

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00106871.</p> <p>Complaint IN00106871 - Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: April 30, May 1-9, 2012</p> <p>Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290</p> <p>Survey Team: Laura Brashear, RN, TC Mary Weyls, RN Teresa Buske, RN</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 9 Medicaid: 55 Other: 15 Total: 79</p> <p>These deficiencies reflect state</p>	F0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	findings cited in accordance with 410 IAC 16.2. Quality review 5/17/12 by Suzanne Williams, RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's personal privacy was maintained for 2 of 10 residents observed during random observations of personal care. (Resident # 89, Resident # 99)</p> <p>Findings include:</p>	F0164	<p>It is the intent of this facility to ensure the resident has the right to personal privacy and confidentiality. 1. Action Taken a. In regards to Resident #89; nursing staff will be in-serviced on providing privacy during toileting. This in-service will include closing the door and utilizing the privacy curtain during the use of a bedside commode. b. In</p>	05/31/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1. On 5/1/12 at 10:40 a.m. and on 5/2/12 at 9:50 a.m., the door to Resident #89's room was closed. Upon opening the door after knocking, the resident was observed to be utilizing the bedside commode. The privacy curtain was not pulled allowing the resident to be exposed during personal care when the door was opened. Nursing staff was observed to be present with the resident in the room.</p> <p>Review of the resident's clinical record on 5/7/12 at 2:42 p.m. indicated the most recent Minimum Data Set (MDS) assessment was completed on 2/6/12. The assessment identified the resident as cognitively intact, and requiring setup and supervision for personal hygiene.</p> <p>Upon interview of the resident on 5/2/12 at 10:20 a.m., the resident indicated it did not bother him that the curtain was not pulled.</p>		<p>regards to Resident #99; nursing staff will be in-serviced on providing privacy during provision of personal care. This in-service will include closing the door, utilizing the privacy curtain, and utilizing a sheet to expose only the necessary parts of the body during bathing. 2. Others Identified a. 100 % audit of all privacy curtains to assure all were adequate and in working order. No findings noted. 3. Systems in Place a. Nursing staff will be in-serviced in regards to providing personal privacy during personal care. This in-service will include closing the door of the resident room during personal care; utilizing the privacy curtain during the use of a bedside commode and/or bathing; utilizing a sheet to only expose the necessary parts of the body during bathing. A pre- and post-test will be given. 4. Monitoring a. The QA team will monitor daily during rounds for compliance; This will be ongoing. b. DON/Designee will randomly perform proficiency audits of staff 3 times weekly. Any staff member who is identified as not providing privacy will have 1 on 1 in-servicing to ensure compliance. c. Administrator/Designee will review all proficiency's as completed in the daily QA stand-up meeting; monthly with the QA team in the QA meeting; and quarterly in the QA meeting</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. During observation on 5/3/12 at 10:20 p.m., Resident #99 was assisted with a bed bath. CNA #8 handed the washcloth to the resident and he bathed his face and top of body. The privacy curtain was not pulled around the end of Resident #99's foot of bed. After the resident washed his face and chest, CNA #8 pulled covers down. The resident did not have any clothes on. Someone knocked on the resident's door, and the door was opened by CNA #8, who did not cover the resident up. CNA #7 entered room. The resident was left uncovered and naked while he bathed his private parts.</p> <p>Resident #99's clinical record was reviewed on 5/4/12 at 3 p.m. A sixty day assessment, dated 3/9/12, indicated the resident was without a cognitive impairment.</p> <p>Review of a facility policy, dated 7/1/11, and titled "Resident Rights", received on 5/9/12 at 3:35 p.m. from the DON (Director of Nursing), documentation indicated the resident had the right to privacy during bathing</p>		with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5-31-12.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	and personal care. 3.1-3(p)(4)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>a. Based on observation, interview, and record review, the facility failed to maintain a safe environment for 1 of 5 random residents reviewed utilizing mechanical air flow beds, in that the facility failed to ensure proper use of the bed according to the manufacturer's directions and ensure recommended servicing was provided. This resulted in Resident E receiving a thermal injury.</p> <p>b. Based on observations, interview, and record review, the facility failed to ensure toilet risers were securely attached to toilets to prevent tipping for random observations of 4 of 12 resident bathrooms [Rooms 207, 218, 220/222 [shared bathroom] and Rooms 224/226 [shared] utilizing risers. Three residents, Residents C, B, and D, were identified as able to independently utilize the toilets. This deficient practice resulted in Resident C sustaining a fall.</p> <p>c. Based on observations and record review, the facility failed to follow</p>	F0323	<p>It is the intent of this facility to ensure proper use of mechanical air flow beds per manufacturer's directions and to ensure recommended servicing was provided to bed. It is the intent of this facility to ensure toilet risers are securely attached to toilets to prevent tipping. It is the intent of this facility to follow manufacturer's directions during transfers with a mechanical lift.