| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155688 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 01/21/2015 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FREELANDVILLE COMMUNITY HOME | 310 W CARLISLE ST, PO BOX 288<br>FREELANDVILLE, IN 47535 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F000000 | This visit was for a Recertification and State Licensure Survey<br><br>Survey dates: January 13, 14, 15, 20, 21, 2015<br><br>Facility number: 000355<br>Provider number: 155688<br>AIM number: 100273640<br><br>Survey team:<br><br>Amy Wininger, RN, TC<br>Terri Walters, RN<br>Dorothy Watts, RN<br>Sylvia Scales, RN<br><br>Census bed type:<br>SNF/NF: 35<br>Total: 35<br><br>Census payor type:<br>Medicare: 4<br>Medicaid: 21<br>Other: 10<br>Total: 35<br><br>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1<br><br>Quality review completed on January 26, | F000000 | By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective February 20, 2015 to the annual licensure survey conducted on January 13, 2015 through January 21, 2015. The facility also respectfully request that these citations be considered for paper compliance. | |

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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| | 2015 by Jodi Meyer, RN | | | |
| F000431 SS=D | 483.60(b), (d), (e)<br>DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br>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.<br><br>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.<br><br>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.<br><br>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.<br>Based on observation, interview, and | F000431 | **It is the practice of this facility to assure that residents'** | 02/20/2015 |

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| | record review, the facility failed to ensure narcotic medications were reconciled, in that, two nurses did not visually verify the narcotic count for 1 of 2 medication carts reviewed for narcotic counts. (C hall)<br><br>During an observation on 1/20/15 at 1:59 P.M., LPN #4 and LPN #1 conducted the end-of-shift narcotic count for the C Hall. Licensed Practical Nurse #1 (LPN) who was the oncoming nurse stood with the narcotic count sheets in a binder on the top of the medication cart for the A and B hall beside the cart for C hall. LPN #4 who was the off going nurse was observed to open the locked medication drawer located in the bottom drawer of the C hall medication cart. LPN #4 looked at the medication blister packs and told LPN #1 how many pills remained in each blister pack. LPN #1 did not verify the narcotic medication count by actually viewing the narcotic medications in each blister pack when matching the narcotic count totals recorded on the med count sheets for 15 different narcotics during the reconciliation of the C Hall medication cart.<br><br>During an interview with LPN #1 on 1/20/15 at 2:05 P.M., she indicated during the end of shift narcotic count, the | | **narcotic medications are reconciled appropriately between off-going and on-coming nurses in accordance with the facility policy.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. Nurses have received training related to proper counting of narcotics. Please see below for measures implemented to prevent reoccurrence. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents receiving narcotics could have been affected. Narcotics are not being counted in accordance with the facility policy. Please see below for measures implemented to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses have been in-serviced related to the counting narcotics between off-going nurses and on-coming nurses in accordance with the facility policy. It has been reiterated that both nurses involved in the counting process must visualize the count on the medications prior to signing the narcotic count sheet. Nursing Administration will be randomly reviewing during narcotic counts to assure it is being completed in | |

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| | off going nurse would observe and call out the amount of medication left in each card. The on-coming nurse would verify only using the binder, which would indicate the amount that should be in the card.<br>She further indicated she did not visually observe the amount of medications actually left in the cart.<br><br>A policy titled "NARCOTICS COUNT" and dated 1/10/11 was provided by the DON (Director of Nursing) on 1/20/15 at 2:00 P.M., it included, "1. One R.N. [Registered Nurse] or one L.V.N. [Licensed Vocational Nurse] going off duty and one R.N. or one L.V.N. coming on duty must count and justify narcotic supply for each individual resident at the change of each shift."<br><br>During an interview with the DON on 1/20/15 at 4:10 P.M., she indicated she was unaware 2 nurses had not been visually verifying the narcotic count.<br><br>3.1-25(m) | | accordance with facility policy. Please see below for systems for monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement tool has been established that randomly reviews 5 narcotic count processes between shifts to assure that it is being completed in accordance to the policy. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** February 20, 2015 | |
| F000441<br>SS=D | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the | | | |

