

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2016
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NAME OF PROVIDER OR SUPPLIER LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: March 29, 30, 31 2016, April 1, 4, 5, 6, 2016</p> <p>Facility number: 001138 Provider number: 155632 AIM number: 200157070</p> <p>Census bed type: SNF/NF: 45 Residential: 17 Total: 62</p> <p>Census payor type: Medicare: 6 Medicaid: 36 Other: 3 Total: 45</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on April 14, 2016.</p>	F 0000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely because the provisions of law require it.</p> <p>The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity to render adequate care. The statement of deficiencies has been taken to the facilities Quality Assurance/Assessment Committee</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>A. Based on observation, interview, and</p>	F 0157	The facility does ensure that residents and resident's families	05/06/2016			

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	<p>record review, the facility failed to ensure a resident was notified of medication changes and new medication orders for 1 of 1 resident who met the criteria for review of notification. (Resident #23)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure that a resident and a resident's family was notified that a medication was not administered according to the physician's order for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #11)</p> <p>Findings include:</p> <p>A. During an interview on 3/30/16 at 10:09 A.M., Resident #23 indicated facility staff did not notify him when medication changes occurred or when new medications/treatments were ordered by the physician.</p> <p>The clinical record of Resident #23 was reviewed on 3/31/16 at 1:49 P.M. The record indicated the diagnoses of Resident #23 included, but were not limited to, myocardial infarction, hypertension, Parkinson's disease, anxiety, moderate intellectual disability, generalized anxiety disorder, mild depression, vascular dementia without behavioral disturbance.</p>		<p>are notified of medication changes, new medication orders, and medications that are not administered according to the physician's orders.</p> <p>On 4/22/16, DON met with resident #23 and informed him/her and his/her family of all cited medication changes and new medication orders.</p> <p>The DON was counseled on the need to maintain a daily review of documentation of proper notification of any medication changes. All nursing staff and facility ID team were reeducated on the requirement for notification of changes to resident or responsible party of changes to medications on or before 4-22-16.</p> <p>DON or designee will review physician's orders report and physicians progress notes daily and confirm that residents and family members have been notified of medication changes, new medication orders, and medications that are not administered according to the physician's orders daily times 4 weeks and then monthly for 6 months. Any negative findings will be reported to the facility QAPI committee. Mandatory all staff in service will be completed by 4/22/16 by DON and Administrator to go over resident and family notification.</p>		

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	<p>Resident #23 was observed on 3/30/16 at 10:04 A.M., seated in a wheelchair. Resident #23 was observed, at that time, to propel the wheelchair without assistance through the 400 hallway.</p> <p>A Significant Change MDS (Minimum Data Set) assessment dated 10/28/15 indicated Resident #23 experienced minimal to moderate cognitive impairment, was able to participate in the assessment, and did not have a guardian or legally authorized representative.</p> <p>A Quarterly MDS dated 1/20/16 indicated Resident #23 experienced minimal cognitive impairment, was able to participate in the assessment, and did not have a guardian or legally authorized representative.</p> <p>A QMRP (Qualified Mental Retardation Professional) Progress note dated 12/2/15 indicated, "...per the 6/22/15 Level II, res [resident] is DD [developmentally disabled] and MI [mental illness]...is his own responsible party..."</p> <p>A Nursing Progress note dated 1/4/16 at 11:48 A.M. indicated, "...New orders received and noted...to obtain a1c [sic] [a blood glucose test] in am [sic]. The note lacked any documentation to indicate</p>			

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	<p>Resident #23 was notified of the new order.</p> <p>A Telephone Order dated 1/13/16 at 9:59 A.M. indicated a new order was received for, "Colace [a stool softener]...2 capsules twice a day for constipation" The order lacked any documentation to indicate Resident #23 had been notified of the new order.</p> <p>A Nursing Progress note dated 1/18/16 at 9:39 A.M. indicated a new order was received for, "Pcn [sic] [Penicillin] [an antibiotic] 500 mg [milligrams] 1 cap QID [four times a day] until gone, and Norco [a narcotic pain medication] 7.5/325 mg 1 every 4-6 hours PRN [as needed] for pain. The note lacked any documentation to indicate Resident #23 was notified of the new orders.</p> <p>A Physician's Telephone Order dated 1/20/16 at 7:54 A.M. indicated a new order was received for, "...CBC [complete blood count], Chem 14 [a comprehensive metabolic blood test], Lipid [a blood test for cholesterol] every 6 months..."The order lacked any documentation to indicate Resident #23 was notified of the new order.</p> <p>A Physician's Telephone Order dated 2/23/16 indicated an order for, "Norco 5</p>			

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	<p>mg/325 mg 1 tablet every 6 hours as needed" was received. The order lacked any documentation to indicate Resident #23 was notified of the new order.</p> <p>A Physician's Telephone Order dated 3/5/16 for Latuda [an antipsychotic medication] 20 mg ...1 tablet every other day..." was received The order lacked any documentation to indicate Resident #23 was notified of the new order.</p> <p>A Physician's Telephone Order dated 3/25/16 indicated new orders were received for, "Claritin [an antihistamine medication] 10 mg 1 tablet by mouth daily...Mucinex ER [an expectorant] 600 mg 1 tablet by mouth twice a day...Augmentin [an antibiotic] 1 tablet by mouth twice a day. The order lacked any documentation to indicate Resident #23 was notified of the new order.</p> <p>The Nursing Progress notes between 1/4/16 at 7:59 A.M. and 3/26/16 at 8:28 A.M. were reviewed and lacked any documentation to indicate Resident #23 was notified of any medication changes or new medication orders during that time.</p> <p>During an interview on 4/5/16 at 10:30 A.M., RN #12 indicated Resident #23 did not have a guardian or responsible party</p>			

