

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
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R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00171371.</p> <p>Complaint IN00171371 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: April 27, 28, & 29, 2015</p> <p>Facility number: 011804 Provider number: 011804 AIM number: N/A</p> <p>Census bed type: Residential: 105 Total: 105</p> <p>Census payor type: Other: 105 Total: 105</p> <p>Sample: Residential sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 000	The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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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R 029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure residents were permitted unrestricted access to their personal room on the secured dementia units for 12 of 17 residents on the Keepsake North Unit and 26 of 27 residents on the Keepsake South Unit.</p> <p>Findings include:</p> <p>On 4/28/15 at 9 a.m., the secured dementia unit, Keepsake North Unit (KNU) was observed. Residents were observed in the common dining room/lounge area of the unit. At the time, all of the resident room doors on the unit were observed to be closed with the exception of two resident rooms,</p>	R 029	<p>R 029 Residents' Rights – access to rooms on secured dementia units 1. Facility leadership contacted each affected resident and/or their personal representative to accept or decline “unrestricted access to their personal apartment” on the secured dementia units. The facility intends to always honor the rights of our residents and to treat each individual with consideration, respect and recognition of their dignity and individuality. 2. All residents that reside on the secured dementia unit have the potential to be affected by this alleged deficient practice. 3. The facility has created a consent form which allows the resident or legal representative (POA, Guardian, etc.) to accept or</p>	07/01/2015

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	<p>room 127 and room 128.</p> <p>On 4/28/15 at 11:55 a.m. in the KNU, CNA #30 was observed to enter a resident's room, by having utilized a key to open the closed door. She entered the room and the door was closed behind her. The room was able to be entered from the hall, as the lock on the door remained unlocked. With surveyor intervention, the lock was observed to be turned in the "locked" position and the door was not able to be opened from the hall, but it was able to be opened from the interior of the room. With surveyor intervention, the lock was returned to the "unlocked" position. At 11:56 a.m., QMA #15 entered the room. At 11:57 a.m. QMA #15 was observed to leave the room, and the resident remained in the room. As QMA #15 left the room, she was observed to turn the lock on the door to the "locked" position, so entry from the hall was required by use of a key.</p> <p>On 4/28/15 at 1:50 p.m., QMA #15 was interviewed. She indicated the resident room doors on the secured dementia were kept locked so resident's will not enter the wrong room. She indicated when a resident wants in their room, "staff will let them in."</p> <p>On 4/29/15 at 8:15 a.m., CNA #31 was</p>		<p>decline "unrestricted access to their personal apartment" and modified our lease to reflect this change. We also offered an apartment key to each resident and/or personal representative to access their apartment and reviewed the facility's key policy which includes a provision to waive having a key. Resident and/or personal representative will be informed that they may change their mind at any time regarding apartment access and use or non use of keys. Each resident's care plan will address the resident's choice on apartment access and use of keys. The administrator or designee will in-service staff regarding resident's right to unrestricted access to their personal apartment and facility policy and practices to that affect 4. The administrator and/or designee will conduct an audit of ten randomly selected resident apartments and resident charts/care plans for consistency and compliance with this practice. Review will be conducted weekly x 4 weeks, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by July 1, 2015.</p>				

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	<p>interviewed and she indicated she works on both of the secured dementia units. CNA #31 indicated they keep the resident room doors locked because residents try to find their rooms and they get in other resident rooms and sometimes get into another resident's bed.</p> <p>On 4/29/15 at 8:45 a.m., the DON (Director of Nursing) on the Memory Care Unit was interviewed. She indicated the following: It was the facility policy for each resident room on the secured dementia unit to be locked (from entry from outside the room). She indicated the family or the resident is given a key to the resident room and nursing and the family make the determination as to which party receives the key. She indicated the rooms were kept locked "for safety." She indicated all the management staff and nursing staff in the facility have a key to resident rooms. The DON indicated if a resident's door was to be kept open, this would be documented on the resident's service plan. She indicated the "default" was to keep the resident room door locked, so this was not a part of the service plan. She indicated on admission, the facility informs the resident and/or family the resident's door will be kept locked, unless the resident and/or family desires differently. At this time, the DON</p>			

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	<p>reviewed the facility "Service Plan." She indicated she didn't see specific information documented in the service plan regarding the resident's door being kept locked. She did reference the verbage in the service plan, which referred to "security, safety and personal belongings." She also indicated the ISDH (Indiana State Department of Health) rights document regarding "the right to maintain personal property."</p> <p>On 4/29/15 at 8:50 a.m., the DON provided a copy of the "Health Facilities: Licensing and Operational Standards...Resident Rights" which included, but were not limited to, the following: "...The resident has a right to a dignified existence, self-determination...The resident has the right to be cared for in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...Reside and receive services in the facility with reasonable accommodations of the individual's needs and preferences, except when the health or safety of the individual or other residents would be endangered..."</p> <p>On 4/29/15 at 9 a.m., the DON on the Memory Care Unit and the Regional Director were interviewed. They</p>			

