

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155419	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/12/2014
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT CRAWFORDSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N WHITLOCK AVE CRAWFORDSVILLE, IN 47933
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00158364.</p> <p>Complaint IN00158364-Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F329, and F465.</p> <p>Survey dates: November 3, 5, 6,7, 10, and 12, 2014.</p> <p>Facility number: 000533</p> <p>Provider number: 155419</p> <p>AIM number: 100267230</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN Vickie Nearhoof, RN Geoff Harris, RN Brooke Harrison, RN November 10 and 12, 2014.</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicaid: 30</p>	F000000		

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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F000314 SS=D	<p>Other: 4 Total: 34</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 11/13/14 by Brenda Marshall, RN.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a system for obtaining a physician's order to treat a pressure ulcer in a timely manner for 1 of 1 resident with an in house developed pressure ulcer. (Resident #35)</p> <p>Finding includes:</p> <p>During initial tour on 11/3/14 at 10:38 a.m., Resident #35 was observed on an air loss mattress.</p>	F000314	<p>It is the standard of this facility that a resident having a pressure sore will receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>1. What corrective action will be done by the facility? The licensed nurse responsible for the alleged improper physician notification is no longer employed by the facility. All professional nursing staff has been retrained on the proper procedure for notifying physicians regarding new or changing treatments for</p>	12/12/2014			

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	<p>During interview of the DON (Director of Nursing) on 11/5/14 at 2:47 p.m., the DON indicated Resident #35 had a stage 3 pressure ulcer developed after admission to the facility.</p> <p>On 11/7/14 at 10:10 a.m. LPN # 3 provided a treatment to the pressure area on the resident's coccyx. The nurse measured the area as 1 cm (centimeter) length by 0.4 cm. width. No depth was observed.</p> <p>During review of Resident #35's clinical record on 11/10/14 at 10:40 a.m., "A Fax Cover Sheet" indicated information was faxed to the resident's physician on 10/3/14 at 9:00 p.m. The documentation included: "found 0.5 x 0.2 cm o/a: [open/area] on coccyx. Applied gauze and tape. Will continue to monitor." Under the title of "Physician response" the word "OK" was noted, with the physician's signature dated 10/6/14.</p> <p>A nurse's note, dated 10/06/14 at 10:00 a.m., included: "O/A [open area] remains to coccyx. MD [medical director] notified for duoderm, vitamin AC and zinc". A nurse's note dated 10/06/14 at 9:30 p.m., indicated a faxed document was returned at 9:30 p.m. with orders for "Apply and change Duoderm q [every] 3</p>		<p>pressure ulcers, including the need for prompt notification and follow up with the physician, if necessary, to make sure that she/he has been notified and that appropriate treatment orders have been received. <b>(See attachment #1)</b></p> <p>2. How will the facility identify other residents having the potential to be affected by this alleged practice? At the time of the survey, no other resident in the facility had been identified with a pressure ulcer. However, if the DON should find that a resident has been identified with a pressure ulcer and that the physician notification and subsequent treatment orders have been delayed, she will ensure that the physician is notified immediately and that treatment orders have been received. Once the resident has been cared for, she will retrain the nurse(s) involved in the delay of physician notification on the facility policy. In addition, the DON will render progressive disciplinary action as indicated by the situation for the nurse(s) involved.</p> <p>3. What measures will be put into place to ensure the practice does not recur? During the interdisciplinary management meeting that occurs at least 5 days a week, the 24-hour report will be reviewed by the clinical management team to determine if there are any new or changed</p>				