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	<p>to notify of medication or treatment changes. RN #12 further indicated, at that time, she was sure staff notified Resident #23 when order changes occurred. RN #12 then indicated, she could not find any documentation to indicate Resident #23 was notified of medication and treatment order changes from 1/4/16 through 3/26/16.</p> <p>During an interview on 4/6/16 at 1:00 P.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate Resident #23 was notified of medication changes and new medication orders between 1/4/16 and 3/26/16.</p> <p>B. On 3/30/16 at 10:32 A.M., Resident #11 was observed sitting in a wheelchair watching TV. Resident #11 was in no distress at that time.</p> <p>The clinical record of Resident #11 was reviewed on 4/3/16 at 10:30 A.M. The record indicated the diagnoses of Resident #11 included, but were not limited to, hypothyroidism, hypertension, and depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 2/17/16 indicated Resident #11 was cognitively intact.</p>			

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	<p>A Care Plan dated 11/23/15 included, but was not limited to, "...problem...Resident has fatigue and takes several rest periods through the day..."</p> <p>A Lab report dated 1/11/16, indicated Resident #11 had an elevated Ultra Sensitive TSH [a test for determining thyroid function] level of 10.88 [normal range is 0.27 - 4.20] and an elevated Free T4 level at 0.88 [normal range 0.90 - 1.70]. Documented on the lab report was the following, "...[symbol for increase] Synthroid [medication used to treat hypothyroidism] 150 TSH recheck 6 weeks 2-23-16..."</p> <p>A Lab report dated 2/23/16, indicated Resident #11 had an elevated Ultra Sensitive TSH level of 8.05. Documented on the 2/23/16 lab report was the following: "...synthroid did not get increased. Will increase to 150 at this time. recheck 6 weeks..."</p> <p>"THE PHYSICIAN'S TELEPHONE ORDERS" dated 11/10/2015 at 2:47 am., read as follows: "...Synthroid Tablet dose order: (1 tablet / 137 mcg)... 2/23/2016...10:46 am... (discontinued)...10:48 am...Synthroid Tablet dose order: (1 tablet / 150 mcg)... 2/23/2016...10:46 am..."</p>			

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	<p>The Medication Administration Record was reviewed and documented that Resident #11 continued to be administered Synthroid 137 mcg once daily from 1/11/16 until 2/24/16 at which time the Synthroid medication was increased to 150 mcg once daily.</p> <p>The clinical record for Resident #11 lacked documentation that Resident #11's family had been notified of the medication error concerning the incorrect Synthroid dosage.</p> <p>During an interview on 4/6/16 at 2:15 P.M., the DON (Director of Nursing) was made aware that Resident #11's Synthroid medication had been increased by the physician on 1/11/16, but Resident #11 did not receive the correct dose until 6 weeks later on 2/24/16. Resident #11 had received a lower dose of Synthroid medication for 6 weeks due to a physician's order that was written on a lab report and not transcribed on the Medication Administration Record and not ordered from the pharmacy. The DON indicated "yes."</p> <p>The Policy and Procedure for "Resident...Family/Legal Representative Notification/Consultation" provided by the DON on 4/5/16 at 2:15 P.M.</p>			

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F 0250 SS=D Bldg. 00	<p>indicated, "...This facility will promptly notify...the resident...the resident's legal representative or interested family member of changes in the resident's condition and/or status...will notify the resident's family or legal representative when...there is a need to alter treatment significantly...will record in the resident's medical record the notification of resident...and resident's representative of the change..."</p> <p>3.1-5(a)(1) 3.1-5(a)(3)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure guardianship services were pursued for 1 of 1 resident who met the criteria for review of social services. (Resident #23)</p> <p>Findings include:</p> <p>The clinical record of Resident #23 was reviewed on 3/31/16 at 1:49 P.M. The record indicated the diagnoses of Resident #23 included, but were not</p>	F 0250	We are amending our response to include: Administrator or designee will review all PASRR consultant recommendations to ensure the careplan team has documented the follow up in resident medical records as indicated to ensure continued compliance weekly times 4 weeks then monthly for 6 months The facility does ensure that guardianship services are pursued for residents who meet the criteria for review of social services. Facility followed through on OBRA recommendation for guardianship services on	05/06/2016

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	<p>limited to, moderate intellectual disability, generalized anxiety disorder, mild depression, and vascular dementia without behavioral disturbance.</p> <p>Resident #23 was observed on 3/30/16 at 10:04 A.M., seated in a wheelchair. Resident #23 was observed, at that time, to propel the wheelchair without assistance through the 400 hallway.</p> <p>A Significant Change MDS (Minimum Data Set) assessment dated 10/28/15 indicated Resident #23 experienced minimal to moderate cognitive impairment and had no guardian or legally authorized representative.</p> <p>A Quarterly MDS dated 1/20/16 indicated Resident #23 experienced minimal cognitive impairment and had no guardian or legally authorized representative.</p> <p>A Face Sheet dated 1/20/16 lacked any documentation to indicate a Primary Contact, Financial Responsible Party, or Health Care Responsible Party.</p> <p>An Annual Review Certification dated 6/22/15 indicated Resident #23 experienced a developmental disability and a mental illness.</p>		<p>resident #23. At this time, physician felt that guardianship was not deemed appropriate. Social Services reviewed current residents that require OBRA annual certification and all were in compliance. Administrator or designee will review all PASRR consultant recommendations to ensure the care plan team has documented the followup in resident medical records as indicated to ensure continued compliance. Any negative findings will be reported to the facility QAPI Committee.</p>	