</p> <p>1. Action Taken a. In regards to Resident #E; The Mechanical air flow bed was replaced and manufacturer's recommendations/directions were followed. b. In regards to Resident #C, #B, and #D; new toilet risers were purchased and securely fastened/bolted to the commode. The Maintenance Director will assess the toilet risers weekly to ensure they are secure and safe. c. In regards to Resident #A; nursing staff will be in-serviced on the appropriate and safe use of the stand-up lift.</p> <p>2. Others Identified a. 100% audit of all mechanical air flow beds was completed. No others identified. b. 100% audit of all toilets risers. No others identified. c. 100 % audit of all residents</p>	05/31/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>manufacturer's directions for 1 of 2 random observations of a resident transferred with mechanical lift. [Resident A]</p> <p>Findings include:</p> <p>a. Facility reported incidents were reviewed on 5/4/12 at 11:00 a.m. A report was noted of Resident E was on a low air loss mattress that was too warm for the resident's comfort and the resident received pink skin and a small blister. The immediate action taken was to change the mattress and check all other speciality mattresses.</p> <p>Resident E's clinical record was reviewed on 5/4/12 at 2:00 p.m. Diagnoses included, but were not limited to, cerebral vascular accident and aphasia. A Minimum Data Set [MDS] assessment dated 12/28/11, coded the resident with severe cognitive impairment, rarely understood, required total assistance of two for bed mobility and transfers, and non ambulatory.</p> <p>A nursing note dated 12/26/11 at 2:20 a.m., was noted of "wife phoned facility couldn't sleep had some concerns about Res. [resident] from when she was in on 12/25/11 at 6:00</p>		<p>who require use of the stand up lift. 3. Systems in Place a. In-serviced/educated nursing staff on correct use of mechanical air flow beds, bedding, settings, and safety according to manufacturer's recommendations. b. In-serviced/educated nursing staff on the correct/proper use of the stand-up lift per manufacturer's recommendations. c. Therapy Department screened all residents for appropriateness of lift use; Nursing updated all CNA pocket worksheets for accuracy. d. In-serviced Maintenance Department on ensuring toilet risers are securely fastened/bolted to the commode; and ongoing monitoring to ensure safety is maintained; and ongoing monitoring of mechanical air flow beds for resident safety. 4. Monitoring a. Maintenance Director\Designee will monitor location of each mechanical air flow bed for scheduled maintenance provided by the vendor; changing filters; and any other recommendations per the manufacturer. This will be on-going for safety. b. Maintenance Director\Designee will monitor all rooms where toilet risers are located; ongoing monitoring for safety. c. DON\Designee will report any new mechanical air flow beds daily in the QA stand up meeting for addition to Maintenance report. d. DON\Designee will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>p.m. This nurse listened to wife's concerns et [and] wife asked this nurse to check on Res. this nurse went to res. room obtained temp at 98.0 [degrees Fahrenheit] informed wife of temp et condition of Res. @ [at] this time."</p> <p>A nursing note dated 12/26/11 at 3:00 a.m. was noted of "Res. mattress was changed et wife was phoned et made aware of." A note at 3:30 a.m. was noted of "DON was notified of need to change mattress, see skin sheet."</p> <p>. Documentation on a form titled "Skin Assessment" dated 12/26/11, completed at 2:30 a.m., was noted of left and right ears-red; Left elbow-1.2 cm [centimeter] diameter excoriation with clear drainage; 4. Right elbow-1 cm diameter blister; 5. Left buttock 4 cm long by 1 cm wide triangle shaped area; 6. Left hip "see below." The additional information was a diagram of an irregular shaped area 10 cm long and 6 cm width on one end and 8 cm on the other end blistered area. 7. Right buttock 4 cm long by 2 cm wide; #8. Left upper thigh 4 cm long by 1 cm wide.</p> <p>On 5/4/12 at 2:00 p.m. the DON was interviewed. The DON indicated the measurements were completed by a</p>		<p>perform random proficiency audits on different shifts for the use of stnad-up lift 3 times a week. e. Administrator\Designee will review all audits as completed to ensure compliance of the mechanical air flow bed safety, safety of toilet risers for all residents, and completion for the use of the stand-up lift. f. Administrator\Designee will review all audits monthly with the QA team and at the quarterly QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5\31\12.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>facility nurse on 12/26/11 at 2:30 a.m.</p> <p>On 5/4/12 at 2:00 p.m. the DON provided a skin assessment completed by the Hospice nurse on 12/27/11 at 7:00 a.m. Documentation on the diagram of a body was noted of a 7.4 cm by 7 cm blister on the right upper outer thigh and a 4.3 by .3 line of purple discoloration above the blistered area.</p> <p>A telephone order from Hospice nurse was noted dated 12/26/11 at 6:10 a.m., for Silvadene, apply to burned areas then apply dry dressing over two times a day until healed. A physician's telephone order dated 12/26/11 at 11:00 a.m., was noted for, "Apply bacitracin to area on R [right] outer thigh then cover with foam et [and] coverall bid [two times daily]."