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	<p>indicated they were unable to locate documentation which indicated the family and/or residents were informed their rooms would be maintained locked, unless the family and/or the resident requested otherwise. The Regional Director indicated the facility does not require the families and/or resident to sign any documentation which indicated they were made aware the resident's room will be maintained locked. He also indicated the facility keeps the doors locked due to keeping wandering residents and/or unwanted visitors out of resident rooms. The Regional Director provided a copy of the facility lease which referenced "safety of the resident." This included, but was not limited to, the following: "Reasonable precautions will be taken for the care and safety of the resident..." The DON also provided a copy of the facility "Receipt of Keys" form which included, but was not limited to, the following: "...We must limit access to the building and apartments for the purpose of security and safety..." At the time, the Regional Director provided a copy of the facility "Residency Agreement." He indicated documentation was lacking in reference to the residents' rooms on the secured dementia unit being kept locked.</p> <p>On 4/29/15 at 9:40 a.m., the Regional</p>			

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	<p>Director was interviewed. He indicated the facility did not have a policy and procedure which addressed locking the resident room doors on the secured Dementia Units. He indicated the facility considered the locking of resident doors to be "best practice." He indicated when he is in the facility, he "checks the doors to make sure they are locked." He indicated this regulation varies from state to state in Assisted Living as to the allowance to lock resident rooms or not. He indicated the resident doors being locked are considered a safety precaution and they also assist with resident falls. He indicated when a resident wants to get into their room, a staff member needs to let the resident in the room, so the staff knows where the resident is. He indicated the locked resident rooms also "helped to reduce residents wandering in spaces that aren't theirs."</p> <p>On 4/29/15 at 10:30 a.m., the DON provided information regarding staffing on the Keepsake North and South units. She indicated the following: on the Keepsake North unit during the day and evening shift 2 CNAs (certified nursing assistants); 1 activity staff and 1 nurse or 1 QMA (Qualified Medical Assistant) were scheduled. For the night shift, 1 Nurse or QMA and 1 CNA were scheduled. On the north unit there are a</p>			

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	<p>total of 17 residents with cognition which ranged from mild-moderate to advanced impairment. Two residents require 2 staff assist with all activities of daily living (ADLs) and transfers (including one resident who requires assistance of two staff and a Sara lift (mechanical lift) for transfers. Nine resident's required 1 assist with ADLs and six residents require cueing for ADLs.</p> <p>On the Keepsake south unit, the following staff were scheduled: for days and evenings 1 nurse, 3 CNAs and 1 activity staff; night shift was 1 nurse and 2 CNAs. Of the 25 residents on this unit, the cognitive status ranged from mild-moderate to advanced impairment. Four residents required 2 staff assist with portions of their ADL care, sixteen residents required 1 assist with their ADL care and the remaining 5 residents required cueing for their ADL activity.</p> <p>On 4/29/15 at 10:35 a.m., a resident was observed in the Keepsake North Unit. She was observed laying on the sofa in the common area of the unit sleeping. At the time, CNA #32 was observed to awaken the resident and assisted her to her room to toilet. CNA #32 was observed to assist the resident to her room, unlock the resident's room door with a key and assist the resident inside</p>			

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R 116 Bldg. 00	<p>her room.</p> <p>On 4/29/15 at 12:50 p.m., the DON of the secured unit was interviewed. She indicated on the secured north unit there was a total of 17 resident with 3 of those residents having keys to their rooms and an additional two residents who requested to keep their rooms doors opened. She indicated on the south secured unit, there was a total of 27 residents with none of those residents having a key to their room and 1 resident requested to have their door remain opened.</p> <p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure reference checks were obtained for 1 of 10 personnel records reviewed. (Director of Food Services #8)</p>	R 116	R 116 Personnel – employee screening 1. Upon identification of the concern reference for Staff Person #8 (food servicesdirector) was completed and added to the personnel file. No concerns were identified. 2. All staff members have the potential to be affected	07/01/2015

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	<p>Findings include:</p> <p>A review of the facility personnel records began on 4-29-2015 at 9:30 a.m. and indicated a record lacked reference checks for the Director of Food Services #8 who had a start date of 10/5/14.</p> <p>An interview with the Executive Director and the Operational Executive Director on 4-29-2015 at 12:10 p.m., indicated they were unable to locate the reference check documentation for the Director of Food Services #8.</p> <p>A current policy, "Reference Checks" dated 9-27-2011 and provided by the Operational Executive Director on 4-29-2015 at 12:45 p.m., indicated "...a minimum of two reference checks will be made on each applicant being considered for any position...."</p> <p>A current policy, "Personnel Files" dated 9-27-211 and provided by the Operational Executive Director on 4-29-2015 at 12:45 p.m., indicated "...each employee will have a personnel file which may include the following...minimum of two reference checks...."</p>		<p>by this alleged deficient practice. The facility office manager reviewed the personnel file of every current facility employee for completion of reference checks. Any concerns were addressed. 3. The facility pre-screening employment hiring procedure was better defined; department managers are assigned the responsibility of conducting the required references for each candidate. The Office Manager and Administrator will verify that references have been completed as part of new hire paperwork review. The regional operations director in-serviced the administrator, office manager and leadership staff regarding the facility employee screening and reference check policy and procedures. 4. The administrator and/or designee will conduct a review of ten employee files for completed references. Review will be conducted weekly x 1 months, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by July 1, 2015.</p>				