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F000322 SS=D	<p>days (AM) and PRN [whenever necessary] to O/A [open area] on buttocks. Consult wound care."</p> <p>Documentation on a "Weekly Pressure Ulcer/Deep Tissue Injury Assessment" indicated on 10/6/14, the area on the coccyx was a stage 2, measuring 1.2 cm length by 0.5 cm width with less than 0.1 cm tunneling, an increase from the measurement documented on 10/3/14.</p> <p>During interview of the DON on 11/10/14 at 11:49 a.m., the DON indicated the physician should have been notified through the physician services at the time the open area was found.</p> <p>A facility policy and procedure, titled "Discovering/Reporting New Pressure Ulcers," received from the Director of Nursing (DON) on 11/10/14 at 2:00 p.m., included "In order to heal pressure ulcers and other skin conditions, the nurse must get a treatment order from the physician."</p> <p>3.1-40(a)(2)</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of</p>		<p>pressure ulcers. If any are identified, nurses' notes, faxsheets, and telephone orders will be reviewed for timely notification of physicians and new treatment orders. If any issues or concerns are identified at that time, the DON will follow up as indicated in question #2. <b>(See attachment #2)</b></p> <p>4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DON will bring the results of the review done by the clinical management team to the monthly meeting of the QA Committee for review and recommendation. This reporting will continue for three months, and if 100% compliance has been achieved, the Committee may decide to stop the reporting requirement; however, the DON and clinical management team will continue to review the 24 hour report and focus charting as indicated above on an ongoing basis, even when the report to the QA Committee is no longer required.</p>	

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	<p>a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who were administered medications by a gastrostomy tube (G-tube) received the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, and dehydration.</p> <p>Findings include:</p> <p>On 11/10/14 at 9:33 a.m., Resident #15 was lying flat on her back in bed. RN #4 did not elevate the head of the bed and administered medications to Resident #15 via G-tube with 30 cc (cubic centimeters) of water before and after each medication administration. RN #4 indicated that she administered approximately 600 cc of water with the medications.</p>	F000322	<p>It is the standard of this facility that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>1. What corrective action will be done by the facility? RN #4 is no longer employed by the facility. The professional nursing staff has been retrained on the policy and procedure for care and treatment of residents with G-tubes, including the need for elevation of the head of the bed to an angle of 30 to 45 degrees. All nursing staff have been retrained on the need to maintain the elevation of the head of the bed for G-tube residents while they are in the bed, including during times of personal</p>	12/12/2014

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	<p>On 11/10/14 at 9:45 a.m., RN #4 indicated Resident #15's head of bed (HOB) was not elevated to 30 degrees. RN #4 indicated the facility's policy was that a resident receiving anything through a G-tube should have HOB elevated to a 30 to 45 degree angle.</p> <p>Physician's orders for Resident #15, dated 10/21/14, included but was not limited to: "...Medicines may be given per G-tube, flush G-tube with 30 cc of water before and after medication administration, and 60 cc water with medications ... "</p> <p>A policy titled, "Enteral Feeding - Medication Administration (G-Tube, N-G Tube, Jejunostomy)", dated June, 2004, and identified as a current facility policy by the Director of Nursing (DON), included but was not limited to: "...If resident is in bed, elevate head of bed to 30-45 degree angle (semi- or high-Fowler's position.) "</p> <p>3.1-44(a)(2)</p>		<p>care. (see attachment #3)</p> <p>2.Howwill the facility identify other residents having the potential to be affectedby this alleged practice. Any resident with a G-tube has thepotential to be affected by this practice. There are three residents in the facilitywho are fed partially, or fully, through a G- tube at this time. None havebeen affected by this practice, but if an observation is made at any time thata resident with a G-tube does not have his/her head of bed elevated asrequired, the DON will address the situation immediately and make sure that thehead of bed is elevated. Once the resident is cared for, she will retrain thenursing staff involved in the proper procedure and will rendercounseling/disciplinary action as indicated by the situation.</p> <p>3.Whatmeasure will be put into place to ensure the practice does not recur? The beds of all residents who arefed through a G-tube have been marked toshow the proper angle for 30 degrees, so that all nursing staff will be able tomaintain the head of the bed at the correct angle. Care plans and CNAassignment sheets for the residents with G-tubes will be updated as needed toreflect the elevation of the heads of their</p>		