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	<p>An Annual Resident Review OBRA (Omnibus Budget Reconciliation Act) Checklist dated 6/22/15 indicated, "...Family/Involvement 1. Guardian-No 2. Guardian Needed-Yes..."</p> <p>A QMRP (Qualified Mental Retardation Professional) Progress note dated 8/13/15 indicated, "...has a cognitive impairment care plan + [and] staff assist him as needed [with] decision-making..."</p> <p>A QMRP Progress note dated 12/2/15 indicated, "...per the 6/22/15 Level II, res [resident] is DD [developmentally disabled] and MI [mental illness]...is his own responsible party..."</p> <p>A QMRP Progress note dated 2/24/16 indicated, "...He remains his own responsible party and the SSD [Social Services Designee] reports that he does well [with] accepting suggestions from staff. Makes decisions [with] assist as needed from Staff [sic].</p> <p>During an interview on 4/5/16 at 10:58 A.M., the SSD indicated she was not aware the Annual Resident Review OBRA Checklist indicated Resident #23 needed a guardian. At that time, the SSD reviewed the Checklist and indicated the documentation did not mean she was supposed to seek guardian services for</p>			

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	<p>Resident #23 because the OBRA Services Coordinator did not verbally indicate Resident #23 needed guardianship services during the 6/22/15 review meeting.</p> <p>A Social Service Progress note dated 4/5/16 at 1:02 P.M. indicated, "...This writer noted that @ [at] the last yearly visit assessment...the OBRA Services Coordinator...recommended that a guardian be appointed for resident, d/t [due to]...developmental disability and...questionable decision making skills prior to admission, and estrangement from...family. This has not been completed...[name of OBRA Services Coordinator] states that her recommendation was not that it need to be done right away, but that it is a possibility for the future...This will be done promptly."</p> <p>A Social Service Progress note dated 4/6/16 at 11:48 A.M. indicated, "...This writer contacted [name of guardianship agency]...to inquire into obtaining an assessment for them to have guardianship of resident..."</p> <p>During an interview on 4/6/16 at 1:00 P.M., the SSD indicated no documentation could be provided to indicate guardianship services were</p>			

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F 0279 SS=D Bldg. 00	<p>pursued for 9 months and 15 days after the recommendation on 6/22/15.</p> <p>During an interview on 4/6/16 at 3:00 P.M. the HFA (Health Facility Administrator) indicated no specific policy for the administration of Social Services could be provided, but it was the standard of practice of the facility to follow Federal and State regulations.</p> <p>3.1-34(a)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the</p>			

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	<p>resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a care plan was developed for a resident who experienced a potential to elope for 1 of 1 resident who met the criteria for review of elopement. (Resident #23)</p> <p>Findings include:</p> <p>The clinical record of Resident #23 was reviewed on 3/31/16 at 1:49 P.M. The record indicated the diagnoses of Resident #23 included, but were not limited to, anxiety, moderate intellectual disability, mild depression, and vascular dementia without behavioral disturbance.</p> <p>Resident #23 was observed on 3/30/16 at 10:04 A.M., seated in a wheelchair and propelling the wheelchair without assistance through the 400 hallway.</p> <p>A Significant Change MDS [Minimum Data Set] assessment dated 10/28/15 indicated Resident #23 experienced minimal to moderate cognitive impairment and experienced no behaviors.</p> <p>A Quarterly MDS dated 1/20/16 indicated Resident #23 experienced</p>	F 0279	<p>The facility does ensure that care plans are developed for residents who experience potential to elope. A care plan was put in place to address the risk of elopement and/or wandering on resident #23. A follow up assessment of elopement and/or wandering was completed and validated the written care plan. The care plan will remain in place for a 30 day time frame and by facility policy assessments will be completed on a quarterly basis.</p> <p>All staff will be inserviced on reporting any resident attempts to leave the facility on or before 4/22/16. All nursing staff were reeducated on the requirement for immediate assessment and care plan implementation for any resident with exit seeking behaviors.</p> <p>The DON will review daily documentation and 24 hour reports daily for 4 weeks and monthly for 6 to ensure immediate assessments and care plans are implemented for any resident with the potential for or newly identified inappropriate exit seeking behavior. Any negative findings will be reported to QAPI and discussed for further action. All staff will be inserviced on reporting attempts by 4/22/16.</p>	05/06/2016			

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	<p>minimal cognitive impairment and no behaviors.</p> <p>The most recent Elopement/Wandering Assessment dated 1/20/16 indicated Resident #23 was, "...no risk for wandering and or [sic] elopement..."</p> <p>A Nursing Progress note dated 3/10/16 at 9:42 P.M. indicated, "Evening shift cook caught this resident opening the 400 hall door and trying to get out. Informed...to get back in facility, with no problems. This nurse did go talk with resident and...never did say how...knew to open door, just sat and smiled. Monitor closely."</p> <p>The Plan of Care dated 3/23/16 for lacked any documentation to indicate a care plan for elopement/wandering had been initiated.</p> <p>During an interview on 4/5/16 at 1:45 P.M., the DON (Director of Nursing) indicated she was not aware Resident #23 had been discovered in the open threshold of the 400 exterior exit door on the evening of 3/10/16.</p> <p>During an interview on 4/6/16 at 12:45 P.M., Cook #1 indicated she had seen Resident #23 sitting in a wheelchair in the open threshold of the 400 hall</p>			