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R 119 Bldg. 00	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on interview and record review,</p>	R 119	R 119 Personnel – employee orientation 1. Upon identification	07/01/2015

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	<p>the facility failed to ensure documentation of the orientation to the facility was completed by the person supervising the orientation for 3 of 10 personnel records reviewed. (CNA-Certified Nursing Assistant #7, Director of Food Services #8, LPN-Licensed Practical Nurse #9)</p> <p>Findings include:</p> <p>A review of the facility personnel records began on 4-29-2015 at 9:30 a.m. and indicated the following staff lacked documentation of orientation to the facility:</p> <p>CNA # 7, with a start date of 2-15-2015, Director of Food Services #8, with a start date of 10-5-2014 and LPN #9, with a start date of 5-12-2014.</p> <p>An interview with the Executive Director and the Operational Executive Director on 4-29-2015 at 12:10 p.m., indicated they were unable to locate the orientation documentation for CNA #7, Director of Food Services #8 and LPN #9.</p> <p>A current policy, "Orientation and Training" dated 7-17-2012 and provided by the Operational Executive Director on 4-29-2015 at 12:45 p.m., indicated "...orientation and training will be</p>		<p>of the concern the facility office manager and immediate supervisor completed the orientation checklist with employee #7 and #9. We were unable to complete for employee #8 as he left employment with the facility. The checklist was added to their personnel files. 2. All staff members have the potential to beaffected by this alleged deficient practice. The facility office manager reviewed the personnel file of every current facility employee for completion of orientation and evidence of such documentation. Any concerns were addressed via orientation programming conducted by the facility office manager,executive director and department supervisors. 3. All new hires will receive general orientation to facility policies and procedures prior to working independently and will sign a statement of acknowledgement of such orientation. This form will be placed in their personnel file. Orientation shall be lead by the executive director, office manager and appropriate department supervisor. The regional operations director in-serviced the administrator, office manager and leadership staff regarding the new employee orientation policy and procedures. 4. The administrator and/or designee will conduct a review of ten employee files for completed orientation. Review will be conducted weekly x 1</p>				

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R 120 Bldg. 00	<p>provided to employees before they are assigned responsibilities in assisting residents...."</p> <p>A current policy, "Personnel Files" dated 9-27-2011 and provided by the Operational Executive Director on 4-29-2015 at 12:45 p.m., indicated "...each employee will have a personnel file which may include the following...record of orientation...."</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for</p>		<p>month, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by July 1, 2015.</p>	

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	<p>nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure staff employed in the facility completed dementia training for 3 of 10 personnel records reviewed.</p> <p>(CNA-Certified Nursing Assistant, #10, LPN-Licensed Practical Nurse #9 and Housekeeping #11)</p> <p>Findings include:</p> <p>A review of the facility personnel records began on 4-29-2015 at 9:30 a.m. and indicated the following staff lacked documentation for the 6 hours of dementia training: CNA #10, with a start date of 10-16-2014,</p>	R 120	<p>R 120 Personnel – employee dementia training</p> <p>1. Upon identification of the concern the facility office manager and wellness directors completed the missing dementia training for employee #9, #10, #11 and #12. The certificate of completion was added to their personnel files. 2. All staff members have the potential to be affected by this alleged deficient practice. The facility office manager reviewed the personnel file of every current facility employee for completion of state required dementia training and evidence of such documentation. Any concerns were addressed via scheduled in-services and use of on line education program.</p>	07/01/2015

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	<p>LPN #9, with a start date of 5-12-2014 and Housekeeping #11 with a start date 9-15-2014.</p> <p>An interview with the Executive Director on 4-29-2015 at 12:25 p.m., indicated the nursing staff were cross trained to work in the memory care units and the housekeeping staff would be expected to clean in the memory care units.</p> <p>An interview with the Business Office Manager #12 on 4-29-2015 at 1:10 p.m., indicated the 6 hour dementia training records were not found for CNA #10, LPN #9 or Housekeeping #11. Further interview with the Business Office Manager #12 indicated CNA #10, LPN #9 and Housekeeping #11 could be assigned to work in the memory care units.</p> <p>A current policy "Ongoing Staff Training/In-servicing" dated 9-27-2011 and provided by the Operational Executive Director on 4-29-2015 at 12:45 p.m., indicated "...attendance at educational offerings and in-services will be recorded for each employee and kept on file...follow state guidelines...."</p>		<p>3. The facility dementia training process was reviewed by facility leadership. The facility will continue to do monthly "Care Connect" dementia training and also use an on line education program to ensure staff members meet the required dementia training hours. New hires will complete the required dementia training within six months of beginning employment with the facility. The regional operations director in-serviced the administrator, office manager and leadership staff regarding the required dementia training requirements. The facility office manager will track ongoing compliance of all employees and report any deficiencies to the executive director and department supervisor for follow up and resolution.</p> <p>4. The administrator and/or designee will conduct a review of ten employee files for completed dementia training. Review will be conducted weekly x 1 month, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by July 1, 2015.</p>				