</p> <p>A progress note documented by the Hospice Medical Director dated 12/29/11 included, but was not limited to: "I was asked to see pt [patient] in followup. Family called ECF [extended care facility] following concern of a warm bed and he was later noted to have a wound of the r [right] leg and buttock suspicious for a thermal injury. ...pt does have an injury noted (see below). ...pt with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>apparent thermal injury appropriately identified and bandaged...."</p> <p>On 5/4/12 at 11:00 a.m. Resident E's family member was interviewed. The family member indicated multiple family members had visited the resident on the evening of 12/25/11. The family indicated at that time warm air was felt coming from underneath the resident's bed. The family indicated this was reported to a nurse. The nurse went to check with another nurse and the visitors left the facility before receiving a response. The family member indicated she called the facility at 1:30 a.m. to inquire about the resident and asked the nurse to check on the resident.</p> <p>The DON provided documentation of an investigation into the incident on 5/7/12 at 11:15 a.m. The documentation included, but was not limited to, "[nurse's name] was phoned by [resident's family member] at 2:20 p.m. she stated she couldn't sleep she was worried about her husband and wanted this nurse to check his bed it was warm she stated when she was at facility on 12/25/11 @ [at] 7 p.m. This nurse checked bed and it was very warm and this nurse informed wife that the mattress was warm et [and] would be changed to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>another mattress. while changing the mattress this nurse found burn marks et blisters on resident's buttocks et r [right] thigh. [Name] Hospice et DON notified at this time."</p> <p>Additional investigation documentation completed by another nurse, dated 12/25/11 was noted of: "On December 25th, 2011 @ [at] 7:00 p.m. [name] resident's family member, told me that his bed 'felt hot.' [Resident's name]. I felt the bed at that time the bed did feel warm to the touch but not hot, the mattress did not, at that time when I felt it, feel uncomfortable or hot, it just felt warm to the touch at 7:00 p.m. I did not feel the resident was being compromised in any way."</p> <p>On 5/4/12 at 1:05 p.m. the DON was interviewed. The DON indicated she was present when a company representative providing the bed through Hospice came in to pick up the mattress. The DON indicated the company representative indicated the mattress had a motor in it and the filter must have clogged. The DON indicated they [the facility] was not aware there was a motor inside the mattress and told the representative they could not have that kind of equipment in the facility. The DON</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated the facility did not have any manufacturer's information/guidelines for the speciality mattress until after the incident. The DON indicated the resident had been placed on the mattress October 4, 2011.</p> <p>Documentation included in the manufacturer's "Rem-Air Operator's Handbook" provided by the DON on 5/4/12 at 1:50 p.m. included, but was not limited to, "General Information ...5. One thin cotton sheet may be used on top of the Rem-Air mattress cover. BE SURE NOT TO COVER THE AIR INTAKE FILTER AT THE FOOT OF THE MATTRESS. ..." Under the section titled "Introduction" information included, but was not limited to, "LIMITATION AND EXCLUSIONS: THE FOREGOING WARRANTY SHALL BE IN EFFECT IF THE FILTER HAS BEEN CHANGED EVERY 30-DAYS (NOT WASHED AND REUSED)...."</p> <p>On 5/7/12 at 10:10 a.m. the Administrator obtained a form titled "Tracking History At Home Health Equipment" documenting servicing of the mattress. The documentation was noted of Resident E receiving the mattress on 10/5/11. The next documentation of the mattress was noted dated 12/26/11 of replacing the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>mattress followed by documentation of inspection of the equipment resulting from a claim from the facility of the mattress causing a third degree burn to a patient. Documentation followed of the equipment being tested and no evidence of overheating found.</p> <p>b 1. On 5/1/12 at 11:05 a.m. with the Maintenance person, 4 of 12 toilet risers were observed loose. The loose toilet risers were observed in bathrooms used for rooms 207, 218, 220, 222, 224 and 226.</p> <p>During Interview of the Maintenance person on 5/1/12 at 11:05 a.m., the Maintenance person indicated he did not have a check system for toilet risers. The Maintenance person indicated If staff have a problem, "they let me know." He indicated he didn't remember any issues with the risers.</p> <p>On 5/1/12 at 11:15 a.m. during interview of LPN #17, the LPN indicated the aides are supposed to check risers, but was unsure when.</p> <p>During interview on 5/1/12 at 11:15 a.m., of CNAs (certified nursing assistance) #9 and 20, the CNAs indicated if a resident requires assistance to the toilet, they check</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the risers and tighten them if necessary.</p> <p>During interview on 5/1/12 at 11:30 a.m., of the DON (Director of Nursing), the DON indicated Residents B, C, and D, resided in the rooms with loose toilet risers and were independent with toileting.</p> <p>b. 2. Resident B's clinical record was reviewed on 5/9/12 at 11:18 a.m.</p> <p>A nurse's note, dated 4/26/12 at 6 a.m., indicated the resident was alert and oriented, continent of bowel and bladder and independent with toileting.</p> <p>b 3. Resident C's clinical record was reviewed on 5/8/12 at 11:53 a.m.</p> <p>Diagnoses were noted of, but not limited to, diabetes, hypothyroidism, hypertension, diastolic heart failure, iron deficiency anemia, hyperlipidemia, and congestive heart failure.