

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00201580 and IN00203344.</p> <p>Complaint IN00201580 - Substantiated. Federal/State deficiency related to the allegations are cited at F441.</p> <p>Complaint IN00203344 - Substantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: June 29 and 30, 2016</p> <p>Facility number: 000572 Provider number: 155535 AIM number: 100267710</p> <p>Census bed type: SNF/NF: 61 Total: 61</p> <p>Census payor type: Medicare: 5 Medicaid: 52 Other: 4 Total: 61</p> <p>Sample: 5</p>	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.	

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 0246 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on July 8, 2016</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents call lights were within reach for 2 of 5 residents observed. (Residents #E and #F)</p> <p>Findings include:</p> <p>1. During an observation, on 6/29/2016 at 4:53 p.m., Resident #E was lying in his/her bed. The resident's call light was</p>	F 0246	<p>F246 Requires the facility to ensure resident's call lights were within reach.</p> <p>1. Resident #E and #F call light was immediately placed in reach.</p> <p>2. All residents have the potential to be affected. All resident's call lights were immediately assessed to ensure the resident was able to reach their call light. See below for corrective measures.</p> <p>3. The call light policy and procedure was reviewed with no</p>	07/05/2016

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	<p>observed lying on the floor below the bed side table.</p> <p>During an interview, on 6/29/2016 at 4:59 p.m., Resident #E indicated he/she was unable to walk without assistance. The resident further indicated he/she has been unable to reach the call light in the last two weeks and when she yelled for help it took over 20 minutes for anyone to come into her room.</p> <p>Resident #E's care plan for immobility was reviewed on 6/30/2016 at 5:30 P.M. The care plan dated 6/22/2016 indicated the resident requires assistance to transfer from bed and was able to use the call light.</p> <p>Record review, on 6/29/2016 5:12 p.m., indicated Resident #E's diagnoses included but were not limited to neuropathy, right hip fracture with surgical repair, Diabetes Mellitus, and anxiety.</p> <p>2. During an observation, on 6/30/2016 at 5:15 p.m., Resident #F's call light was clipped to the bed on the lower edge of the lifting sheet below the resident left hand and hip. The resident was observed with left sided immobility.</p> <p>During an observation, on 6/30/2016 at</p>		<p>changes made. (See attachment A) The staff was inserviced on the above procedure.</p> <p>4. The DON or her designee will conduct 4 observations ensuring call lights are in resident's reach. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before July 5, 2016.</p>	

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	<p>5:40 p.m., Resident #F's call light was clipped to the edge of the lift sheet located at the left hip area three inches below the left immobile hand. The resident was turned to the right away from the call light. The resident's left arm was positioned behind the residents back and left hip.</p> <p>During an interview, on 6/30/2016 at 5:41 p.m., Certified Nurses Aide (CNA) #1 indicated Resident F's call light should have been clipped to his/her right side. The CNA further indicated two hours ago the resident was turned and the call light was on the right side.</p> <p>During an interview, on 6/30/2016 at 5:42 p.m., CNA #2 indicated Resident F's call light was suppose to be clipped on the right chest area of his/her clothing. The CNA further indicated she was not aware of how the call light became clipped on the left side of the bed. CNA #2 indicated the resident would have been unable to move the call light from the right side to the left side.</p> <p>During an interview, on 6/30/2016 at 5:55 p.m., Corporate Registered Nurse (CRN) #1 indicated the call light will not work for the resident on her/his left side due to the immobility of the left upper extremity. The call light needed to be</p>			