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R 121 Bldg. 00	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight</p>			
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	<p>loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to ensure tuberculin skin testing was completed for 7 of 10 staff at hire (Housekeeping #11, CNA-Certified Nursing Assistant #14, Assistant Food Service #13, Director of Food Services #8, Wellness Director #15, QMA-Qualified Medication Aide #16 and the Executive Director).</p> <p>Findings include:</p> <p>A review of the facility personnel records began on 4-29-2015 at 9:30 a.m. and indicated the following: Housekeeping #11 (start date of 9-15-2014) had a tuberculin skin test on 8-14-2014 and the second step tuberculin skin test was completed on 10-22-2014 (10 weeks after the first step). CNA #14 (start date of 2-15-2015) did not have documentation of the administration of any tuberculin skin test. The Director of Food Services #8 (start date of 10-5-2014) did not have documentation of the first step tuberculin test being read after it was administered and there was not documentation of a second step tuberculin skin test or a documented negative tuberculin skin test result during the preceding twelve months.</p>	R 121	<p>R 121 Personnel – employee Mantoux (TB) tests</p> <p>1. Upon identification of the concern the wellness directors completed the missing dementia training for Houskeeper #11, C.N.A. #14, Assistant Food Services #13, Wellness Director #15, Q.M.A. #16, and executive director. Employee #8 no longer works at the facility.</p> <p>2. All staff members have the potential to be affected by this alleged deficient practice. The facility office manager reviewed the personnel file of current facility employee for completion of required Mantoux (TB) testing. Any concerns were addressed.</p> <p>3. Nursing leadership will conduct a Mantoux/TB testing on current staff via “whole house” in-services during the month of June. All current employees will receive required 1st and 2nd step. All new hires, ongoing, will complete their required first and 2nd step mantoux (TB) testing or chest x-ray within state prescribed deadlines as part of orientation. Facility Wellness Directors and/or designees will be responsible for implementation. The regional nurse in-service the administrator, office manager and nursing leadership regarding Mantoux/TB requirements and facility policy and procedures. The facility office manager will track ongoing compliance of all</p>	07/01/2015

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	<p>Assistant Food Service #13 (start date of 10-13-2014), Wellness Director #15 (start date of 1-6-2015), QMA #16 (start date 1-6-2015) and the Executive Director (start date 3-16-2015) did not have documentation of the second step tuberculin skin test or a documented negative tuberculin skin test result during the preceding twelve months.</p> <p>An interview with the Executive Director on 4-29-2015 at 11:20 a.m., indicated there were no additional TB (tuberculosis) records for the staff.</p> <p>Further interview with the Executive Director on 4-29-2015 at 12:10 p.m., indicated the following staff had incomplete or missing TB records: Housekeeping #11, CNA #14, Assistant Food Services #13, Director of Food Services #8, Wellness Director #15 and QMA #16. The Executive Director indicated she did not complete a second step tuberculin skin test.</p> <p>A current policy "Pre-Employment Physical" dated 9-27-2011 and provided by the Operations Executive Director on 4-29-2015 at 12:45 p.m., indicated "...the physical exam must include a test for tuberculosis..."</p> <p>A current policy "...Tuberculosis Testing</p>		<p>employees and report any deficiencies to the executive director and wellness directors for follow up and resolution.</p> <p>4. The administrator and/or designee will conduct a review of ten employee files for Mantoux/TB compliance. Review will be conducted weekly x 1 months, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>These systematic changes will be completed by July 1, 2015.</p>				

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R 148 Bldg. 00	<p>Procedure" dated 9-27-2011 and provided by the Executive Director on 4-29-2015 at 12:10 p.m., indicated "...if the first test is negative...a second test should be administered in one week...."</p> <p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and</p>	R 148	R 148 Sanitation and Safety	07/01/2015

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	<p>record review, the facility failed to ensure hazardous chemicals and areas housing hazardous equipment were maintained in a safe and secure manner on 3 of 3 floors in the facility.</p> <p>Findings include:</p> <p>On 4/28/15 at 10:45 a.m., the third floor of the facility was toured with the Maintenance Supervisor. At the time, the mechanical room, which housed a furnace was observed to be unlocked. The Maintenance Supervisor indicated this door should be locked at all times. The Maintenance Supervisor had the key to lock this door and attempted to do so, but was unable to lock the door. He was unsure why the door would not lock. At 10:50 a.m., the electrical closet on the third floor was found to be unlocked. This room housed an electrical panel. The Maintenance Supervisor indicated this room should also be locked at all times.</p> <p>On 4/28/15 at 11 a.m., the second floor of the facility was toured with the Maintenance Supervisor. A door to the room which housed the electrical panel, was observed to be unlocked. A Janitor closet also on the second floor was observed to be unlocked. Inside the unlocked Janitors closet were the</p>		<p>Standards – storage</p> <ol style="list-style-type: none"> 1. Upon identification of the concern the facility maintenance supervisor replaced the batteries of each non working door lock and confirmed that the doors were locking properly. Housekeepers were also instructed to secure their supply carts. 2. All residents have the potential to be affected by this alleged deficient practice. The maintenance supervisor and assistance conducted a full house audit of all storage doors and housekeeping carts to ensure locks were functional. Any concerns were addressed. 3. Housekeeping staff will check the storage areas in their respective areas each workday. The maintenance supervisor or designee will check storage door locks during routine rounds for proper function. The administrator and designee in-serviced staff on the importance of immediately reporting any issues with the properly closing and locking of storage doors. They are to complete a maintenance request form and also contact the maintenance person on call. Repairs will be made as quickly as possible. Housekeepers were also in-serviced on securing their carts. 4. The administrator and/or designee will randomly check ten (10) storage area doors for proper 				