</p> <p>A plan of care was noted, dated 3/21/12, indicating the resident had multiple risks for falls related to IDDM (insulin dependant diabetes mellitus) HTN (hypertension) diastolic heart failure and CHF(congestive heart</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>failure).</p> <p>Review of a nurse's note, dated 3/23/12 at 3 a.m., indicated "Resident turned emergency BR [bathroom] light on- upon entering room found res [resident] sitting on floor [with] legs folded to side on L [left] upper leg/thigh on floor in front of toilet. When questioned about what happened he stated that 'the riser was loose when I grabbed it et [and] I knew I was going to fall'...."</p> <p>A "Monthly Summary" on 3/23/12 at 7 a.m. indicated "...does use toilet l'ly [independently] @ [at] times." [sic]</p> <p>A "Maintenance Work Order" dated 3/24/12 received from the DON on 5/9/12 at 3 p.m. indicated Misty Lane bathroom 224 & 226 -riser is not effective (needs either replaced or fixed). The bottom of the form under the title "work done" indicated "Checked Riser to see if was tight. Tightened front clamp. Done 3/29/12."</p> <p>During interview of the DON on 5/9/12 at 3 p.m., the DON indicated the work order was concerning the riser that was loose during Resident C's incident.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>b 4. Resident D's clinical record was reviewed on 5/9/12 at 12 noon.</p> <p>A nurse's note dated 1/15/12 at 4:15 p.m., indicated the resident is alert and oriented.</p> <p>c. On 5/3/12 at 12:23 p.m., Resident A was observed to be transferred from the wheelchair to the bed utilizing the Invacare stand up mechanical lift by CNAs # 9 and #7. The resident was lifted with sling in place around the resident's upper body and around the resident's upper thighs. The resident's knees were against the knee pads when lifted. As the resident was lifted, the resident held onto the handles of the lift. CNA #9 utilized the remote to activate the lift. The resident was lifted and the resident's feet were in the air beyond the point of weight bearing. The resident moaned. CNA #9 immediately lowered the resident to weight bearing with both feet. The resident was then placed in bed.</p> <p>Review of the resident's clinical record on 5/7/12 at 10:20 a.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 4/9/12. The assessment identified the resident with long/short term memory problems, moderately</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>impaired in cognitive decision making skills, required extensive assistance with transfers, and total dependence for personal hygiene.</p> <p>Review of the manufacturer's guidelines for the Invacare stand up lift on 5/7/12 at 1:55 p.m. indicated :...NOTE: The stand up lift may be operated by one (1) healthcare professional for ALL lifting preparation, transferring from and transferring to procedures with a cooperative, weight-bearing individual able to support the majority of his/her own weight....1. Make sure of the following:...B. Patient's feet are positioned on the footplate as shown in STEP 2B of FIGURE 1..."</p> <p>This federal tag relates to Complaint IN00106871.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0441 SS=F	<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 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>a. Based on observation, interview, and record review, the facility failed to</p>	F0441	It is the intent of this facility to maintain a sanitary environment	05/31/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>maintain a sanitary environment to prevent the development and transmission of disease and infection for 5 of 5 residents randomly observed with active Clostridium Difficile [c-diff] infections [Residents #5, #109, #99, A, and #89] in that staff were not utilizing personal protective equipment when in close contact with infected residents or their environment; cleaning solutions being utilized were not effective for disinfectant of c-diff and bathrooms were not sanitized to prevent possible transmission to uninfected residents; signage was not posted to alert any visitors to check with nursing for any precautions that should be employed, and laundry of infected residents was not identified to alert staff of need to launder separately. This deficient practice had the potential to affect all 79 residents of the facility.</p> <p>b. Based on observations and record review, the facility failed to ensure 1 of 3 random observations of glucose testing meters and/or insulin multi-dose injection pens were handled in a manner to prevent potential contamination of the medication cart in that barriers were not utilized when the meters/pens were in contact with surfaces of residents' rooms and were placed on</p>		<p>to prevent the development and transmission of disease and infection. It is the intent of this facility to ensure glucose testing meters and/or insulin multi-dose injection pens is handled in a manner to prevent potential contamination of the medication cart. It is the intent of this facility to ensure hand hygiene is maintained during catheter handling. 1. Action Taken a. In regards to Resident #5, Resident #109, Resident #99, Resident A, and Resident #89; CDC guidelines obtained. Notification signs were placed on each resident's door, PPE was stocked in nightstands outside each room, appropriate disinfecting solution was obtained, all staff were educated on Contact Precautions, appropriate disinfecting, and infection control policies, CNA pocket worksheets were also updated. b. In regards to Resident #27; LPN #17 was in-serviced/educated on the appropriate use of barriers to prevent contamination of the medication cart. c. In regards to Resident #1; CNA #9 and LPN #17 were in-serviced/educated on appropriate glove usage, handwashing, and changing of gloves after handling a catheter. 