well as deep cleaning on a regular basis. The sugar canister has no scoop inside. The scoop is stored outside the canister and is cleaned per policy and schedule. There are no boots or apparel stored in the dry storage room or any area of the kitchen. There are no blankets on the milk crates inside the back door of the kitchen. Staff or others who enter the kitchen don a hair covering prior to entry. If staff or others who enter have facial hair, designated facial hair coverings are donned. Proper hand washing including time duration is practiced in the dietary department. Feet are not used by dietary staff to open or close appliances or to touch appliances in any way. Residents who consume food/drinks stored or prepared in the dietary department have the potential to be affected by this finding. The Administrator/Dietary Manager/Designee will make rounds 5 days weekly on various shifts and to include some weekend days. On these rounds the following will be observed: A) Cleanliness of all floors/baseboards throughout B) Cleanliness of steam table and steam table water C) Placement and cleanliness and storage of any scoops for canisters D) All foods labeled and dated appropriately (counters/refrigerators/freezers/dry storage etc.) E) No</p>	

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	<p>flakes with the lid open.</p> <p>i) A pair of dingy, work boots were under a food storage shelf, on the dry storage room floor.</p> <p>j) Four, soiled, white, bed blankets were piled on two milk-crates inside the back door of the kitchen.</p> <p>k) At 6/9/16 at 10:25 a.m., CNA (Certified Nursing Assistant) #14 walked into the kitchen without a hairnet restraint to deliver a used meal tray.</p> <p>l) At 6/9/16 at 10:37 a.m., the DON (Director of Nursing) came into the kitchen without a hairnet restraint.</p> <p>m) The fully-bearded Plant Operations Director entered the kitchen area, on 6/9/16 at 10:45 a.m., without a beard cover.</p> <p>2. During an observation of the kitchen on 5/15/16 at 9:40 a.m., the following observations were made:</p> <p>a) The floor around the baseboards throughout the kitchen and dry storage room were again observed to have dried food particles, fresh food items, small pieces of paper debris, dirt, and grime buildup.</p>		<p>clothes/blankets/personal items in kitchen area F) Hand washing observed for 3 dietary staff (on these monitoring rounds) for correctness G) All hair on all people in the kitchen (dietary) appropriately covered (head and facial) H) Review of all cleaning schedules to see that cleaning is done and documented I) Review of water changes documented in steam table compartments Any concerns found will be corrected immediately. These monitoring rounds will continue until 4 consecutive weeks of zero negative findings are achieved. Afterwards, they will occur 3 days weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an in-service held 6/29/16, for dietary staff by the dietician the following was reviewed: A) Cleaning Policies & Procedures--Review B.) Cleaning schedules--performing timely and documenting (emphasis on floors/baseboards/steam table) C.) Labeling/Dating Food/Drinks-Policy & Procedure (How? When? Why? By whom?) D.) Steam table cleaning--how to deal with lime build up/changing water correctly/timely E.) Storage of "scoops" for dry goods (Where? How? By whom?) F.) Why clothes/boots/blankets/personal items cannot be kept in the kitchen area G.) Hand</p>	

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	<p>b) A pack of cigarettes, a cigarette lighter, and a cell phone were observed on the counter in the kitchen.</p> <p>c) A tray with four juice glasses uncovered and undated were on the kitchen counter.</p> <p>d) Heavy lime buildup was observed in the five wells of the steam table. Large pieces of lime-scale buildup and a single kernel of corn were observed floating in the hot water.</p> <p>e) At 9:57 a.m., Dietary Cook #15 washed her hands for 6 seconds, turned off the faucet with her bare hand and then pureed vegetables.</p> <p>f) At 10:08 a.m., Dietary Cook #15 was observed handwashing and scrubbed with soap her hands for 6 seconds. She then proceeded to remove two pans of chicken from the oven.</p> <p>g) Dietary Cook #15 removed pans from the oven and used her foot to close the oven door, touching the door's surface with the sole of her shoe.</p> <p>h) The Dietary Cook #15 picked an alcohol swab up from the floor and placed it on the kitchen counter, then</p>		<p>washing—Policy & Procedure H.) Hair Covering in the Dietary Department—Hair nets—Facial Hair coverings I.) Instructing those authorized to enter the kitchen area on hair covering requirements J.) Opening and closing appliances properly K.) Q & A Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. At the monthly Q.A. meetings the results of the dietary monitoring will be reviewed. Any concerns will have been addressed as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored weekly by the Administrator until resolution.</p>	