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	<p>following chemicals: a spray bottle of A-456-11 Disinfectant, which indicated on the bottle was "Hazardous to Humans"; A spray bottle of Ultra Concentrated laundry freshener, which had written on the bottle "Keep out of reach of children"; 1 spray bottle of "Acid Bathroom cleaner" which had written on the bottle "Keep out of reach of children"; and 1 spray bottle of "Peroxide glass and surface cleaner" that also had written on the bottle "keep out of reach of children." The Maintenance Supervisor indicated these doors should be locked at all times.</p> <p>On 4/28/15 at 11:05 a.m., the Maintenance supervisor was interviewed. He indicated he does not keep a log for documenting the mechanical, electrical and/or janitor closet doors were checked and locked. He indicated all the doors in the facility were checked last week.</p> <p>On 4/28/15 at 11:15 a.m., the Keepsake North secured dementia unit was observed. The laundry room door was observed to be unlocked. Inside the laundry room on a shelf, which was approximately 5 feet 9 inches from the ground, were observed the following chemicals: two 20 ounce bottles of Niagra Spray Starch; one 16 ounce bottle of Hydrogen Peroxide; two 16 ounce</p>		<p>function. Review will beconducted weekly x 2 months, and monthly thereafter. Results of these audits will be reviewed bythe QA Committee, who will establish the threshold of compliance and makefurther recommendations accordingly.</p> <p>These systematic changes will be completed byJuly 1, 2015.</p>	

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	<p>bottles of Soothe and Cool Fresh Shampoo and Body Wash (bottle indicated for external use only); and 1 quart spray bottle of Bright Solutions tropical mist (deodorizer); one bottle of (product name) disinfectant, and one bottle of all purpose spray and glass cleaner. All of the above chemicals indicated on the bottle, with the exception of the shampoo and body wash, to "Keep out of reach of children." At the time, the laundry room door was observed to require being manually pulled shut to securely close the locked door.</p> <p>On 4/28/15 at 11:30 a.m., a bottle of Purell Hand Sanitizer (PHS) was observed on top of the medication cart in the hall of the Keepsake North Secure Dementia unit.</p> <p>On 4/28/15 at 12:50 p.m. and 1:40 p.m., the Purell Hand sanitizer remained on top of the medication cart.</p> <p>On 4/28/15 at 2:20 p.m., the DON of the Secured Dementia unit provided a list of "confused and ambulatory" residents in the facility. This form indicated on the unsecured second floor of the facility, there were 2 residents who were considered "confused and ambulatory." This list also indicated on the secured</p>			

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	<p>Keepsake North unit, there were 8 resident's who were considered to be "confused and ambulatory."</p> <p>On 4/29/15 at 8:10 a.m. the Keepsake North Unit laundry room door is observed unlocked. The door appeared to be closed but was able to be pushed opened by hand without the use of a key.</p> <p>On 4/29/15 at 11 a.m., the DON of the Secured Dementia Unit was interviewed. She indicated the laundry room door on the secured unit should always be locked as this was the safety mechanism to keep chemicals in the laundry room secure.</p> <p>On 4/29/15 at 11:50 a.m., the Maintenance Supervisor provided the current facility policy and procedure for "24 hour locking of Electrical, Mechanical, Janitor Doors and Closet Doors." This policy was dated 8/12/13. This policy included, but was not limited to, the following: "Purpose: To ensure that the safety of staff, residents, and all other personnel is in order. If a door is unlocked please do the following: Make sure door is closed and able to lock..."</p> <p>On 4/29/15 at 12 p.m., the DON of the Secured Dementia Unit provided copies of the labels from the following chemicals found unlocked in the second</p>			

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	<p>floor janitors closet: A-456-II: "...hazardous to humans...harmful if absorbed through skin. causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking...Remove and wash contaminated clothing before reuse"; "Acid bathroom cleaner:...for industrial use only, keep out of reach of children...wear suitable glove and eye protection...do not drink... ; Peroxide Glass and surface cleaner...Keep out of reach of children..."</p> <p>On 4/29/15 at 2 p.m., Housekeeper #13 was observed on the secured north dementia unit. She had her housekeeping cart positioned in the hall, just outside of a resident's room. At the time, she was observed to be in the resident's room, out of sight of her housekeeping cart. At the time, a bottle was observed to be hanging in full view of anyone passing by in the hallway, on the trash compartment of her housekeeping cart. The bottle was observed to be "spic and span, multi purpose cleaner." At 2:01 p.m., Housekeeper #13 was interviewed. She indicated she "only keeps the spray bottle hanging on the trash compartment when I'm using it."</p> <p>This deficiency was cited on the annual</p>			

