STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/21/2011
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTERS OF BRAZIL		STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN47834	

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: November 14, 15, 16, 17, 18 and 21, 2011 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 Survey Team: Mary Weyls, RN Teresa Buske, RN Laura Brashear, RN Debra Skinner, RN Census Bed Type: SNF/NF: 97 Total: 97 Census Payor Type: Medicare: 12 Medicaid: 61 Other: 24 Total: 97 Stage 2 Sample: 44 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed on	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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	November 22, 2011 by Bev Faulkner, RN			
F0323 SS=D	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. Based on observation, record review and interview ,the facility failed to maintain a safe environment during 2 of 2 random observations; in that Resident # 27's side rail was observed with space greater 4 3/4 inches and Resident #58 was observed in the beauty shop utilizing portable oxygen and oxygen tank not maintained at a distance from hair dryer as per facility policy. Findings include: 1. On 11/18/11 at 10:14 a.m., Resident #58 was observed in the Beauty Shop sitting under the hair dryer. The resident was utilizing oxygen at 2 liters per nasal cannula with a portable oxygen tank . The portable oxygen tank was hanging on the back of the resident's wheelchair and the portable oxygen tank was directly against the hair dryer. The hair dryer heat was set on normal. The air from the functioning hair dryer	F0323	Correction and specific corrective actions are prepared and/or executed solely because provisions of Federal and/or State Laws. Exceptional Living Centers of Brazil desires this Plan of Correction to be considered the facility's allegation of Compliance. Preparation and. or execution of the Plan of Correction in general, or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Exceptional Living Centers of Brazil of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Compliance is effective. **12/09/2011** **F 323** 1. A) Residents #27 side rail was assessed and changed immediately with a Federal Guideline appropriate side rail with space less then 4 ¾" upon identification of alleged inappropriate spacing. B) Resident # 58 was removed from the Beauty Shop immediately upon identification of the alleged non compliance of Facility's Protocol for Hair Salon Safety. 2. A) All residents using side rails have potential to be effected by	12/09/2011

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	felt warm to the touch. Interview of LPN #12 on 11/18/11 at 10:13 a.m., who was present in the beauty shop, indicated she was not sure of current policy but would obtain the policy. Interview of the Beautician on 11/18/11 at 10:20 a.m., indicated she has always left the oxygen on residents while in the beauty shop. She indicated that in another facility where she works the policy was different. The Beautician indicated she had asked the maintenance person regarding the oxygen use in the beauty shop. Review of the facility's policy and procedure titled "HAIR SALON SAFETY," dated 12/11/09, on 11/18/11 at 12:35 p.m., indicated "....4. OXYGEN SAFETY a. If possible remove the oxygen while in the salon (the resident's nurse can let you know if the person can be without their oxygen while in the beauty salon). b. If oxygen must be used while in the beauty salon 1. Keep the hair dryer setting on the lowest heat possible. Keep the oxygen tank as far from the dryer as the tubing will allow without creating another hazard for individuals walking in the area...."		alleged deficiency. The side rails of all affected residents were checked per Federal Recommended Guidelines to ensure proper placement of all side rails.**(See attachment A)** Maintenance Director/Designee has read the Federal / State requirements for bed safety and will perform weekly preventative Maintenance examination of all residents that utilize side rails to assure the side rails meet Federal /State Guidelines. **(See attachment B).** DON/Designee will monitor resident's clinical file to ensure each affected resident has proper Physician Order, Side Rail assessment, and Careplan to assure compliance with Facility Policy and Procedure for Side Rail Placement. B) All residents using Oxygen who go to the Beauty Shop have the potential to be affected by alleged deficiency. All current residents who go to the Beauty Shop and at the time of admission any resident that is requesting Beauty Shop services will be assessed by the DON/Designee to determine continuous oxygen therapy need.**(See attachment C)** 3.A) The DON/Designee will communicate daily/prn basis with the Maintenance Supervisor/Designee of the addition/ removal of any side rail to ensure that the facility is following State and Federal Recommended Guidelines	