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	<p>placed a pan of chicken in the oven without washing her hands.</p> <p>i) At 10:19 a.m., Dietary Cook #15 was observed handwashing and scrubbed with soap her hands for 7 seconds and turned off the faucet with her bare hand.</p> <p>On 6/15/16 at 10:30 a.m., Dietary Cook #15 indicated she should have washed her hand the length of time it would take to sing the "happy birthday song " twice.</p> <p>During the kitchen tour, the DM indicated the nightshift dietary staff were responsible for the majority of cleaning the kitchen; all prepared food items in the kitchen should have been labeled and dated; no personal items nor blankets were to be stored in the kitchen. The dietary staff used the blankets to keep warm when they went outside for a cigarette break and placed the used blankets on the milk crates when they returned to work. The DM indicated anyone entering the kitchen should have worn a hair restraint and should have worn a beard restraint when facial hair was longer than 1/8 inch. Staff should have washed their hands with soap and water for 20 seconds.</p> <p>A policy, identified as current, titled, "Date Marking," dated 2011, was provided by the DM on 6/9/16 at 3:20</p>			

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	<p>p.m. The policy indicated, "Guideline: All foods stored will be properly labeled...all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines...."</p> <p>The DM provided a current policy, titled "Hair Restraints," on 6/9/16 at 3:20 p.m. The policy indicated, "Guideline: Hair restraints shall be worn by all Dining Services staff when in food production, dishwashing areas...Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas...."</p> <p>On 6/15/16 at 12:02 p.m., the DM provided a current policy, titled "Glove and Hand Washing Procedures," which indicated, "Guideline: All employees will use proper hand washing procedures and glove usage in accordance with State and Federal Sanitation Guidelines...Wet hands and apply soap...Scrub 20 seconds or more...Turn off faucet with paper towel...."</p> <p>A policy, identified as current, titled, "Code of Dress and Personal Appearance," dated 2010, was provided</p>			

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F 0465 SS=D Bldg. 00	<p>by the DM on 6/16/16 at 8:50 a.m. The policy indicated, "Procedure: 1. The following practices and guidelines will be enforced by the Dining Services Manager ...Purses, coats, and other personal items shall be kept out of the food preparation or service area...."</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure area near a nurses' station was free of odor for 1 of 2 nurses' stations (Clearwater Cove/Moonlight Bay) and failed to ensure functional/comfortable living environments for 5 of 28 resident rooms reviewed for sanitary environments (Rooms #105, #107, #121, #123 and #126).</p> <p>Findings include:</p> <p>On 6/9/16 at 10:43 a.m., there was strong urine odor in the locked unit by the nurse's station for Clearwater Cove and Moonlight Bay. The urine odor was again</p>	F 0465	<p>It is the policy of the facility to ensure that the environment is free of odors. It is further the policy of the facility to see that the residents live in a functional and comfortable environment. The areas around the nurses' stations Clearwater Cove and Moonlight Bay are free of odors.</p> <p>Resident rooms #105, #107, #121, #123 and #126 have had the needed cleaning and repairs as stated in the survey.</p>	07/05/2016

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	<p>noticed on 6/10/16 at 10:42 a.m., and 2:05 p.m., 6/13/16 at 2:00 p.m., 6/14/16 at 3:00 p.m., and 6/15/16 at 11:09 a.m.</p> <p>On 6/16/16 at 9:50 a.m., during environmental rounds with the Plant Operations Director and the Housekeeping Supervisor, the following issues were observed:</p> <p>a. Rooms #105 and #107 shared bathroom: Towels were wrapped around the base of the toilet. The wall to the right of the bathroom sink had exposed drywall and was unpainted.</p> <p>b. Rooms #121 and #123 shared bathroom: The wall across from the toilet was heavily scuffed above the baseboard with a round chipped area (measured as 3 inches x 3 inches, by the Plant Operations Director) with drywall dust observed on the floor below the chipped area and a deep gouged area to the left of the chipped area that was measured 2 inches, by the Plant Operations Director. The baseboard to the side left of the toilet (facing) was indented. The base of the door frame leading into room #123 was chipped and was rust colored. The kick panel on the door leading into room #123 was broken with an exposed jagged edge.</p> <p>c. Room #126-A: The wall behind the</p>		<p>A.) The bathroom shared by rooms #105 and #107 have had the towels removed from the base of the toilet and that area has been cleaned and repaired. The drywall to the right of the sink in that bathroom has been repaired and painted.</p> <p>B.) The bathroom shared by rooms #121 and #123 has had the wall across from the toilet repaired around the baseboard as well as a gouged out area. The baseboard to the side left of the toilet has been replaced. The base of the door frame leading into room #123 has been repaired. The kick panel on the door leading into room #125 has been replaced.</p> <p>C.) In room 126-A the wall behind the head of the bed has been repaired.</p> <p>D.) The soiled utility room has been deep cleaned.</p> <p>E.) The soiled barrels are emptied before they begin to</p>	