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R 216 Bldg. 00	<p>state licensure survey on 4/17/14 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure the self medication evaluation was completed per the facility policy for 1 of 2 residents reviewed for self administration of medications. (Resident #9)</p> <p>Findings include: The record review for Resident #9 began on 4-28-2015 at 9:30 a.m. and indicated diagnoses included but were not limited to diabetes, hypertension, hyperlipidemia,</p>	R 216	<p>R 216 Evaluation – resident self medication 1. Upon identification of the concern the wellness director completed the missing self medication administration assessment for resident #9 and updated the care plan. 2. All residents who self administer their medications have the potential to be affected by this alleged deficient practice. The wellness directors and designees performed a new self administration assessment for</p>	07/01/2015

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	<p>esophageal reflux, allergic rhinitis and insomnia.</p> <p>A review of the March 2015 physician's recapitulation indicated the following: "...may self administer all medications as ordered...."</p> <p>A review of the "Resident Self Medication Evaluation" dated 2-13-2014 indicated Resident #9 was able to self administer medications.</p> <p>An interview with the Wellness Director #15 on 4-29-2015 at 9:50 a.m., indicated there was not any other "Self Medication Administration Evaluations" completed since 2-13-2014.</p> <p>Further interview with the Wellness Director #15 on 4-29-2015 at 10:10 a.m., indicated the most recent Resident Evaluation and Service Plan was completed on 3-11-2015. A statement on the Independent Living Package page indicated the following: "...Resident must be able to pass self-administering checklist in order to administer their own medications..." The Wellness Director #15 indicated the "Self Medication Administration Evaluation" was the self-administering checklist and the form should have been completed.</p>		<p>each resident whois currently doing their own medications. Plans of care were updated. Anyconcerns were addressed.</p> <p>3. Per facility policy, the selfadministration of medications assessments will be completed by a licensed nurseat time of admission, quarterly thereafter, or if a significant change ofcondition.</p> <p>The wellness directorsconducted an in-service for licensed nurses reviewing the self administrationpolicy and procedure. Tracking of this required assessment will be done via EMRsystem and monitored by Wellness Directors.</p> <p>4. The wellness director(s) and/or designee will conduct a regular audit review of all residents whoself-administer their own medications. Reviewwill be conducted monthly x 3 months, and quarterly thereafter. Results of these audits will be reviewed bythe QA Committee, who will establish the threshold of compliance and makefurther recommendations accordingly.</p> <p>These systematic changes will be completed byJuly 1, 2015.</p>	

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R 272 Bldg. 00	<p>A current policy, "Self Administration of Medications" dated 2-8-2013 and provided by the Wellness Director #15 on 4-29-2015 at 9:30 a.m., indicated "...staff members are responsible for evaluating residents who self-administer medication prior to admission and at least once quarterly...."</p> <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, interview and record review the facility failed to ensure soup was served at the recommended temperature on the Keepsake North Memory Unit potentially affecting 18 of 18 residents.</p> <p>Findings include:</p> <p>Facility menus for the lunch meal on 4/28/15, provided at the time of the entrance into the facility on 4/27/15 at 9:30 a.m., indicated the lunch meal included, fried chicken or meatloaf, mashed potatoes, gravy, green beans, and</p>	R 272	<p>R 272 Food and Nutritional Services – foodtemperatures</p> <ol style="list-style-type: none"> 1. Uponidentification of the concern the facility food service personnel addressed theconcern. 2. All residents have the potential to beaffected by this alleged deficient practice. The facility food services staff will monitor and record food servingtemperatures to ensure that items are at the proper and safe servingtemperatures. Any concerns will beaddressed accordingly. 3. Thecorporate food services director has in-serviced food service personnel on thefacility's "Food Temperatures" policy and 	07/01/2015

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	<p>creamy potato soup.</p> <p>During an observation of the lunch meal in the Keepsake North Memory Unit on 4/18/15, the following was observed:</p> <p>At 11:45 a.m., Dietary Server #1 was observed to take the temperatures of the food for the lunch meal. The temperatures of the fried chicken, meatloaf, mashed potatoes, and green beans were within the recommended range at the time of service. The temperature of the creamy potato soup registered 120 degrees on the facility thermometer. When queried, she was not able to identify if 120 degrees was an appropriate temperature for a hot food and could not define the recommended temperature range for hot foods.</p> <p>At 11:58 a.m., Dietary Server #1 was observed to start dishing the creamy potato soup into bowls for the residents. Dietary Server #1 was requested to stop the service of the creamy potato due to the soup not being at the recommended temperature for service. Dietary Server #1 indicated the temperature of the soup had been going up, but then went back down again. During the continuous observation, the temperature of the creamy potato soup never reached the temperature of 141 degrees or above.</p>		<p>procedures in the event food is notat the proper temperature. She has alsomonitored by observation during site visits.</p> <p>4. Theadministrator and/or designee will conduct audit reviews of the servingtemperatures of food, ensuring temperatures are recorded and proper. Reviews will be conducted randomly five timesa week x 4 weeks, then weekly x 2 months, and quarterly thereafter. Results of these audits will be reviewed bythe QA Committee, who will establish the threshold of compliance and makefurther recommendations accordingly.</p> <p>These systematic changes will be completed byJuly 1, 2015.</p>	