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	Review of the clinical record of Resident #58 on 11/21/11 at 11:34 a.m., indicated the physician order, dated 8/15/11, of oxygen at 2 liter nasal cannula continuously due to Chronic Obstructive Pulmonary Disease. The most recent Minimum Data Set assessment, dated 11/9/11, indicated the resident was severely cognitive impaired and required total dependence for transfers. Interview of the Administrator on 11/18/11 at 12:35 p.m., indicated the policy was posted in the Beauty shop.		regarding addition/removal Residents care plan and CNA assignment sheets will supply staff with information indicating each resident in need of a side rail. B) DON/Designee will review and educate staff regarding facility's revised Hair Salon Safety guidelines form. DON/Designee will review Hair Salon Safety form with all new employees. Facility revised Hair Salon Safety form will be posted in facility Beauty Shop. Any resident requesting beauty Shop services (that have continuous Oxygen in use) will be assessed by DON/Designee to determine continual need. Any resident that cannot have Oxygen removed for the use of a hair dryer will follow revised Facility policy to decrease risk during dryer usage. **(See attachment C and attachment D).** A list of residents who require Oxygen during time in the beauty shop will be provided to the beautician and updated as needed. 4. A) The Maintenance Supervisor/Designee will monitor for correct placement of all side rails to ensure side rail placement meets Federal /State Guidelines. Monitoring will be done on a weekly and a PRN basis. The results of the monitoring will be reviewed by the Administrator and presented for review by the QA team during quarterly QA meetings. **(See attachment B)**	

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			B) Oxygen use in the Beauty Shop will be monitored weekly X4 weeks and at least quarterly by DON/Designee. The results of the monitors will be reviewed by the Administrator and presented to the QA team during the quarterly QA meetings. 5. Date of compliance 12/09/2011	
	2. On 11/18/11 at 11:09 a.m., Resident #27 was observed sitting on the edge of the bed. LPN#4 was observed to perform a blood glucose finger stick and administer medications to the resident. A side rail was observed attached to the left upper side of the resident's bed. The device was observed to have a large space in between the vertical bars of the device, and between the top of the mattress and top horizontal bar. On 11/18/11 at 11:50 a.m., with LPN #4, measurements of the space between the vertical bars measured 13 and one half inches. The space in between the mattress and top horizontal bar measured nine inches. On 11/18/11 at 2:35 p.m., the Administrator was interviewed. The Administrator indicated the resident had purchased the rail herself. The Administrator indicated she interviewed maintenance staff and discovered Assistant Maintenance			

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	Staff #5 had attached the rail to the resident's bed about a month ago. The Administrator was interviewed on 11/21/11 at 3:29 p.m. The Administrator indicated she had talked with LPN #4 and the nurse indicated the resident's daughter had brought the side rail in and LPN #4 thought it had been checked per facility policy and Maintenance Staff #5 attached the rail to the resident's bed. The Administrator indicated it was the policy of the facility to have any items brought in for residents checked in with nursing staff before placing in residents' rooms. A facility policy titled "Side Rail Screen Procedure," dated 8/05, provided by LPN, Unit Manager #11 on 11/21/11 at 4:21 p.m., included, but was not limited to, "Purpose: To ensure appropriate use of side rails. Procedure: 1. Complete the side rail screen form within 10 days of admission, quarterly, with significant changes and annual MDS [Minimum Data Set] assessments. ...3. Determine the reason for side rail use. ..6. Reason/rationale for use of side rail(s) must be addressed thoroughly in the plan of care. ..." The side rail screen form included,			