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	<p>exterior door between 6:00-6:30 P.M. on 3/10/16. Cook #1 then indicated she had immediately notified a nurse and returned to the kitchen.</p> <p>During an interview on 4/6/16 at 12:55 P.M., the DON indicated the 400 hall exterior exit door was not equipped with a safety device on 3/10/16. The DON then indicated an Elopement/Wandering Assessment had not been completed, a plan of care was not developed, and no documentation could be provided to indicate any interventions had been implemented to monitor Resident #23 for elopement or wandering. The DON further indicated the 400 exterior exit door had been equipped with a safety device on or about 3/23/16 and a care plan was initiated at that time.</p> <p>A Policy and Procedure for Elopement and Wandering Management provided by the DON on 4/6/16 at 1:00 P.M. indicated, "...For each resident identified as having...elopement potential, an appropriate safety care plan...will be developed and implemented with specific approaches, preventative measures and measurable goals..."</p> <p>3.1-35(b)(1)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medications were administered according to the physician's order for 2 of 5 residents who met the criteria for review of unnecessary medications. (Resident #11, Resident # 25)</p> <p>Findings include:</p> <p>1. On 3/30/16 at 10:32 A.M., Resident #11 was observed sitting in a wheelchair watching TV. Resident #11 was in no distress at that time.</p> <p>The clinical record of Resident #11 was reviewed on 4/3/16 at 10:30 A.M. The record indicated the diagnoses of Resident #11 included, but were not limited to, hypothyroidism, hypertension, and depression.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 2/17/16 indicated Resident #11 was cognitively intact.</p>	F 0282	<p>The facility does ensure that medications are administered according to the physicians orders. Resident #11 medication orders were clarified on 4/6/16 and remains on the correct dosage. DON or designee will review physician's orders report and physicians progress notes and confirm that appropriate action has been taken for medication administration changes, indications, and/or discontinuation of medication daily times 4 weeks and then monthly for 6 months. Any negative findings will be reported in QAPI meeting and discussed for further action.</p>	05/06/2016

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	<p>A Care Plan dated 11/23/15 included, but was not limited to, "...problem...Resident has fatigue and takes several rest periods through the day..."</p> <p>A Lab report dated 1/11/16, indicated Resident #11 had an elevated Ultra Sensitive TSH [a test for determining thyroid function] level of 10.88 [normal range is 0.27 - 4.20] and an elevated Free T4 level at 0.88 [normal range 0.90 - 1.70]. Documented on the lab report was the following, "...[symbol for increase] Synthroid [medication used to treat hypothyroidism] 150 TSH recheck 6 weeks 2-23-16..."</p> <p>A Lab report dated 2/23/16, indicated Resident #11 had an elevated Ultra Sensitive TSH level of 8.05. Documented on the 2/23/16 lab report was the following: "...synthroid did not get increased. Will increase to 150 at this time. recheck 6 weeks..."</p> <p>"THE PHYSICIAN'S TELEPHONE ORDERS" dated 11/10/2015 at 2:47 am., read as follows: "...Synthroid Tablet dose order: (1 tablet / 137 mcg)... 2/23/2016...10:46 am... (discontinued)...10:48 am...Synthroid Tablet dose order: (1 tablet / 150 mcg)... 2/23/2016...10:46 am..."</p>			

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	<p>The Medication Administration Record was reviewed and documented that Resident #11 continued to be administered Synthroid 137 mcg once daily from 1/11/16 until 2/24/16 at which time the Synthroid medication was increased to 150 mcg once daily.</p> <p>During an interview on 4/6/16 at 2:15 P.M., the DON (Director of Nursing) was made aware that Resident #11's Synthroid medication had been increased by the physician on 1/11/16, but Resident #11 did not receive the correct dose until 6 weeks later on 2/24/16. Resident #11 had received a lower dose of synthroid medication for 6 weeks due to a physician's order that was written on a lab report and not transcribed on the Medication Administration Record and not ordered from the pharmacy. The DON indicated "yes."</p> <p>2. On 3/31/16 at 1:24 P.M., Resident #25 was observed to be sitting up in a recliner in his room. Resident #25 was observed to be in no apparent distress.</p> <p>The clinical record for Resident #25 was reviewed on 3/29/16 at 11:22 A.M., the diagnoses included, but were not limited to, Diabetes mellitus type 1, and hypertension.</p>			

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	<p>The physicians orders included, but were not limited to, "...Insulin Aspart [slow acting insulin]100 UNI/ML (milliliter) Solution sub-Q (subcutaneous) dose ordered: 1ml/100unit) three times a day as needed FOR [sic]: Type 1 Diabetes Mellitus Administration Instructions: 151-200=2 units, 201-300=6units, 301-350=8 units, 351-400=10 units, 401-450=12 units if accucheck (blood sugar) is greater than 451 give sliding scale and recheck in 15 min, if still greater than 451 give 14 units and recheck in 15 min, if still greater than 451 call doctor, Call doctor if blood sugar is less than 65 and resident is not going to eat, otherwise do not hold Lantus/Levamier [long acting insulins]...."</p> <p>The orders continued to include "Blood Sugar Check twice a day 0600 [6:00 A.M] and 1600 [4:00 P.M.]... Notify physician if blood sugar > [greater than] 451 Notify physician if blood sugar < [less than] 65..." dated 3/6/15.</p> <p>The Medication Administrator Record (MAR) from March 1 to March 31, 2016 for Resident #25 included, but was not limited to the following:</p> <p>The 6AM blood sugar checks were listed</p>			