2. Others Identified a. 100% audit of all residents with a current infection to ensure the correct isolation precautions in place, with the correct personal protective equipment in place and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>top of medication carts. [Resident #27]</p> <p>c. Based on observation and record review, the facility failed to ensure hand hygiene was maintained for 1 of 1 random observation of Foley catheter handling (Resident #1), in that gloves worn to handle the catheter were not removed before touching any other items in the resident's room.</p> <p>Findings include:</p> <p>a 1. On 4/30/12 at 11:30 a.m., LPN #21 was interviewed on the Moonlight Bay Alzheimer unit. The LPN indicated there were no residents in any kind of isolation. No signs were observed on residents' doors alerting visitors to check with nursing staff before entering rooms.</p> <p>Resident #5's clinical record was reviewed on 5/2/12 at 10:00 a.m. A physician's order was noted dated 4/30/12 for Flagyl [anti-infective] 500 mg by mouth every six hours times two weeks for c-diff. A final laboratory report for a stool specimen collected on 4/26/12 was noted dated 4/30/12 for c-diff antigen positive for c-diff toxin A and B. A nursing note dated 4/25/12 was noted of physician</p>		<p>readily available to staff. No other residents identified. 3. Systems in Place a. Staff in-serviced and educated on types of isolation, appropriate types of personal protective equipment for each type of isolation included; personal protective equipment, and applying the personal protective equipment appropriately, signage, and barriers as appropriate. b. Each ancillary department will be in-serviced (housekeeping, laundry, dietary, maintenance, etc) in regards to their area and appropriate PPE and disinfecting processes. All departments will be notified in the daily QA stand-up meeting of any resident with an infectious process and the precautions that are in place. c. The CNA QA pocket worksheet will be updated daily to ensure the current information is available. 4. Monitoring a. DON\Designee will audit C.N.A QA pocket worksheets daily to ensure information is current. This will be an ongoing process. b. IDT will monitor daily of all residents identified with any type of isolations to ensure the appropriate personal protective equipment is readily available for staff and staff is utilizing the equipment correctly. This will be an ongoing process. c. DON\Designee will monitor daily the medication carts for appropriate barrier use to prevent contamination of medication cart.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>notified of resident having liquid brown stool with strong odor from colostomy, and an order was received to send stool sample for c-diff.</p> <p>RN #3 was interviewed on 5/2/12 at 3:15 p.m. The RN indicated Resident #5 was not in isolation, due to having a colostomy.</p> <p>Housekeeper #4 was interviewed on 5/2/12 at 3:20 p.m. The housekeeper was observed mopping the hallway of the unit. The housekeeper indicated she had just mopped Resident #5's room. The floor of the room was observed to be wet. The housekeeper indicated there had not been any special information to her regarding any special cleaning techniques to be used to clean the resident's room. The housekeeper indicated she used disposable gloves to clean the room but no other protective equipment. The housekeeper indicated she utilizes the cleaning solutions of "Solutions 64" in the rooms and "Solutions 56" in the showers and bathrooms. The housekeeper indicated she had not been made aware of any special cleaning required for any room on the unit.</p> <p>On 5/2/12 at 4:15 p.m. CNAs #5 and</p>		<p>Audit 3 times a week, the QA team will monitor daily during rounds as an ongoing process.</p> <p>d. DON\Designee will audit\monitor appropriate hand washing, glove use; and glove changes during and following catheter care. This will be an ongoing process.</p> <p>e. Administrator\Designee will review all audits and/or proficiency's as completed in the daily QA stand up meeting and quarterly with the Medical Director in the quarterly QA meeting.</p> <p>f. DON\Designee will present a monthly Infection Control Analysis at the QA meeting with the IDT; and quarterly in the QA meeting with the Medical Director. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5\31\12.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#6 were observed to manually transfer Resident #5 from the bed to geri-chair. The CNAs were wearing disposable gloves. The resident required total assistance of two for transfers. The staff indicated the resident had a colostomy and is incontinent of urine. The staff indicated they wear gloves to provide care to the resident. The staff indicated the resident's colostomy is emptied in the resident's bathroom as needed.</p> <p>On 5/2/12 at 4:30 p.m. the resident's colostomy bag was checked with RN #3. While wearing gloves, the RN pulled the resident's blankets down covering the resident in the chair and manipulated the colostomy bag. Brown loose stool was observed in the colostomy bag. The RN indicated the resident's stools were a lot better than what they had been. The RN indicated the resident's stools prior to starting on the Flagyl were liquid and foaming. With the same gloves on, the RN readjusted the resident's blankets and moved a doll the resident frequently holds. The RN removed the gloves and washed hands.