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	but was not limited to the type of side rails utilized and the reason for use including requested by the resident. Additional information provided with the facility's policy included but was not limited to "Warning RISK OF SERIOUS INJURY OR DEATH, When using side rails, only use side rails in which any gaps between the rail body members are small enough to prevent a patient from getting his or her head or neck inside the rail body. Failure to do so could result in injury or possible suffocation. ..." Safety guidelines provided by the FDA [Federal Drug Administration] identified the area within the rail as Zone 1 as a potential area for entrapment. Dimensional limits for Zone 1 recommend the space be less than 4 and 3/4 inches. 3.1-45(a)(2)			

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F0441 SS=D	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 proper handwashing was completed by a licensed nurse	F0441	Correction and specific corrective actions are prepared and/or executed solely because provisions of Federal and/or State Laws. Exceptional Living Centers of Brazil desires this Plan of Correction to be considered the facility's allegation	12/09/2011

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	providing peritoneal dialysis services for 1 of 1 residents in a Stage 2 sample of 44; in that RN #9 failed to wash hands and/or change gloves after contamination. (Resident # 127) Findings include: On 11/17/11 3:40 p.m., RN# 9 initiated peritoneal dialysis for Resident # 127. RN #9 was observed to wash her hands and put on gloves. The nurse then placed a mask over her mouth with her gloved hands and then pushed her hair back to place the straps of the mask around her ears. The nurse walked around the bed to retrieve the bag of dialysis solution and a thermometer from the resident's bedside table. The nurse placed the dialysis solution on a table next to the resident's bed. Next the nurse removed the external bag from around the dialysis solution and used the thermometer to check the temp of the solution (by placing the thermometer on the outside of the bag). The nurse handled the instructions attached to an IV Pole, wiped the organizer with a solution titled "Alcavis" placed on a wipe, then connected the extension set to the		of Compliance. Preparation and. or execution of the Plan of Correction in general, or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Exceptional Living Centers of Brazil of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Compliance is effective. **12/09/2011** **F 441** 1. There was no negative clinical outcome to resident #127 from the alleged deficiency. Licensed Nurse involved with providing the services for resident #127 has been re- educated regarding Peritoneal Dialysis Administration by the DON/Designee **(See attachment E).** 2. One of One resident has the potential to be effected by the alleged deficiency. All Licensed Nurses will be re-educated by DON/Designee for following facilities policy and procedure regarding Peritoneal Dialysis Administration. **(See attachment F)** 3. Upon hire the DON/Designee will educate each new licensed Nurse on Facility's Policy and Procedure for administering Peritoneal Dialysis to ensure compliance for alleged deficiency. **(See attachment F).** 4. The DON/Designee will monitor Licensed Nurses performances of Peritoneal Dialysis Administration. Currently the facility does not have any	

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	"stay safe disc." The clamp was then opened on the extension set that allowed the fluid to drain from the resident. During review of the facility's procedure concerning peritoneal dialysis, received on 11/18/11 at 10:30 a.m., from the DON (Director of Nursing), documentation indicated to place the mask and then wash hands and to use a cleansing agent "Alcavis" to clean the extension set and tips of fingers prior to initiating the dialysis. During interview of the DON on 11/18/11 at 10:30 a.m., the DON indicated RN #9 should have washed her hands after getting supplies ready and prior to donning the mask. The DON indicated the information provided, concerning peritoneal dialysis, was the information provided by an RN that works at a dialysis unit. The DON indicated all nursing staff was inserviced concerning peritoneal dialysis by the staff nurse from the dialysis unit. 3.1-18(l)		residents who receive peritoneal dialysis. However, the DON/Designee will observe licensed nurses perform peritoneal dialysis if the facility admits a resident with this need. The DON/Designee will monitor the performance as follows; 5 days per week for two weeks, weekly for four weeks, monthly for two months and at random as needed. Deficient practices will be addressed with the individual immediately by DON/Designee. The results for the monitors will be reviewed by the Administrator and the QA team during the quarterly QA meetings.**(See attachment F-Stay-Safe CAPD Training Check List).** 5. Date of Compliance 12-09-11	

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