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F000323	483.25(h)		<p>beds. <b>(seeattachment #4)</b></p> <p>As part of regular rounds done bymanagers and licensed nurses during their tours of duty, beds of residents withG-tubes will be observed to make sure that they are elevated at a minimum ofthe 30 degree angle. Any identified issues will be addressed as indicated inquestion #2. <b>(see attachment #5)</b></p> <p>4.Howwill the corrective active be monitored to ensure the practice does not recur and what QA will be put into place? The DON will bring the results ofthe monitoring rounds to the monthly meeting of the QA Committee for review andrecommendation. This reporting will continue for three months, and if 100%compliance has been achieved, the Committee may no longer request a report;however, the DON, nurses, and managers will continue to monitor the position ofthe heads of the beds for G-tube residents as indicated above on an ongoingbasis, even when the report to the QA Committee is no longer required.</p>		

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SS=D	<p><b>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>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, interview, and record review, the facility failed to utilize safety devices in accordance with a plan of care and in accordance with manufacturer's directions for 1 of 3 residents reviewed for accidents. (Resident #32)</p> <p>Finding includes:</p> <p>During the Stage I staff interview on 11/5/14 at 10:27 a.m., RN #4 was interviewed. The nurse indicated Resident #32 had fallen within the last 30 days and had a history of getting up without assistance.</p> <p>On 11/5/14 at 10:30 a.m., the resident was observed in a recliner in her room. A pressure pad alarm was underneath the resident. The alarm box was positioned on an overbed table next to resident. The box was not secured to anything and was within the resident's reach.</p> <p>On 11/7/14 at 10:00 a.m., the resident was observed in a recliner in her room. The foot rest of the chair was elevated. A</p>	F000323	<p>It is the standard of this facility to 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>1. What corrective action will be done by the facility? All nursing staff has been retrained on the proper positioning of alarm monitors as indicated by manufacturers' instructions. <b>(See attachment #6)</b></p> <p>2. How will the facility identify other residents having the potential to be affected by this alleged practice? Any resident who requires the use of an alarm has the potential to be affected. There are other residents in the facility who have chair alarms that are connected to a monitor at this time – none have been adversely affected. In the future, if an alarm is not positioned as per manufacturer's instructions, the DON will make sure that the practice is corrected immediately and that the resident is safe. Once that is done, she will retrain all involved nursing staff on the proper</p>	12/12/2014			

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	<p>pressure pad alarm was underneath the resident and the alarm box was dangling by the connection cord. A corner of the box was in contact with the floor.</p> <p>On 11/7/14 at 2:30 p.m., the resident was observed in her room in a recliner. A personal tab alarm was clipped to the resident. The alarm box was not secured to anything and was on the arm of the resident's chair.</p> <p>Resident #32's clinical record was reviewed on 11/7/14. A nursing note, dated 9/18/14 at 10:00 a.m., indicated the resident had fallen at 9:45 a.m. The note indicated the resident had stated she needed to walk.</p> <p>The DON (Director of Nursing) was interviewed on 11/7/14 at 11:36 a.m. The DON indicated the resident had gotten out of the chair in her room, started to walk and fell. The resident had unplugged the alarm. The DON indicated on 9-24-14 the resident had fallen in her room from a chair. The resident had leaned forward in her chair to pick up puzzle pieces that had fallen onto the floor. At that time the approach for an alarm was implemented to utilize a clip alarm in the chair and not the pressure pad alarm. The DON indicated that was the current plan for the resident.</p>		<p>procedure for utilizing the alarm. If indicated by the situation, she will also render discipline/counseling to those involved in the noncompliance.</p> <p>3. What measures will be put into place to ensure the practice does not recur? Straps have been installed on all chair alarms/monitors so that they can be anchored to the back of the chair or wheel chair. The CNAs will document on the Alarm Checklist during their respective shifts that the monitor is anchored behind the chair/wheel chair, and/or out of the reach of the resident.</p> <p>At the morning clinical management meeting which occurs at least 5 days a week, the Alarm Checklist from the previous day will be reviewed for compliance. As part of regular rounds done by managers and licensed nurses during their tours of duty, they will observe the placements of the alarm monitors. Any identified issues will be addressed as outlined in question #2. <b>(see attachment #7)</b></p> <p>4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DON will bring the results of the monitoring rounds and</p>				