</p> <p>On 5/3/12 at 10:40 a.m. CNAs #15 and #16 were observed providing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>incontinence care to Resident #5. The staff were observed to be wearing disposable gloves. After applying a gait belt, identified as only utilized for Resident #5 due to colostomy, the staff manually transferred from a geri-chair to bed. The staff's uniforms were in contact with the resident's gown and against the resident's mattress. The staff were observed to be wearing gait belts utilized for other residents around their uniforms. While not wearing gloves, CNA #15 took a pink wash basin to the resident's bathroom and filled with water. The staff member placed the pan on a towel on the resident's bed side table. The resident's brief was removed and the peri-area washed, the resident turned, and buttocks and thighs cleansed. After completion of cleansing the resident, an incontinence brief was applied. CNA #15 took the basin while wearing clean gloves, went to the resident's bathroom and emptied the basin in the sink. The CNA returned the basin to the resident's closet, placing another pink basin inside of the basin utilized to cleanse the resident's skin. The CNAs indicated the resident's roommate utilizes the same bathroom.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The linens and trash utilized to cleanse the resident had been placed into gray bags placed on the resident's bed during the care. After completion of the care, the linens and trash were transported to the shower room and deposited into the gray barrels utilized for the unit.</p> <p>The resident's care plan, dated 4/30/12, addressed the problem of resident on Flagyl times 14 days after antibiotic completed for c-diff. Approaches included monitor resident, peri-care after each incontinent episode, apply barrier cream to bottom, give meds per MD [medical doctor] order, notify MD of any changes, colostomy care every shift.</p> <p>a 2. On 5/3/12 at 12:00 p.m., LPN #14 identified Resident #109 as being treated for c-diff on the unit. At that time the resident was observed in her room. The resident was in a chair seated on the roommate's side of the room visiting with the roommate. The door to the resident's room had been closed. A bed side commode was observed sitting in the middle of the room across from Resident #109's bed.</p> <p>At this time the resident was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>interviewed. The resident indicated she utilized the bed side commode and knew she had an infection. The resident indicated she didn't want to give it to any body else. The resident indicated at times she empties the commode in the toilet in the bathroom of her room and rinses it out in the sink. The resident indicated bleach was hard to get so she utilized the "foam" [hand washing soap above the bathroom sink] and a washcloth to clean the bucket to the commode. The resident indicated she hangs the washcloth on the footboard of her bed to dry. The resident's bathroom was shared with another resident room where two residents reside.</p> <p>Resident #109's clinical record was reviewed on 5/3/12 at 12:30 p.m. A nursing note dated 4/24/12 indicated the resident returned from the hospital on 4/24/12, toilets self, is continent of bowel and bladder, is up on her own. A Social Service Progress Note dated 5/1/12 indicated the resident had moderately impaired cognition, and needs reminders in regard to safety.</p> <p>A lab report dated 4/30/12 of a stool sample collected on 4/28/12 was noted of positive for C diff toxin A and B and c-diff antigen. Documentation</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>on the report was noted of toxigenic strain of c-diff identified. Communicability of disease is high if diarrhea is present.</p> <p>A plan of care was noted, dated 4/30/12, which addressed the problem of Resident put on Flagyl times 14 days for c-diff. Approaches were noted of use bed-side commode to toilet resident. Assist with peri-care as needed. 3. Monitor resident. Notify MD of any changes. Give Meds per MD order.</p> <p>a 3. During interview on 5/3/12 at 9:30 a.m. CNA #7 indicated she wasn't sure if any residents on her assignment were in precautions. The CNA indicated she wears gloves during resident care, if needed, and was not aware of needing to wear gowns during care of any resident.</p> <p>During observation on 5/3/12 at 10:20 a.m., Resident #99 was assisted with a bed bath. CNA #8, while wearing gloves, washed BM [bowel movement] from Resident #99's bottom. CNAs #7 and 8 assisted the resident during the bed bath, and repositioned the resident. Neither CNA were wearing gowns to cover their uniforms.</p> <p>Resident #99's clinical record was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reviewed on 5/7/12 at 10:32 a.m.</p> <p>A physician order was noted, dated 5/1/12, indicating the resident was to receive Vancomycin [antibiotic] 250 milligrams four times a day for 10 days.</p> <p>The most recent culture, dated 4/26/12, indicated the resident was positive for Clostridium Difficile. Another culture was noted, dated 3/14/12, of positive for Clostridium Difficile with a physician's order for Flagyl 500 mg bid for ten days.</p> <p>A plan of care addressing C-difficile was not available until 5/3/12, which indicated staff were to wear gown and gloves, and the resident was in contact isolation.