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| | development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | A. Based on observation, interview, and record review, the facility failed to ensure handwashing procedures were followed by a resident (Resident #19) and/ or soiled items were properly disposed of by staff per facility policy for 1 of 1 resident observed being toileted in contact | F000441 | **It is the practice of this facility to assure that all procedures and services are conducted in a manner that is in accordance with infection control guidelines.** ***The correction action taken for those residents found to be affected by the deficient practice*** | 02/20/2015 |

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| | isolation.<br>(Resident #19)<br><br>B. Based on observation, interview, and record review, the facility failed to ensure proper hand washing and/or hand hygiene was performed by staff, in that, hand washing and/or hand hygiene was not performed between glove changes during 1 of 1 observations of Stage IV wound dressing change. (Resident #1)<br><br>Findings include:<br><br>A.1. On 1/14/15 at 9:47 A.M., Resident #19's clinical record was reviewed. Resident #19 had been admitted to the facility on 12/2/13. Her current 5 day Minimum Data Set assessment (MDS) dated 12/26/14, indicated extensive assistance of 1 staff needed for ambulating in corridor, frequently incontinent of urine, and a cognition score of 10 (moderate cognitive impairment). Diagnoses included, but were not limited to, psychosis, bipolar disorder, and urinary tract infection.<br><br>On 1/15/15 at 11:15 A.M., Resident #19 was observed ambulating with a walker to hall A's facility community shower room/bathroom. Restorative CNA #1 assisted Resident #19 who was wearing a gait belt. Resident #19 pulled her own | | ***include:*** Resident #19 is now being cued related to washing of hands as part of infection control. This resident's soiled supplies are also being disposed of properly in accordance with facility policy. Resident #1 is receiving services related to treatments and services in accordance with the facility's infection control policy. ***Other residents that have the potential to be affected have been identified by:*** All residents are receiving services within acceptable parameters of infection control including proper hand washing between glove changes. Resident's soiled supplies are being disposed of properly in accordance with the facility policy. Residents are being cued for washing of hands in accordance with proper infection control. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted for nurses and CNAs related to proper infection control practices. The in-service addresses proper hand washing and proper changing of gloves. The in-service also addresses disposing of soiled supplies in an acceptable manner based on proper infection control standards. The in-service also addresses assisting the residents wash their hands as part of the infection control process. The | |

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| | slacks down and sat on the commode.<br>Restorative CNA #1 applied gloves and checked Resident #19's disposable brief and indicated there was bm (bowel movement) soiling.<br>Restorative CNA #1 removed her gloves and disposed of gloves in the trash can in the bathroom that contained a tan colored trash bag.<br>Restorative CNA #1 then washed her hands and applied new gloves. She removed the soiled disposable brief and placed in the tan trash bag in the bathroom trash can.<br>Restorative CNA #1 then washed her hands and applied new gloves.<br>Resident #19 voided in the commode.<br>A new disposable brief was applied by Restorative CNA #1 and she also assisted the resident to pull her slacks up.<br>Restorative CNA #1 then removed her gloves and disposed of gloves as she had before in the bathroom trash can.<br>Restorative CNA #1 then applied an antibacterial hand gel and applied new gloves.<br>Resident #19 then handed soiled toilet paper she had been holding to Restorative CNA #1 for disposal.<br>Resident #19 indicated she had wiped herself after voiding. Restorative CNA #1 wrapped the toilet tissue in the glove she had been wearing as she removed her gloves and placed them in the bathroom | | facility will be randomly observing staff that is providing services to assure that proper infection control protocol is followed in accordance with the facility policy.<br>***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 residents during provision of services including treatment changes and toileting related to following of proper infection control procedures including glove changes and hand-washing by both staff and residents This tool will also observe to assure that soiled supplies are disposed of properly. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. The tool will be completed randomly for all shifts in a 7 day period. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** February 20, 2015 | |

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| | trash can.<br>Restorative CNA #1 then washed her own hands.<br>Resident #19 exited the bathroom with Restorative CNA #1 without Resident #19 washing her hands.<br><br>On 1/15/15 at 11:27 A.M., CNA #2 entered the shower room/bathroom Resident #19 had just exited. She indicated she was going to clean the commode. She used a disposable bleach wipe labeled Microdot. She cleaned the surface of the commode seat (top and underneath) and the rim of the commode. She disposed of the wipes and gloves in the bathroom trash can and washed her hands. She then removed the tan trash bag from the bathroom trash can and tied up the bag. She indicated she was going to take the trash bag directly to the facility trash dumpster (outside). After disposing of the trash bag in the facility dumpster she returned to the facility and washed her hands.<br><br>On 1/20/15 at 10:51 A.M., the Director of Nursing (DON) was interviewed regarding toileting of Resident #19 while in contact isolation. The clinical record of Resident #19 was reviewed with the DON at that time. A lab report dated 1/8/15, indicated a urine culture was positive for the organism extended | | | |