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	<p>head of the bed was marred.</p> <p>During an interview on 6/16/16 at 9:31 a.m., LPN #8 indicated the smell of urine could get strong around the nurse's station at times. She indicated she did not know how often the housekeeping staff cleaned the soiled utility room.</p> <p>On 6/16/16 at 10:00 a.m., the Housekeeping Supervisor indicated there could be an odor if the soiled linen barrels were full. She indicated the barrels are emptied 3 to 4 times each day.</p> <p>On 6/16/16 at 10:03 a.m., the Plant Operations Director indicated the facility had a work request system. He indicated when areas in need of repair were identified, the staff would complete a "Maintenance Work Order," form. The forms would be placed into a mailbox next to the maintenance room. He indicated he would check the mailbox daily for work requests and the work would be approved and scheduled. The Plant Operations Director indicated he had not been made aware of the issues identified during the environmental rounds.</p> <p>A copy of an undated document titled, "Resident Rights," was provided by the Administrator on 6/15/16 at 2:38 p.m.</p>		<p>exude an offensive odor</p> <p>Residents who reside in the facility have the potential to be affected by this finding. The Administrator/Housekeeping Supervisor and Maintenance Director will make a facility wide tour of resident rooms and common areas noting needed repairs or needed cleaning and noting these concerns. The Maintenance staff will complete at least 5 repairs off of this list weekly as well as continue the routine day to day maintenance duties. Likewise, the Housekeeping Supervisor will see that 5 areas requiring (deep) cleaning will be completed weekly, as well as being sure regular housekeeping takes place. The listed areas for both Maintenance and Housekeeping will continue until all areas have been addressed. The Administrator and the Housekeeping</p>	

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	<p>The document indicated, "Resident Rights...Environment-The facility must provide a...clean, comfortable, home-like environment...."</p> <p>An undated policy, identified as current, titled, "Physical Plant," was provided by the Plant Operations Director on 6/16/16 at 10:33 a.m. The policy indicated, "Daily Inspections...Buildings and Grounds...As areas needing repair are identified, they should be dealt with immediately. If that is not possible, the issue...and/or resident room number should be recorded for proper follow up...Weekly Inspections...Bathrooms-Facility/Resident Rooms: Inspect facets and toilets throughout the facility for proper operations. Any leaking...toilets repair as needed...Monthly Inspections...Paint and Wall Coverings: Inspect for damage, schedule for repair and complete room...touch ups...Rooms: The rooms shall be inspected and any deficiencies shall be documented and scheduled for repair...."</p> <p>An undated policy, identified as current, titled, "General Cleaning Policies And Procedures, Utility Room," was provided by the Administrator on 6/16/16 at 11:15 a.m. The policy indicated, "Purpose: To maintain a clean...environment...Procedure: 2.</p>		<p>Supervisor and the Maintenance Director will tour the facility weekly to verify that the cleaning and repairs have been completed. Any newly discovered concerns will be added to the list as discovered. The weekly touring will be ongoing as part of the Preventive Maintenance Program and the Quality Assurance Program.</p> <p>At an all staff in-service held 6/29/16, the following was reviewed:</p> <p>A.) What makes a safe, sanitary, functional and comfortable environment?</p> <p>B.) How to report a Maintenance request</p> <p>C.) How to report a deep cleaning need</p> <p>D.) Who is responsible to report a Maintenance or Housekeeping issue?</p> <p>E.) Why should these types</p>	

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	Remove General Waste...d. Wipe all surfaces of the waste container with saturated cloth...." 3.1-19(f)		of concerns be reported timely? F.) Discussion Additional in-servicing for the Maintenance staff and the Housekeeping staff included a review of the Preventive Maintenance Program (for Maintenance staff) as well as a review of the role/duties of the housekeeping staff (for Housekeeping staff). Planning and discussion of the weekly tours by the Administrator/Maintenance Supervisor and the Housekeeping Supervisor to verify that repairs and cleaning was being done was also reviewed. These tours will be ongoing. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.	