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	<p>as follows:</p> <p>3/1 -154 mg/dL (milligram per deciliter) (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/3 -252 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/4 - 252 mg/dL (4 units ordered), documentation was lacking insulin was administered.</p> <p>3/5 -152 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/9 - 177 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/11 -179 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/12 -176 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/13 -163 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/15 - 164 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/17 - 174 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/18 -180 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p>			

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	<p>3/23 - 162 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/25 -167 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>The 4 PM blood sugar checks were listed as follows:</p> <p>3/1 - 246 mg/dL (4 units ordered), documentation was lacking insulin was administered.</p> <p>3/3 - 232 mg/dL (4 units ordered), documentation was lacking insulin was administered.</p> <p>3/4 - 192 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/7-184mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/9 -177 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/12 - 165 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/13 - 144 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/15 - 186 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p>			

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	<p>3/16 - 235 mg/dL (4 units ordered), documentation was lacking insulin was administered.</p> <p>3/18 - 200 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/22 - 252 mg/dL (6 units ordered), documentation was lacking insulin was administered.</p> <p>3/23 - 252 mg/dL (6 units ordered), documentation was lacking insulin was administered.</p> <p>3/25 - 203 mg/dL (4 units ordered), documentation was lacking insulin was administered.</p> <p>3/26 - 176 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/27 - 227 mg/dL (4 units ordered), documentation was lacking insulin was administered.</p> <p>3/29 - 164 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>3/31 - 175 mg/dL (2 units ordered), documentation was lacking insulin was administered.</p> <p>The MAR also included Insulin Aspart sliding scale was administered on the following days and times:</p> <p>3/17 at 5:10 P.M., 3/26 at 7:04 A.M., 3/27 at 6:21 A.M., 3/28 at 6:06 A.M., and</p>			

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	<p>3/31 at 7:00 A.M. Documentation of the amount of insulin that had been administered was lacking for these days and times.</p> <p>During an interview with LPN #55 she indicated when administering sliding scale insulin a box would pop up on the electronic medication administration record (EMAR). She indicated in this box the residents blood sugar and amount of insulin should be documented.</p> <p>During an interview with the MDS Coordinator on 4/1/16 at 10:30 A.M., she indicated the days and times and initials documented were days insulin was administered to Resident #25. She nurses were to document the amount of insulin. She further indicated there was documentation was lacking that insulin had been administered on several days where the blood sugars would have required administration.</p> <p>During an interview on 4/1/16 at 11:52 A.M., LPN #8, indicated after checking a resident's blood sugar nurses would administer sliding scale insulin according to the physician 's orders listed in the MAR. LPN #8 indicated the amount of insulin given should then be documented in the MAR. LPN #8 indicated if there was no time or initials on the MAR it</p>			

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	<p>indicated the medication was not given, she further indicated if the amount was not documented there was no way to indicate the correct amounts had been administered. She indicated the facility policy was to document not only the dose but the administration of all medications.</p> <p>The labs for Resident #25 were reviewed and included, but were not limited to, a hemoglobin A1c (a test to monitor blood sugar control over 3 months) dated 3/9/16 was 9.7 with a reference range of 4.3 to 6.1.</p> <p>The care plans included, but were not limited to. A care plan for potential for fluctuating blood sugars related to Diabetes Mellitus initiated 3/21/16. The interventions included but were not limited, monitor for signs and symptoms of high, low blood sugars, and monitor weights and intake.</p> <p>During an interview with the Director of Nursing (DON) on 4/6/16 at 9:10 A.M., she indicated the documentation was lacking that Insulin Aspart sliding scale had been administered as ordered for March 1, 2016 to March 31, 2016.</p> <p>During an interview with the Administrator on 4/6/16 at 3:10 P.M., she indicated it was the policy of the facility</p>			

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F 0441 SS=D Bldg. 00	<p>to administer medications to the Residents as ordered by the physician.</p> <p>The facility provided a policy for Physician's orders dated 8/2015, it included ...It is the policy of the facility to ensure medication and treatment accuracy by review of each resident's monthly Physician Order Summary (POS), Medication Administration Record (MAR), and Treatment Administration Record (TAR) by a licensed nurse..."</p> <p>3.1-35(g)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program</p>			

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	<p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure, infection control practices were followed for a resident whom met the criteria for the review of isolation. (Resident #58)</p> <p>1. During a random observation on 3/30/16 at 1:45 P.M., Resident #58 was observed to be lying in bed in no apparent distress. During this observation 2 large trash cans were observed to be in the restroom of Resident #58 room. These cans were observed to have red biohazard bags inside of them, the lids of the trash cans were askew and there was bagged trash observed to be above the top of one of the trash cans. A white plastic 3 drawer cabinet was observed right inside of the bathroom. This cabinet contained,</p>	F 0441	<p>The facility does ensure infection control practices are followed for residents who meet the criteria for the review of isolation. There are no resident's in isolation at this time. A mandatory all staff inservice will be held by facility infection control preventionist on or before April 22, 2016 to review guidelines, facility policy and standard and transmission based precautions. The facility has added hypochlorite solution (also known as common household bleach) to their cleaning products for use in rooms of residents with uncontained C-diff infection. The infection log, 24 hour report log and medical record charting will be monitored daily for documented signs and symptoms of infections to ensure appropriate monitoring and procedures are in place.</p>	05/06/2016	