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R 356 Bldg. 00	<p>At 12:05 p.m., Dietary Server #2 was interviewed. During the interview he indicated hot foods were to be greater than 141 degrees at the time of service.</p> <p>A current facility policy "Food Temperatures", with a review date of 5/23/13, indicated "...If hot foods are not 140 (degrees) they will be reheated until temperature reaches 140 (degrees) or higher...."</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or</p>			

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	<p>death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>Based on interview and record review to facility failed to maintain a complete emergency information file containing a photograph of each resident, potentially affecting 6 of 105 residents in the facility.</p> <p>Findings include:</p> <p>The facility emergency information file was reviewed on 4/28/15 at 11:07 a.m. During the review it was noted photographs of 6 residents were missing of the 105 residents currently residing in the facility. Their admission dates into the facility of the 6 residents ranged from 3/25/15 to 4/25/15.</p> <p>The Executive Director was interviewed on 4/28/15 at 1:42 p.m. During the interview she indicated photographs of residents were to be taken immediately upon their admission.</p>	R 356	<p>R 356 Clinical Records – Emergency Book</p> <p>1. Upon identification of the concern the facility office manager and wellness directors printed the missing resident pictures from the facility's EMR system and placed them in the emergency information binder.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The facility office manager reviewed the entire resident emergency information binder and verified that all information was current including photograph of each resident.</p> <p>3. The facility office manager or designee will monitor the binder and ensure that each new resident's information including photograph is placed in the binder within 24 hours of admission. Information will also be updated as needed due to changes of information. The regional operations director in-service the administrator, office manager and nursing leadership regarding procedures for updating emergency book. The facility office manager will track ongoing accuracy of binder information and report any deficiencies to the</p>	07/01/2015			

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R 414 Bldg. 00	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview and record review, the facility failed to ensure staff washed their hands for the recommended length of time and during use of disposable gloves for administration of a respiratory treatment and after obtaining a blood sugar for 2 of 5 residents (Resident # 10 and #11) observed during medication administration by 2 of 2 nurses (Nurse #3 and #4). Furthermore the facility failed to ensure the staff used an uncontaminated disposable glove during medication administration, potentially</p>	R 414	<p>executive director for follow up and resolution. 4. The administrator and/or designee will review the entire emergency information binder for completeness and compliance. Review will be conducted weekly x 1 month, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by July 1, 2015</p> <p>R 414 Infection Control – hand washing 1. No adverse effects were identified or noted due to this alleged deficient practice. Residents #10 and #11 remain healthy. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The facility wellness director's conducted a hand washing in-service and reviewed the facility's hand washing policy and addressed hand washing technique, length of time, use of hand sanitizer, proper use of disposable gloves and</p>	07/01/2015

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	<p>affecting 89 of 105 residents whose medications were administered by the facility.</p> <p>Finding include:</p> <p>1. During an observation on 4/27/15 at 12:00 p.m., Nurse #3 was preparing medication for administration, when an unidentified resident was attempting to stand up from a chair with a walker. Nurse #3 assisted the resident and touched the resident's shoulder for standby assistance. The resident left the Wellness Center and Nurse #3 did not wash her hands with soap and water or use hand sanitizer before she resumed preparing medications for administration.</p> <p>2. During an observation on 4/28/15 at 11:45 a.m., Nurse #3 was preparing to test Resident #11's blood sugar in the resident's apartment. Nurse #3 prepared the supplies to perform the test, donned disposable gloves and proceeded to test the resident's blood sugar. When the test was completed the nurse gathered the trash and removed the disposable gloves and discarded them in the trash. The nurse gathered the glucose meter and supplies and placed them in a small plastic storage basket. The nurse did not wash her hands or use hand sanitizer before or after donning gloves. Nurse #3</p>		<p>the difference between contaminated and uncontaminated gloves. The in-service also included "return demonstration" by each participant to ensure understanding.</p> <p>4. The administrator and/or designee will conduct an audit review to observe staff for proper hand washing and randomly select 5 employees to demonstrate technique. Review will be conducted 5 times a week x 1 month, 3 times a week x 1 month, weekly x 1 month, then monthly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>These systematic changes will be completed by July 1, 2015.</p>				