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	<p>A plan of care with initial date of 3/3/14, and most recent update on 9/25/14, addressed the problem of at risk for falls due to history of falls, cerebral vascular accident, diagnosis of seizures, and impaired cognition. The most recent update, dated 9/25/14, included "Change pressure alarm to chair to a pull alarm while in the chair."</p> <p>The manufacturer's directions for the pressure pad alarm (no date) provided by the DON on 11/12/14 at 9:55 a.m., included, but was not limited to: "Chair Sensor Pads Place the monitor out of reach of the resident. Suitable monitoring location includes the back of handle of wheelchair. Make sure the resident cannot tamper with the monitor."</p> <p>The manufacturer's directions for the 'Personal Sentry Fall Monitoring System User Instructions' (no date) provided by the DON on 11/12/14 at 9:50 a.m., included but was not limited to, "How to Use the Personal Sentry Monitoring System The monitor is mounted to either a chair or bed using the clip on the back of the monitor or using the optional Universal Mounting Bracket or Chair Strap."</p> <p>This Federal tag relates to Complaint</p>		<p>alarm checklists to the monthly meeting of the QA Committee for review and recommendation. This reporting will continue for three months, and if 100% compliance has been achieved, the Committee may no longer request a report; however, the DON, nurses, and managers will continue to monitor the position of the alarm monitors and the alarm checklists as indicated above on an ongoing basis, even when the report to the QA Committee is no longer required.</p>				

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F000329 SS=D	<p>IN00158364</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident's blood pressure was monitored for medication efficacy/necessity for 1 of 5 people reviewed for unnecessary medication (Resident A).</p> <p>Finding includes:</p>	F000329	<p>It is the standard of this facility that all residents' drug regimens will be free from unnecessary drugs, including providing adequate monitoring of vital signs as indicated by the medication and the physician's orders.</p> <p>1. What corrective action will be done by the facility? RN #4 is no longer employed by this facility. All professional nursing staff has been retrained on the</p>	12/12/2014

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	<p>During interview of Resident A on 11/5/14 at 10:46 a.m., the resident indicated the staff did not want him walking long distances without assistants of staff due to problems of dizziness and passing out.</p> <p>Resident A's clinical record was reviewed on 11/6/14 at 2:53 p.m. A diagnosis of HTN (hypertension) was noted.</p> <p>A plan of care was noted, dated 9/11/14, identified a problem of "I have had lots of falls in the past. I get dizzy and feel like I am going to pass out some times...</p> <p>A physician's order, with an original order date of 9/23/14, indicated Metoprolol (medication for the treatment of high blood pressure) 25 mg (milligram) twice daily, and doxazosin (medication for the treatment of high blood pressure) 2 mg every morning.</p> <p>A physician's order was dated 11/4/14 at 6 a.m., of "Add blood pressure parameters d/t (due to) resident takes Metoprolol Hold if SBP (systolic blood pressure) is below 100 or DBP (diastolic blood pressure) is below 70 or HR (heart rate) below 60." [sic]</p> <p>Resident A's November 2014 MAR (Medication Administration Record) was</p>		<p>importance of monitoring residents' parameters, as prescribed by their physician, regarding those residents receiving blood pressure medications. <b>(See attachment #8)</b></p> <p>2. How will the facility identify other residents having the potential to be affected by this alleged practice? Any resident receiving medication that affects blood pressure has the potential to be affected. The Director of Nursing has completed an audit identifying all residents who take blood pressure medication and who have parameters assigned by their physician. No other resident has been found to be affected at this time. <b>(See attachment #9)</b> If the DON should determine that a resident who has parameters for receiving blood pressure medication, is not having their blood pressure or pulse taken or recorded, or that the physician has not been notified if the blood pressure/pulse readings were not within the physician/pharmacist parameters, she will make sure that the resident's blood pressure and/or pulse is checked immediately and the physician notified if necessary. Once she has made sure that the resident's condition is stable, she will retrain the nurse involved in the noncompliance and will render progressive disciplinary action as indicated by the</p>				