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F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review the facility failed to ensure complete and accurate documentation was maintained	F 0514	At the monthly Q. A. meetings, the results of the monitoring (tours) by the Administrator/Housekeeping Supervisor/Maintenance Director will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by the Administrator weekly until resolved. It is the policy of the facility to complete and accurate	07/05/2016	

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	<p>for 1 of 3 residents reviewed for documentation of a controlled medication (Resident C).</p> <p>Finding includes:</p> <p>Resident C's clinical record was reviewed on 6/13/16 at 10:53 a.m., diagnosis included but not limited to, infection and inflammatory reaction due to internal right knee prosthesis. The most recent Minimum Data Set (MDS) assessment was completed on 6/6/16. The assessment identified the resident was cognitively intact at decision making skills.</p> <p>The record indicated a physician order, dated 6/2/16, for Hydrocodone-Acetaminophen (pain medication) tablet 5-325 mg (milligram), give two tablets by mouth every four hours as needed for severe pain.</p> <p>A facility document titled, "Control Drug Receipt/Record/Disposition Form" was provided by the DON on 6/13/16 at 12:14 p.m. The record indicated Resident C received pain medication 19 times from the dates of 6/3/16 thru 6/12/16.</p> <p>Review of medication administration record (MAR) indicated Resident C received 6 doses of pain medication fro</p>		<p>documentation is in place and maintained for residents on controlled substances. Resident C has their meds signed out on both the narcotic book record as well as the medication administration sheet. The effectiveness of the pain med is also documented.</p> <p>All residents who reside in the facility and who receive controlled substances have the potential to be affected by this finding. The DON/Designee will monitor controlled substances that are signed out of the narcotic record to see that all doses are entered in the medication administration record as well. Further, documentation of the effectiveness of the prn meds will be verified. Note: Residents on regularly scheduled controlled substances will be monitored for pain management effectiveness.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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	<p>6/2/16 thru 6/12/16 and the medication was effective in relieving pain. The record lacked documentation of resident receiving the other doses that were signed out of the narcotic book by the staff nurse.</p> <p>During an interview on 6/13/16 at 12:25 p.m., the Director of Nursing (DON) indicated Resident C asked for pain medication every 4 hours. She further indicated his pain medication was signed out of narcotic book, but the nursing staff had not always documented the medication administration or its effectiveness into the computer system</p> <p>During an interview on 6/13/16 at 12:25 p.m., LPN #1 indicated she had not documented the pain medication administration and effectiveness into the computer system for Resident C.</p> <p>During an interview on 6/13/16 at 2:48 p.m., the DON indicated staff should have signed out the narcotic medication in the book and also should have documented the medication administration and effectiveness in the computer system.</p> <p>An undated policy, identified as current, titled, "Controlled Substances Storage and Handling", provided by the</p>		<p>Any concerns will be addressed as found. This monitoring will be done for 3 residents 5 days weekly in each of the 4 sections (Moonlight Bay, Misty Lane East, Misty Lane West and Clearwater Cove). This will include some weekend days. The monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. After that, monitoring will occur for 2 residents 3 days weekly (in all 4 sections) for a period of not less than 6 months to ensure ongoing compliance.</p> <p>After that, random monitoring will occur.</p> <p>At an in-service held 6/29/16, for nursing staff who administer meds the following was reviewed:</p> <p>A.) Medication Administration--Policy & Procedure for Controlled Substances</p>	

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	<p>Administrator on 6/14/16 at 7:55 a.m., included but not limited to, "... a. Record each dose at the time of administration on the following:</p> <ol style="list-style-type: none"> 1. MAR <ol style="list-style-type: none"> a. Date b. Time c. Initial of nurse administering dose d. If a PRN order, document effectiveness 2. Controlled Substances Count sheet <ol style="list-style-type: none"> 1. Date 2. Time 3. Signature of nurse who administered dose 4. number of dose remaining" <p>This Federal tag relates to complaint IN00202272.</p> <p>3.1-50(a)(2)</p>		<p>B.) Documentation requirements for controlled substance administration</p> <p>C.) Documentation of the effectiveness of an administered controlled substance</p> <p>D.) Med errors—as related to documentation</p> <p>E.) Q and A</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly Q. A. meetings, the results of the DON/Designee documentation of controlled substance administration will be reviewed. Any concerns will have been addressed as found. Any patterns will be identified. If necessary, an Action Plan will be written by</p>	

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			the committee. Any Action Plan will be monitored by the Administration weekly until resolution.		