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	<p>yellow isolation gowns and red bags.</p> <p>The clinical record for Resident #58 was reviewed on 4/5/16 at 11:29 A.M., the admission diagnoses included a necrotic foot ulcer and cellulitis. The current diagnoses list included, but was not limited to C-diff (clostridium difficile) a highly contagious, multiple-drug resistant organism (MDRO), that causes, fever, chills, diarrhea.</p> <p>A lab dated 3/22/16 indicated Resident #58 had been positive for C Diff.</p> <p>A physicians order dated 3/22/16 included, but were not limited to Flagyl (an antibiotic)500 mg (milligrams) three times a day for four weeks.</p> <p>A care plan dated 3/22/16 for C diff. The interventions included, use good handwashing before and after care, wear gloves, and Help resident wash hands.</p> <p>During an interview on 4/5/16 at 9:40 A.M., housekeeper (HSK) #4 indicated she normally cleaned the rooms on the 300 hall, including the room Resident #58 resided in, she indicated she was unaware of any special needs for any rooms down the hallway and she cleaned them all the same.</p>		<p>Housekeeper#4 is to be re-educated on standard precautions and appropriate cleaning procedures for transmittable infections versus non-transmittable infections. Housekeeper #6 is to be re-educated on use of proper cleaning materials and/or solutions and when to use proper PPE in transmittable infectious rooms versus non transmittable infectious rooms. CNA #66 is to be re-educated on the proper use of PPE and handwashing and individual verbal counseling will be provided. LPN#55 will be re-educated on the proper use of PPE.</p> <p>The Administrator or designee will conduct weekly audits for 6 months of 5 random staff members to interview or observe infection control procedure implementation and report any negative findings to the QAPI committee.</p>		

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	<p>During an interview on 4/5/16 at 10:10 A.M., HSK #6 indicated she was the housekeeper for the rooms on the 300 hall that day. She indicated in the room for Resident #58 she used the same cleaner (X-Ray) to wipe down the surfaces in the room and the same facility Multi-Clean Century Maintenance Cleaner. She further indicated she only wore gloves when cleaning the room and was instructed there was no need to wear a gown when cleaning the room.</p> <p>The Material Safety Data Sheets and Manufactures instructions for the X-Ray cleanser and Multi-Clean Century Maintenance Cleanser was requested from the DON on 4/5/16 at 10:40 A.M.</p> <p>During an interview with the Maintenance Director (MD) on 4/6/16 at 9:50 A.M., he indicated the facility had not been using a cleanser effective with C Diff. He indicated the housekeeping staff had been instructed on 4/5/16 to start using a bleach solution to mop the floors and SANI-CLOTH BLEACH (a disposable germicidal wipe) to wipe down the items in the room.</p> <p>2. During an observation of care on 4/6/16 at 9:30 A.M., CNA #66 and LPN #55 were observed to enter the room of Resident #58. During this observation the</p>			

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	<p>following breaks in infection control were observed:</p> <p>At 9:31 A.M., CNA #66 was observed to enter the room without a gown and gloves. CNA #66 was observed to pick up a writing tablet belonging to Resident #58 off of a box of gloves. CNA #66 was observed to remove a pair of gloves from the box and put them on and then don a gown. The box of gloves on top of the white isolation cart was observed at that time to be empty.</p> <p>At 9:36 A.M., during this observation LPN #55 was observed to get on top of Resident #58 bed to assist with transferring him. At that time the gown was observed to be lifted and her pant legs were observed to be in contact with the bed.</p> <p>During an interview with LPN #55 at 9:40 A.M. she indicated, they had received training on how to care for a resident with C diff. She indicated that training included, to always wear a gown and gloves, all linens and trash were to remain in room in the red bags. She further indicated once items were taken in the room they were not to be taken out unless properly sanitized first.</p> <p>At 9:40 A.M., CNA #66 was observed to</p>			

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	<p>wash her hands and then take a dishes that had been used by Resident #58 to the kitchen to be washed, CNA #66 was not observed to perform hand hygiene after touching the dishes that had been removed from the room.</p> <p>During an interview with the Director of Nursing on 4/6/16 at 11:15 A.M., she indicated the infection control program was the responsibility of all of the nurses in the facility. She indicated they would initiate the process in the electronic medical record (EMR) in the facility QA folder. She indicated the information in the folder was internal documentation and included, her audits of staff compliance, infection surveillance and monitoring. She indicated if a problem with these were identified she would then in-service the staff. The DON indicated Resident #58 was in contact isolation for C diff. She further indicated all staff were to wear gloves and a gown when entering the room of Resident #58 for any reason and this was part of the training. At that time the DON was made aware of the concerns with the observation of care of Resident #58.</p> <p>During an interview with the administrator on 4/6/16 at 1:44 P.M., she indicated it was the policy of the facility to provided effective infection control to</p>			

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	<p>maintain the safety and health of all residents. She indicated the housekeeping staff had been using bleach in the mop water when cleaning Resident #58's room. She further indicated the dishes of a Resident with C diff should be either washed separately or they should use disposable dishes to decrease the spread of C diff. When made aware of the observations and interviews the administrator indicated she was not aware these practices were not being observed.</p> <p>On 4/6/16 at 11:12 A.M., the facility provided a policy titled "Standard and Transmission-Based Precautions " dated 12/15. The policy included, but was not limited to, "Contact Precautions: When required, contact precautions are used IN ADDITION TO standard precautions. a. Contact precautions should be considered on an individual basis for resident with known or suspected infections... that represent an increased risk for contact transmission... ensure that room of residents on Contact Precautions are prioritized for frequent cleaning and disinfection..."</p> <p>On 4/6/16 at 11:15 A.M., a policy titled "Infection Prevention and Control" dated 11/15 was provided by the facility. It included, but was not limited to, "...with</p>			