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F000371 SS=F	<p>reviewed on 11/10/14 at 1:55 p.m. The record indicated the resident's blood pressure was monitored in the a.m. on November 8th, 9th and 10th. The record did not indicate the blood pressure and/or pulse were monitored any other dates or times.</p> <p>During an interview on 11/10/14 at 1:55 p.m., RN #4 indicated she passed a.m. medication to Resident A on November 8th, 9th and 10th, 2014 and did not check the resident's pulse prior to administering the blood pressure medication.</p> <p>On 11/10/14 at 3:20 p.m., the DON (Director of Nursing) indicated the resident blood pressure and pulse was taken weekly, however, she could not find any documentation where the blood pressure and pulse were being taken prior to the administration of the blood pressure medication "Metoprolol".</p> <p>This Federal tag relates to complaint IN00158364</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>		<p>situation.</p> <p>3. What measures will be put into place to ensure that this practice does not recur? The Director or Nursing or designee will audit the MAR at least 5 days a week for all residents identified as receiving blood pressure medication. She will check to see that the blood pressure and/or pulse has been taken and recorded. She will also check to see if the nurse has followed up with the physician if the blood pressure or pulse results were outside of the parameters given by the physician/consultant pharmacist. Any identified issues will be addressed as indicated in question #2.</p> <p>4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DON will bring the results of the MAR audits to the monthly meeting of the QA Committee for review and recommendation. This reporting will continue for three months, and if 100% compliance has been achieved, the Committee may no longer request a report; however, the DON will continue to audit the MARs on an ongoing basis, even when the report to the QA Committee is no longer required.</p>				

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure pureed food was prepared under sanitary conditions and failed to ensure adequate hand washing. This had the potential to affect 33 of 34 residents in the facility who recieved food prepared in the kitchen.</p> <p>Finding includes:</p> <p>On 11/5/14 at 11:35 a.m., Cook #2 was observed washing her hands two times at the kitchen hand washing sink. Cook #2 turned on the faucet, wet her hands with water, applied soap, scrubbed her hands with soap for 8 seconds, turned off the water with her wet hands, and grabbed a paper towel to dry her hands. During the same observation Cook #2 repeated the procedure and scrubbed hands for 13 seconds, turned off the water with wet hands, and grabbed a paper towel to dry hands.</p> <p>On 11/7/14 at 11:42 a.m., Cook #1 was observed during preparation of pureed food. Cook #1, without wearing gloves, was observed to leave the food preparation area, take the parts of the</p>	F000371	<p>It is the standard of this facility to ensure that all foodis stored, prepared, and distributed under sanitary conditions, including useof adequate handwashing by dietary staff.</p> <p>1.What corrective active will be done by the facility? All dietary staff have beenretrained on proper handwashing procedures and have participated in a returndemonstration. <b>(See attachment #10)</b></p> <p>2.How will the facility identify other residents havingthe potential to be affected bythis alleged practice? All residentshave the potential to be affected by this practice.</p> <p>3.What measures will be put into place to ensure thepractice does not recur? The Dietary Services Manager will performrandom daily checks, with use of a checklist, to ensure that the dietary staffis following the facility policy and procedure for properhandwashing. If she observes that staff is not following acceptable handwashingprocedures, she will</p>	12/12/2014