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| | spectrum beta lactamase (ESBL). A physician's order dated 1/8/15 indicated a new order had been received for contact isolation due to a urine culture had been positive for ESBL. The DON indicated the resident currently remained in contact isolation r/t (related to) ESBL. She indicated Resident #19 frequently used a facility community bathroom. She indicated the commode was to be cleaned after each use by Resident #19. She added it needed to be cleaned with a bleach wipe each time. She indicated red trash bags (bio-hazard bags) had been available in the facility community bathrooms to be used to dispose of the soiled disposable brief, soiled gloves, and toliet tissues used by Resident #19. She indicated the red trash bags were not to be placed in the facility dumpster for disposal. The DON indicated the facility had a service for removal of bio-hazard materials from the facility.<br><br>On 1/21/15 at 10:39 A.M., the DON was made aware of Resident #19 being toileted on 1/15/15 at 11:15 A.M., and soiled items had been placed in a regular trash bag and disposed of in the facility's dumpster. The DON was also made aware that Resident #19 had not washed her hands after toileting. The DON indicated, at that time, the trash from toileting of Resident #19 (who was in | | | |

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| | contact isolation) should have been placed in red bio-hazard bags and taken to the bio-hazard room for disposal. The DON indicated, Resident #19 needed to wash her hands after toileting.<br><br>On 1/20/15 at 12:00 P.M., a facility policy (revision date 9/13) entitled, "POLICY/PROCEDURE Isolation-Contact " was reviewed. The policy included but was not limited to, " ...Contact Isolation practices are to provide maximum protection to prevent the spread of microorganisms among residents, staff, and visitors, by direct or indirect contact..." "...Examples of illnesses with isolated organisms that require contact isolation... Extended Spectrum Beta Lactamases [ESBL]..." "...13. Resident may leave room to participate in dining, activities, or therapies after preparing the resident by the following:..." "...Ensure resident's hands are thoroughly washed [alcohol based hand sanitizer or hand sanitizing wipes may be used] prior to leaving room..."<br>B. 1. During an observation of care on 1/15/15 at 10:00 A.M., the following was observed:<br><br>CNA #10 and LPN #1 were observed to perform handwashing and apply clean gloves. During an interview, at that time, | | | |

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| | CNA #10 indicated additional trash can liners were needed and was observed to exit the room with gloved hands.<br><br>LPN #1 indicated during an interview, at that time, she was preparing to change the dressing of a Stage 4 coccyx wound for Resident #1. CNA #10 was then observed to re-enter the room, remove gloves, apply clean gloves, remove individual pieces of trash from a receptacle and place in a trash bag, place the bag in the receptacle, remove gloves, pull up the front of his pants, and apply clean gloves. CNA #10 was then observed to open the closet with gloved hands, retrieve an article of clothing for Resident #1, pull up the front of his pants, return to the bedside of Resident #1, and assist Resident #1 to reposition in the bed by placing his gloved hands on the back and the leg of Resident #1. CNA #10 was observed to not perform handwashing and/or hand hygiene between glove changes.<br><br>LPN #1 was then observed to pull the privacy curtain with a gloved hand, prepare the wound dressings, remove the gloves, and apply clean gloves. LPN #1 was then observed to remove the dressing and cleanse the wound with gloved hands. LPN #1 was observed, at that time, to remove the gloves, apply clean | | | |

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| | gloves, and apply the new wound dressing. LPN #1 was observed to not perform handwashing and/or hand hygiene between glove changes.<br><br>During an interview on 1/21/15 at 10:55 A.M., the HFA (Health Facilities Administrator) indicated handwashing and/or hand hygiene should be performed between glove changes.<br><br>The Policy and Procedure for Handwashing provided by the HFA on 1/21/15 at 11:00 A.M. indicated, "...Purpose:...To reduce transmission of organism...To prevent the occurrence of infection...indications for handwashing...after removing gloves..."<br><br>3.1-18(b)(2)<br>3.1-18(l) | | | |