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F 0520 SS=D Bldg. 00	<p>an MDRO [multi-drug resistant organism], ensure that gloves and gowns are used for contact...Contact precautions are indicated for residents with MDRO's who are ill and totally dependent on caregivers for ADL's [activities of daily living] and those who's secretions or drainage cannot be controlled...All facility personnel will be trained in basic infection control practices upon hire, including information on standard precautions...hand hygiene and use of personal protective equipment. Direct care staff will receive more intensive infection control training as job appropriates"</p> <p>3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(j) 3.1-18(l)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to</p>			

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	<p>identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed to implement an effective quality assessment and assurance program to identify potential concerns including infection control practices and cleaning regimen for 1 of 1 residents with Clostridium difficile. The facility also failed to ensure the complete quality assessment and assurance committee met quarterly. (Resident #58)</p> <p>1. During a random observation on 3/30/16 at 1:45 P.M., Resident #58 was observed to be lying in bed in no apparent distress. During this observation 2 large trash cans were observed to be in the restroom of Resident #58 room. These cans were observed to have red biohazard bags inside of them, the lids of the trash cans were askew and there was</p>	F 0520	<p>We are amending our response to include: a review of QAPI attendance logs will be reviewed at each QAPI meeting monthly for 6 months</p> <p>The facility does ensure that an effective quality assessment and assurance program is in place to identify potential concerns including infection control practices and cleaning regimens. The facility also ensures that the complete committee meets quarterly at minimum. The facility has moved QAPI Committee meeting date to better meet the Medical Directors schedule. Administrator will ensure that the medical director is in attendance at least once per quarter. If and when physician does not attend QAPI Committee meeting for 2 consecutive months, the administrator will call and call and send notice to ensure that he/she will be in attendance the following</p>	05/06/2016

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	<p>bagged trash observed to be above the top of one of the trash cans. A white plastic 3 drawer cabinet was observed right inside of the bathroom. This cabinet contained, yellow isolation gowns and red bags.</p> <p>The clinical record for Resident #58 was reviewed on 4/5/16 at 11:29 A.M., the admission diagnoses included a necrotic foot ulcer and cellulitis. The current diagnoses list included, but was not limited to C-diff (clostridium difficile) a highly contagious, multiple-drug resistant organism (MDRO), that causes, fever, chills, diarrhea.</p> <p>A lab dated 3/22/16 indicated Resident #58 had been positive for C Diff.</p> <p>The physicians orders included, but were not limited to Flagyl (an antibiotic)500 mg (milligrams) three times a day for four weeks.</p> <p>A care plan dated 3/22/16 for C diff. The interventions included, use good handwashing before and after care, wear gloves, and Help resident wash hands.</p> <p>During an interview on 4/5/16 at 9:40 A.M., housekeeper (HSK) #4 indicated she normally cleaned the rooms on the 300 hall, including the room Resident #58 resided in, she indicated she was</p>		<p>month. A review of QAPI attendance logs will be reviewed at eachQAPI meeting to ensure continued compliance</p>	

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	<p>unaware of any special needs for any rooms down the hallway and she cleaned them all the same.</p> <p>During an interview on 4/5/16 at 10:10 A.M., HSK #6 indicated she was the housekeeper for the rooms on the 300 hall that day. She indicated in the room for Resident #58 she used the same cleaner (X-Ray) to wipe down the surfaces in the room and the same facility Multi-Clean Century Maintenance Cleaner. She further indicated she only wore gloves when cleaning the room and was instructed there was no need to wear a gown when cleaning the room.</p> <p>The Material Safety Data Sheets and Manufactures instructions for the X-Ray cleanser and Multi-Clean Century Maintenance Cleanser was requested from the DON on 4/5/16 at 10:40 A.M.</p> <p>During an interview with the Maintenance Director (MD) on 4/6/16 at 9:50 A.M., he indicated the facility had not been using a cleanser effective with C Diff. He indicated the housekeeping staff had been instructed on 4/5/16 to start using a bleach solution to mop the floors and SANI-CLOTH BLEACH (a disposable germicidal wipe) to wipe down the items in the room.</p>			

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	<p>2. During an observation of care on 4/6/16 at 9:30 A.M., CNA #66 and LPN #55 were observed to enter the room of Resident #58. During this observation the following breaks in infection control were observed:</p> <p>At 9:31 A.M., CNA #66 was observed to enter the room without a gown and gloves. CNA #66 was observed to pick up a writing tablet belonging to Resident #58 off of a box of gloves. CNA #66 was observed to remove a pair of gloves from the box and put them on and then don a gown. The box of gloves on top of the white isolation cart was observed at that time to be empty.</p> <p>At 9:36 A.M., during this observation LPN #55 was observed to get on top of Resident #58 bed to assist with transferring him. At that time the gown was observed to be lifted and her pant legs were observed to be in contact with the bed.</p> <p>During an interview with LPN #55 at 9:40 A.M. she indicated, they had received training on how to care for a resident with C diff. She indicated that training included, to always wear a gown and gloves, all linens and trash were to remain in room in the red bags. She further indicated once items were taken</p>			