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	<p>food processor to the dishwashing area, grabbed the sprayer and sprayed off the food processor equipment, placed the equipment into the dishwasher, and returned to the food preparation area and continued food preparation without washing her hands.</p> <p>On 11/12/14 at 10:10 a.m., during an interview with the Dietary Manager (DM), the DM indicated the staff should have washed their hands for at least 20 seconds and used paper towels to turn off the faucet when hand washing was completed. The DM indicated the staff should wash their hands prior to returning to the food preparation area after rinsing equipment with sprayer in dishwashing area.</p> <p>On 11/10/14 at 11:59 a.m., the DM provided a current policy and procedure titled, "Hand washing/Alcohol-Based Rub" dated June 2004. The document included but was not limited to, "...personnel should always wash their hands (even when gloves are worn)...After touching inanimate sources that are likely to be contaminated...Before preparing food." The handwashing procedure included, but was not limited to: "...apply soap, using friction, rub hands together...do this for at least 20 seconds...use paper towels</p>		<p>stop what they are doing and bring it to their attention. Staff will not be able to resume their work until they are observed by the DSM in rewashing their hands by using the appropriate practice. Once they have done it successfully, the DSM will allow them to return to their duties. She will also render disciplinary action for continued noncompliance.</p> <p><b>(See attachment #11)</b></p> <p>4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? The DSM will bring the results of her handwashing checklist to the interdisciplinary morning management meeting that occurs at least 5 days a week for review by the team. In addition she will bring the results to the monthly QA Committee meeting. This reporting will continue for three months, and if 100% compliance has been achieved, the Committee may no longer request that a checklist and report be done; however, the DSM will continue to observe her staff and their handwashing activities on an ongoing</p>				

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F000465 SS=D	<p>to turn off faucet."</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.</p> <p>Based on observation, interview and record review, the facility failed to ensure the environment was free from odors throughout the building.</p> <p>Finding includes:</p> <p>The facility had four communal restrooms for resident use. On 11/3/14 at 10:40 a.m., there was a strong urine odor detected throughout the facility, in close proximity to the communal restrooms. The urine odor was again noted on 11/3/14 at 2:30 p.m., 11/5/14 at 9:40 a.m., and 1:15 p.m., 11/6/14 at 9:30 a.m. and 3:00 p.m., 11/7/2014 at 10:00 a.m. and 3:10 p.m., 11/10/14 at 10:05 a.m. and 2:40 p.m., and 11/12/14 at 9:25 a.m.</p> <p>On 11/10/14 at 3:00 p.m., the Administrator indicated he had noticed a urine odor on the back hall that day.</p> <p>During an interview with Housekeeper #5 on 11/12/14 at 2:05 p.m., she</p>	F000465	<p>It is the standard of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public including an environment free of odors.</p> <p>1. What corrective action will be done by the facility? Bathrooms were immediately cleaned by the housecleaning staff during the survey.</p> <p>2. How will the facility identify other residents having the potential to be affected by this alleged practice? There is a potential for all residents to be affected by this alleged practice.</p> <p>3. What measures will be put into place to ensure the practice does not recur? No specific source of the odor has been determined. However, in order to improve the situation, the following practices have been completed. All resident mattresses in the facility have been deep cleaned. All chair</p>	12/12/2014

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	<p>indicated there was a urine odor in the building.</p> <p>A "Housekeeping Schedule" (no date) provided by the Director of Nursing on 11/12/14 at 3:11 p.m., included but was not limited to, all communal bathrooms were cleaned two times a day.</p> <p>This Federal tag relates to complaint IN00158364 3.1-19(f)</p>		<p>or wheelchair cushions of incontinent residents are being replaced, as needed. Chair cushions and recliners will continue to be assessed for odors daily by nursing and management staff. All communal bathrooms continue to be scrubbed twice a day. Housekeeping schedules for cleaning mattresses and bathrooms will continue to be followed. Nursing staff has been retrained on appropriate toileting procedures and on appropriate adult brief usage and changing. C.N.A.'s have been retrained on proper bedmaking, especially for incontinent residents. <b>(See attachment #12)</b></p> <p>4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? All department heads, during daily random rounds, will observe for odors and report any noted to the Director of Housekeeping and Maintenance. Any continuing issues will be discussed at the daily morning management meetings and brought to the quarterly QA meeting for review, as needed.</p>		