</p> <p>a.4. On 5/3/12 at 12:23 p.m., Resident A was observed to be transferred to bed by CNAs #9 and #7. The CNAs were observed to wear gloves only during incontinence care of the resident. The resident was noted to have loose non-formed bowel movement. CNA #9, with gloves on, was observed to cleanse the resident's buttocks. The CNA was observed to change gloves after cleansing the resident with two different washcloths. The soiled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>cloths were placed in a regular plastic bag for laundry. CNA #9 then applied new gloves and cleansed the resident's buttocks again. The CNA removed her right glove and opened the cabinet and removed a tube of soothing cream. The CNA, with her contaminated, gloved left hand, was observed to touch the outside of the cabinet. A new glove was observed to be applied to her right hand. The soothing cream was applied to the resident's buttocks. Without changing the contaminated gloves, the CNA was observed to move the resident's overbed table, empty the basin into the bathroom sink, wipe out the basin with paper towel, and place the basin back into the cabinet. The CNA then removed her contaminated gloves. A bedside commode was observed to be present in the resident's room.</p> <p>Resident A's room was observed not to be posted for any type of precautions.</p> <p>Interview of CNAs #7 and #9 on 5/3/12 at 12:30 p.m. indicated Resident A did not utilize the bedside commode in the resident's room.</p> <p>Review of the clinical record of Resident A on 5/7/12 at 10:20 a.m. indicated the resident was positive for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Clostridium Difficile antigen and Clostridium Difficile toxin on 4/17/12. A physician's order was noted for Flagyl 500 milligram one four times daily for 2 weeks and then to re check stool for Clostridium Difficile.</p> <p>Interview of Assistant Director of Nursing on 5/3/12 at 4:03 p.m. indicated Resident A was currently symptomatic and being treated for Clostridium Difficile.</p> <p>a 5. On 5/3/12 at 10:40 a.m., CNA/QMA #10, with gloves on, was observed in Resident #89's room completing incontinence care. The CNA was observed not to have any type of gown on. The CNA was observed to place the soiled linen and trash into regular plastic bags. A strong bowel movement odor was noted. The CNA was observed to place the bedside commode bucket under the chair wrapped in a plastic bag.</p> <p>Interview of CNA/QMA #10 on 5/3/12 at 10:55 a.m. indicated the bedside commode bucket had been emptied into the toilet of the bathroom and rinsed with water from the bathtub. The CNA indicated disinfectant had not been utilized as she was unaware the disinfectant could be kept in the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>bathroom. The CNA also indicated the roommate utilized the toilet in the bathroom. The CNA indicated Resident #89 utilized the bedside commode and that the resident was having multiple episodes of diarrhea.</p> <p>Interview of Resident #89 on 5/3/12 at 10:42 a.m. indicated he had two episodes of diarrhea this a.m.</p> <p>Review of the clinical record of Resident #89 on 5/7/12 at 2:42 p.m. indicated the resident was positive for Clostridium Difficile on 4/16/12 and 5/3/12. A physician's order was noted dated 5/3/12 of Vancomycin 250 milligrams four times daily for two weeks and then recheck the stool for clostridium difficile and to continue the Flagyl.</p> <p>a 6. Interview of Housekeeper #11 on 5/3/12 at 10:30 a.m., indicated she utilized Chemical 64 on the floors and surfaces with a clean rag in each resident room. The housekeeper also indicated Chemical 56 was utilized on the inside of the toilet and that she changed her mop heads three times daily. The housekeeper was unaware of any resident currently in precautions for any type of infection.</p> <p>a 7. Interview of laundry staff person</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#19 on 5/3/12 at 4:11 p.m. indicated gowns and gloves were utilized during any washing procedures. The laundry person indicated if a resident was in isolation, their linens/laundry would be in red bags and washed separately. The laundry staff indicated no residents had currently been in precautions. The laundry staff person also indicated that water soluble laundry bags were being purchased, but were currently not being utilized.</p> <p>a 8. Interview of the ADON on 5/3/12 at 11:43 a.m. indicated the following residents were tracked for Clostridium Difficile for April 2012: Resident #84, Resident A, Resident #99, Resident #109, Resident #5, and Resident # 89. The ADON also indicated observations of staff care with residents had been done, and no concerns had been noted.</p> <p>The ADON indicated Residents #84 and # 99 were tracked in March 2012 for Clostridium Difficile and Residents # 25 and #84 were tracked in February 2012 for Clostridium Difficile.</p> <p>The Assistant Director of Nursing [ADON] was interviewed on 5/3/12 at 10:45 a.m. The ADON indicated residents positive for c-diff infections,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012	
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>or with symptoms of, utilize bed side commodes. The commodes are then bagged and taken to the shower room and cleaned and disinfected. The toilets in the shower rooms are then disinfected after each time. The ADON indicated shared bathrooms are not utilized for residents with the infection.</p> <p>On 5/3/12 at 3:56 p.m. the Administrator provided manufacturer's information for the product "Solutions 25," identified by the Administrator as the product utilized by nursing staff to disinfect toilets in the shower rooms and bed side commodes. The microbial efficacy of the disinfectant did not include c-diff. The Administrator indicated it did not cover c-diff. The other products identified as being utilized in resident rooms and bathrooms [Solutions 56 and Solutions 64] manufacturer's information provided by the Administrator on 5/3/12 at 3:56 p.m. also did not include the products were effective for c-diff organisms or spores. At that time, the Administrator indicated they were not effective.</p> <p>During the interview with the ADON on 5/3/12 at 10:45 a.m., the ADON indicated signs are not utilized on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/09/2012
NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>residents with c-diff rooms for visitors to check with nursing staff before entering as the rooms were not considered to be contaminated. The staff member indicated families are encouraged to not sit on bed side commodes. Nursing staff are in-serviced to utilize universal precautions i.e. gloves and handwashing. Housekeeping is always instructed to use universal precautions and is not in contact with anything potentially contaminated with c-diff.</p> <p>A facility policy titled "Standard Precautions," dated 7/1/11, provided by the ADON on 5/3/12 at 4:00 p.m. included, but was not limited to, "Guideline: It is the intent of the facility that Standard Precautions synthesize the major features of UP (Blood and Body Fluid Precautions-designed to reduce the risk of transmission of bloodborne pathogens) and BSI (body substance isolation-designed to reduce the risk of transmission of pathogens from moist body substances) and applies them to all patients receiving care in hospitals, regardless of their diagnosis or presumed infection status. Standard Precautions apply to 1) blood; 2) all body fluids, secretions, and excretions except</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>sweat, regardless of whether or not they contain visible blood; 3) non-intact skin; and 4) mucous membranes. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the facility. RESPONSIBILITY: All facility staff PROCEDURE: I. Standard Precautions Use Standard Precautions or the equivalent, for the care of all patients. a. Handwashing b. Gloves c. Mask, eye protection, face shield d. Gown, e. Patient Care Equipment f. Environmental Control g. Linen g. Occupational Health and Bloodborne Pathogens i. Patient Placement ...D. Gown Wear a gown (a clean, nonsterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. ...Remove a soiled gown as promptly as possible, and wash hands to avoid transfer of microorganisms to other patients or environments. E. Patient-Care Equipment Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and transfer of microorganisms to other patients and environments. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately. ...F. Environmental Control Ensure that the hospital has adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces, and ensure that these procedures are being followed. G. Linen Handle, transport, and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures and contamination of clothing, and that avoids transfer of microorganisms to other patients and environments. II. Patient Placement Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is not available, consult with infection control professionals regarding patient placement or other alternatives."</p> <p>b . On 5/7/12 at 11:20 a.m., LPN #17</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was observed to complete a blood glucose test for Resident #27 using a blood glucose meter. The LPN was observed to take a disinfected blood glucose meter into the resident's room and place the meter on the bedside table without a barrier. After completing the test, the LPN picked up the meter that had been used, remove soiled gloves, and place the meter on top of the med cart without a barrier. The LPN utilized alcohol hand gel and then disinfected the used meter with Gluco Chlor disinfectant and placed the clean meter on a clean barrier on top of the med cart. The LPN had to repeat the blood glucose test for Resident #27. The LPN used a second disinfected meter, entered the resident's room, and placed the meter on the bedside table without a barrier. The test was completed. The LPN removed her gloves and exited the room. The LPN then placed the used meter on top of the med cart without a barrier. The LPN utilized alcohol hand gel and then disinfected the used meter with Gluco Chlor and placed the meter on a clean barrier.</p> <p>Interview of the Director of Nursing on 5/9/12 at 3:45 p.m., indicated the policy and procedure did not address the use of a barrier for meters in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>residents' rooms. However, the DON indicated the staff have been trained to always place the meter on a barrier if the meter was sat down while in a resident's room and to always use a barrier when placing the meters on top of the med carts.</p> <p>The meter's manufacturer's directions, provided by the DON on 5/9/12 at 3:40 p.m., indicated the meter was appropriate for use in a clinical setting but did not include any information regarding infection control.</p> <p>c. On 5/4/12 at 12:44 p.m., Resident #1 was observed to be transferred from the chair to the bed by CNAs # 9 and #10. The resident was observed to have supra pubic catheter. CNA #9, with gloves on, was observed to handle the catheter bag and tubing. Without changing the contaminated gloves, the CNA was observed to remove the resident's pants and brief.</p> <p>On 5/7/12 during observation of Resident #1's treatments, LPN # 17, with gloves on, was observed to reposition the resident with the assistance of CNA #10. The LPN handled the resident's catheter bag and tubing. Without changing the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>contaminated gloves, the LPN repositioned the resident and the resident's covers before removing gloves and washing hands.</p> <p>Review of the facility's current policy and procedure titled "Standard Precautions" dated 7/1/11 on 5/9/12 at 3:55 p.m. indicated "...A. Handwashing: 1. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites..."</p> <p>3.1-18(b)(2) 3.1-18(l) 3.1-19(g)</p>			