

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/27/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN 46360
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F0000	<p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00106795 and IN00107956 investigated on 5/22/12.</p> <p>This visit was done in conjunction with PSR to the Recertification and State Licensure Survey completed on 6/14/12.</p> <p>This visit was done in conjunction with the PSR to the Investigation of Complaint IN00109456 completed on 6/14/12.</p> <p>This visit was done in conjunction with the Investigation of Complaint IN00112634.</p> <p>Complaint IN00106795: Not Corrected. Complaint IN00107956: Corrected.</p> <p>Survey Dates: July 25, 26, and 27, 2012</p> <p>Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700</p> <p>Survey Team: Heather Tuttle, RN. TC. 7/26-7/27/12</p>	F0000	<p>This provider wishes the Plan of Correction to be considered our credible allegation of compliance. Preparation and or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of facts alleged or conclusions set forth in statements of deficiencies. This Plan of Correction is prepared and or executed solely because it is required by the provision of State and Federal laws. This provider is requesting paper compliance.</p>	

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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	<p>Lara Richards, RN. Shannon Pietraszewski RN.</p> <p>Census Bed Type: 90 SNF/NF 90 Total</p> <p>Census Payor Type: 20 Medicare 60 Medicaid 10 Other 90 Total</p> <p>Sample: 14</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/01/12 by Suzanne Williams, RN</p>			

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F0441 SS=D	<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>Based on record review and interviews, the facility failed to follow</p>	F0441	Resident B was seen by the physician on 5/8/12 and was	08/07/2012			

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	<p>the infection control policy and procedure for a resident who was diagnosed with a case of scabies by a licensed dermatologist for 2 of 4 residents reviewed for scabies in the sample of 14. (Residents #B and #C)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 7/27/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, fever, diabetes type two, acute neuropathy, osteomyelitis, anemia, chronic kidney disorder, septic shock, and muscle weakness.</p> <p>Review of a Physical Exam completed and signed by the Licensed Dermatologist dated 5/8/12 indicated the resident was diagnosed with scabies. He was positive for mites, positive for feces, and positive for eggs.</p> <p>Further review of the Physical Exam indicated the resident was to be treated with elimite as directed for the scabies rash.</p> <p>Continued review of Resident #B's record indicated the resident had a roommate (Resident #C) at the time</p>		<p>treated on 5/9/12 and 5/17/12 with Elemite by the nursing staff. Residents bedding, linen and towels were decontaminated by housekeeping on 5/8/12, 5/9/12, 5/10/12 and 5/11/12. Housekeeping also disinfected the resident's personal belongings (bed, dressers and wheelchair) and the resident was provided with his own hooyer lift sling on 5/8/12. Resident B rash was resolved on 6/8/12. Resident B and his new roommate were retested on 7/27/12 as a follow up and both results are negative. Resident C has been discharged from the facility. No actual harm came to any resident affected by the alleged deficiency. An entire skin check on all residents at the facility was conducted on 5/11/12. Other residents with skin rashes on 5/11/12 were tested on 5/11/12 and all results were negative. Residents with current rashes on 7/27/12 were tested and all results were negative. On 8/3/12, additional residents with rashes were tested, and all results were negative. Staff was inserviced on Infection control on 5/8/12 by the SDC. Staff also inserviced on preventing the spread of infection on 7/30/12 by SDC. The SDC gave staff the option of providing prophylactic treatment of scabies on 7/30/12. Staff signed a declination form of the prophylactic treatment if they refused the treatment.</p>		

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	<p>of the confirmed case of Scabies. Resident #B still remained in the room with Resident #C during his treatment for scabies. Resident #B's linens, bed, and equipment were cleaned, but Resident #C was not treated.</p> <p>Interview with the Infection Control Nurse on 7/27/12 at 10:45 a.m., indicated when Resident #B returned from the Dermatologist with the diagnosis of scabies, the facility did an inservice to all the staff and offered them treatment as well for scabies if anyone had a rash. On 5/9 and 5/10/12 the facility did an entire skin check on all the residents at the facility. The facility found eight residents with rashes and performed skin scrapings on them to determine if they had scabies. All the skin scrapings came back negative for scabies. At that time no residents were treated for scabies or given elimite treatments except for Resident #B.</p> <p>Interview with the Director of Nursing on 7/27/12 at 10:45 a.m., indicated Resident #B had a roommate at the time. She further indicated the facility did not perform any skin scrapings for Resident #C nor did they treat the resident for scabies to prevent</p>		<p>Handwashing inservices were also completed on 5/21/12 and 7/30/12 by the SDC. The nurse practitioner completed scabies inservice for staff focusing on scabies in the long-term care setting on 8/7/12. The ED, DON, and SDC reviewed the recommendation from the Center of Disease Control for the treatment and prevention of sarcoptes scabiei (scabies) on 7/27/12. Staff completed handwashing competencies on 6/1/12. Any new staff hired after 6/1/12 has had a handwashing competency completed in orientation. The SDC initiated handwashing audits weekly on 6/4/12. The SDC will continue to monitor handwashing techniques weekly. She will observe 5 employee handwashing techniques weekly x 12 weeks on all shifts. Skin rashes were discussed in the monthly PI meeting on April 18, 2012 and June 20, 2012. Skin infections will continue to be monitored by the SDC in PI monthly. Results of the Handwashing audits will be discussed in PI monthly x 6 months or until the facility achieves at least 95% compliance threshold prior to discontinuing audits.</p>		

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	<p>reinfestation. The Director of Nursing further indicated they did not treat all the staff that provided care for Resident #B to prevent the spread of scabies. She further indicated Resident #B lived on the 500 unit, and none of those residents were treated for scabies, and only three residents on the 500 unit had their skin scraped.</p> <p>The Director of Nursing indicated the facility had notified the State Department of Health on 3/26/12 of a possible outbreak of scabies but no confirmed cases, just many residents with rashes. At that time, the spokesperson from the Department of Health in the Epidemiology department indicated if the facility had one confirmed case of Scabies, then the entire facility should be kwelled (treated with elimite) as precautionary. The Epidemiologist also referred the facility to follow the Center for Disease Control (CDC) guidelines for treatment and to prevent reinfestation.</p> <p>Review of the 11/10 Center for Disease Control and Prevention for Scabies, provided by the Infection Control Nurse, indicated "Prevention and Control: Scabies usually is passed by direct, prolonged skin to skin contact with an infested person.</p>				

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	<p>However, a person with crusted scabies can spread the infestation by brief skin to skin contact or by exposure to bedding, clothing, or even furniture that he/she has used. Scabies treatment usually is recommended for members of the same household, particularly for those who have had prolonged skin to skin contact. All household members and other potentially exposed persons should be treated at the same time as the infested person to prevent possible re-exposure and reinfestation. Persons with crusted scabies and their close contacts including household members should be treated rapidly and aggressively to avoid outbreaks. Institutional outbreaks can be difficult to control and require a rapid, aggressive, and sustained response."</p> <p>This deficiency was cited on 5/22/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint IN00107956.</p> <p>3.1-18(b)(1)</p>			

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

PRINTED: 08/10/2012
FORM APPROVED
OMB NO. 0938-0391

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