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	<p>escorted Resident #11 to the elevator and down to the dining room. Nurse #3 returned to the Wellness Center and put the glucose meter and supplies in the medication cart before she washed her hands with soap and water.</p> <p>3. During an observation on 4/28/15 at 12:30 p.m., Nurse #4 went into the bathroom adjacent to the Nurse's station to wash his hands. The nurse was in the bathroom for total of 15 seconds and proceeded to prepare Resident #10's medication for administration. Nurse #4 prepared Gabapentin (for nerve pain) 100 mg (milligrams), 1 capsule in a plastic medication cup and DuoNeb (an inhaled breathing treatment) 0.5 mg 3 mg/3 ml (milliliter) in 1 vial. When the nurse entered the resident's apartment the medication cup containing the capsule fell to the floor. Nurse #4 indicated the pill would need to be discarded. The nurse picked the pill up from the floor, disposed the capsule in the sharps container on the medication cart and prepared another Gabapentin capsule to give the resident. The nurse entered Resident #10's apartment and administered the oral medication. Nurse #4 did not wash his hands or use hand sanitizer after retrieving the capsule from the floor; before preparing the medication for administration, or before or after</p>			

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	<p>administration of the capsule.</p> <p>During the observation of Resident #10 receiving her medications on 4/28/15 at 12:40 p.m., Nurse #4 was observed to removed disposable gloves from his pants pocket with one of the disposable gloves falling onto the floor. The nurse picked the glove up from the floor, donned the contaminated glove and another clean glove. He proceeded to prepare the respiratory medication in the nebulizer's medication cup, place the oxygen mask over the resident's nose and mouth and turn on the nebulizer to administer the breathing treatment to Resident #10. Nurse # 4 was not observed to wash his hands before donning the disposable gloves. While Resident #10's breathing treatment was given, Nurse #4 removed the disposable gloves and washed his hands with soap and water, lathering his hands for 20 seconds before rinsing with water. When Resident #10's nebulizer treatment was completed, Nurse #4 donned disposable gloves and removed the resident's oxygen mask, and nebulizer's medication cup and tubing for cleaning. When the nurse finished cleaning the nebulizer equipment, the nurse removed the disposable gloves and washed his hands with soap and water and lathered his hands for 10 seconds before rinsing with</p>			

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	<p>water.</p> <p>An interview on 4/29/15 at 9:25 a.m. with Nurse #3 indicated hands should be lathered for 30 seconds before rinsing with water. She indicated hands should be dried with clean and dry paper toweling and also indicated the water should be shut off with a clean and dry paper towel. She indicated hands should be washed with soap and water before and after using disposable gloves. She further indicated if disposable gloves were dropped on the floor, the gloves should be thrown away.</p> <p>An interview on 4/29/15 at 9:35 a.m., with QMA (Qualified Medication Aide) #5 indicated hands should be lathered for 20 seconds during hand washing before rinsing with water. She indicated handwashing should be done before and after wearing disposable gloves. She also indicated if gloves were dropped onto the floor, the gloves should be thrown away.</p> <p>An interview on 4/29/15 at 9:55 a.m., with CNA (Certified Nursing Assistant) #6 indicated hands should be lathered for the length of time it would take to sing the Happy Birthday song before rinsing hands with water. The CNA indicated hands should be washed before and after wearing gloves. She also indicated</p>			

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	<p>resident care items, including disposable gloves should be thrown away if they were dropped on the floor.</p> <p>An interview on 4/29/14 at 10:03 a.m., with Nurse #4 indicated hands should be lathered for the time it takes to sing the Happy Birthday song 2 times through, before rinsing with water. The nurse also indicated hands should be washed before putting on gloves and immediately after removing the gloves. He further indicated if medications or gloves were dropped on the floor, they should not be used should be discarded.</p> <p>An interview on 4/29/15 at 10:55 a.m., with Keepsake's (locked memory unit) DON (Director of Nursing) indicated the staff's hands should be lathered for the length of time it took to sing the Happy Birthday song or the Alphabet song, during hand washing.</p> <p>An interview on 4/29/15 at 10:55 a.m., with Assisted Living's (AL) DON indicated staff should perform handwashing before putting on gloves and immediately after removing disposable gloves. The AL DON also indicated if disposable gloves were dropped on the floor; the gloves should be thrown away.</p>			

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	<p>An interview on 4/29/15 at 1:15 p.m., with the ED (Executive Director) indicated the facility did not have a policy that indicated when hand washing should be done during use of disposable gloves. The ED indicated it was standard practice to do hand washing before and after donning gloves.</p> <p>An interview on 4/29/15 at 1:15 p.m., with the AL DON indicated hand washing with soap and water before and immediately after glove use was a standard practice and should be done by the staff.</p> <p>A current facility policy, provided by the AL DON on 4/29/15 at 11:55 a.m., titled Hand Washing, with an approval dated of 5/22/13, indicated, "...Hands are washed: 1. a. When visibly soiled. b. Before, during and after preparing food. c. Before and after caring for a resident.... 2. Turn on water.... 3. Wet your hands with clean, running water and apply soap.... 4. Rub your hands together to make a lather and scrub them well.... 5. Continue rubbing your hands for a minimum of 20 seconds. (An approximately 20 seconds is to hum the "Happy Birthday" song from beginning to end twice.)...."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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