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	<p>in the room they were not to be taken out unless properly sanitized first.</p> <p>At 9:40 A.M., CNA #66 was observed to wash her hands and then take a dishes that had been used by Resident #58 to the kitchen to be washed, CNA #66 was not observed to perform hand hygiene after touching the dishes that had been removed from the room.</p> <p>During an interview with the Director of Nursing on 4/6/16 at 11:15 A.M., she indicated the infection control program was the responsibility of all of the nurses in the facility. She indicated they would initiate the process in the electronic medical record (EMR) in the facility QA folder. She indicated the information in the folder was internal documentation and included, her audits of staff compliance, infection surveillance and monitoring. She indicated if a problem with these were identified she would then in-service the staff. The DON indicated Resident #58 was in contact isolation for C diff. She further indicated all staff were to wear gloves and a gown when entering the room of Resident #58 for any reason and this was part of the training. At that time the DON was made aware of the concerns with the observation of care of Resident #58.</p>			

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	<p>On 4/6/16 at 11:12 A.M., the facility provided a policy titled "Standard and Transmission-Based Precautions " dated 12/15. The policy included, but was not limited to, "Contact Precautions: When required, contact precautions are used IN ADDITION TO standard precautions. a. Contact precautions should be considered on an individual basis for resident with known or suspected infections... that represent an increased risk for contact transmission... ensure that room of residents on Contact Precautions are prioritized for frequent cleaning and disinfection..."</p> <p>On 4/6/16 at 11:15 A.M., a policy titled "Infection Prevention and Control" dated 11/15 was provided by the facility. It included, but was not limited to, "...with an MDRO [multi-drug resistant organism], ensure that gloves and gowns are used for contact....Contact precautions are indicated for residents with MDRO's who are ill and totally dependent on caregivers for ADL's [activities of daily living] and those who's secretions or drainage cannot be controlled...All facility personnel will be trained in basic infection control practices upon hire, including information on standard precautions...hand hygiene and use of</p>			

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R 0000 Bldg. 00	<p>personal protective equipment. Direct care staff will receive more intensive infection control training as job appropriates"</p> <p>3. During the QA and A interview with the administrator on 4/6/16 at 1:44 P.M., she indicated the facility had not identified the concerns with the infection control and isolation process. At that time she indicated the QA and A committee met monthly and consisted of all of the facility department heads and the Medical director. She indicated the Medical director had not attended a meeting this quarter. She indicated the Medical director had been invited to attend all of the meeting.</p> <p>3.1-52(a)(2) 3.1-52(b)(2)</p> <p>This visit was for a State Residential Licensure Survey. Residential Census: 17 Sample: 7 This State finding is cited in accordance with 410 IAC 16.2-5.</p>	R 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared solely because the provisions of	

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R 0356 Bldg. 00	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 death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on observation, interview, and record review, the facility failed to ensure 2 of 2 nurses interviewed who had worked in the residential area of the facility were aware of the residential emergency information file and the file	R 0356	law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity to render adequate care. The statement of decencies has been taken to the facilities Quality Assurance/Assessment Committee The facility does ensure that residential nurses are awareof the residential emergency information file and the file location. Residential staff have been made aware that there is anemergency binder and the location of the	05/06/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/06/2016
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	<p>location for the 17 residents who resided on the residential unit.</p> <p>Findings include:</p> <p>On 4/6/16 at 12:46 P.M., the residential unit nurse, RN #8 was asked to locate the residential emergency information file for the 17 residents who resided on the residential unit. RN #8 was unable to locate the facility residential emergency information file at that time. RN #8 indicated at that time she was unaware of an emergency information file for the residential unit. RN #8 was made aware the emergency information file contained personal information such as the resident's name, room number, a resident photograph, telephone numbers of doctors, family members and other personal information that would be needed in the event of an emergency such as a disaster or an emergency evacuation of the facility. RN #8 indicated at that time she was unaware of an emergency file containing personal information that would be needed for each resident on the unit in an emergency.</p> <p>On 4/6/16 at 12:47 P.M. RN #12 also present during interview with RN #8 indicated she was also unaware of an emergency information file containing information for each resident of the</p>		<p>binder. All residential staff will beinserviced by 4/22/16 to review information in the binder and to ensure understanding of binder location. Upon hiring new residential staff, the Administrator will ensure that staff is educated on specifics and location of binder. Administrator will conduct 5 random audits/interviews of 5 employees per month for the next 6 months to ensure staff understanding of binder location and content. RN #8 received additional education on the importance of the 'Emergency Evacuation Resident Information Sheets' binder.</p>		

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	<p>residential unit.</p> <p>On 4/6/16 at 12:51 P.M., the facility provided the residential emergency information file binder labeled "Emergency Evacuation Resident Information Sheets" that had been located in the business office of the facility.</p> <p>On 4/6/16 at 1:03 P.M., the Business Office Manager indicated the emergency information file was kept in the business office. The Business Office Manager at that time provided facility documentation entitled "FACILITY ORIENTATION" and "GENERAL ORIENTATION" which included, but was not limited to, information regarding fire, disaster and evacuation. She indicated new employees were provided that information during orientation.</p> <p>On 4/6/16 at 2:14 P.M., during interview with Business Office Assistant, she indicated the residential emergency information file stays in the business office. She indicated the nurses have a key to the business office to retrieve the resident emergency information file on weekends, evening, and night shifts, if needed.</p> <p>The Business Office Assistant also indicated she was unaware of a facility policy regarding the residential</p>			

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

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	emergency information file.				