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	<p>moved to the resident's right side. The CRN #1 further indicated facility policy was for staff to ensure the resident's call light was within reach for all resident's whom required assistance with activities of daily living (ADL).</p> <p>During an interview, on 6/30/2016 at 6:45 p.m., Resident #F's family member indicated upon visiting Resident #F the call light has been located out of the resident's reach on several occurrences in April and May of this year. A few of the occurrences the call light had been clipped to the light chain located on the right head of the bed and wrapped around the right bed rail when the resident was lying on his/her back.</p> <p>Resident #F's care plans for ADL assistance, Communication and decreased vision was reviewed on 6/30/2016 at 5:40 P.M. The care plans dated 6/08/2016 indicated Resident #F had decreased vision, difficulty understanding others, and impaired mobility. The interventions included but were not limited to providing assistance with ADL's, encourage resident to participate in ADL's, and ensure assistive devices are in place and functioning properly.</p> <p>Record review, on 6/29/2016 5:12 p.m.,</p>			

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F 0441 SS=D Bldg. 00	<p>indicated Resident #F's diagnosis included but were not limited to cerebrovascular accident, dementia, anxiety, and seizure disorder.</p> <p>3.1-19(a)(3)</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 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</p>			

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	<p>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. Based on observation, interview and record review, the facility failed to maintain infections control practices in regards to glove use, handwashing, and incontinent care for 1 of 5 resident's reviewed for infection control. (Resident #F)</p> <p>Finding includes:</p> <p>1. The Clinical Record for Resident #F was reviewed on 6/29/2016 at 4:52 p.m. Diagnoses included, but were not limited to, cerebrovascular accident, dementia, anxiety, and seizure disorder.</p> <p>During incontinent care on 6/30/2016 at 5:43 p.m., the following was observed:</p> <p>CNA (Certified Nursing Assistant) #1 and CNA #2 entered Resident #F's room to provide incontinent care. CNA #1 and CNA #2 without washing their hands or using hand gel donned gloves and gathered Resident #F's brief and wipes. CNA #2 assisted Resident #F to roll to onto her back. CNA #2 pulled the front of Resident #F's brief open and wiped the</p>	F 0441	F441 Requires the facility to maintain infection control practices in regarding to glove use, handwashing and incontinent care. 1. Resident #F had incontinent care provided properly. 2. All residents have the potential to be affected. CNA #1 and CNA #2 was inserviced immediately on providing incontinent care. See below for corrective measures. 3. The perineal care and handwashing policy and procedure were reviewed with no changes made. (See attachment C and D) The staff was inserviced on the above procedure. 4. The DON or her designee will observe 2 residents receiving peri-care ensuring perineal care is being provided correctly maintaining infection control practices. The DON or her designee will also observe 2 staff members washing their hands ensuring that hand hygiene is properly being conducted maintaining infection control practices. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months,	07/05/2016

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	<p>resident from front to back with a moistened cloth, by folding the cloth over between wipes. CNA #1 assisted the resident to roll onto her right side while CNA #2 performed incontinent bowel care by wiping in between both buttocks outward. After CNA #2 cleaned the resident she placed protective cream onto her gloves and wiped the cream back and forth and in a circular motion across the residents buttocks. CNA #1 assisted the resident to roll back onto her back. CNA #2 placed more protective cream onto her glove and wiped from back to front on each side of the residents labia area. CNA #2 and CNA #1 assisted the resident to place on her pants. CNA #1 and CNA #2 removed their gloves and assisted Resident #F to sit in her wheel chair. CNA #1 and CNA #2 did not change their gloves or wash their hands during the incontinence procedure.</p> <p>During an interview on 6/30/2016 at 5:51 p.m., CNA #2 indicated proper glove use during incontinence care should of been to remove soiled gloves and replace clean gloves when placing on protective cream. CNA #2 further indicated you should never wipe from back to front when placing cream on the labia area of the resident.</p> <p>During an interview on 6/30/2016 at 5:52</p>		<p>then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment __) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 5, 2016.</p>	

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	<p>p.m., CNA #1 indicated hands should be washed or should use hand gel after removing gloves.</p> <p>During an interview, on 6/30/2016 at 5:55 p.m., Corporate Registered Nurse (CRN) #1 indicated the proper procedure for incontinence care would be to remove gloves once they became soiled and wash/gel hands before donning or after removing gloves.</p> <p>A copy of the current Handwashing/Hand Hygiene Policy and Procedure was provided by the Assistant Director of Nursing. The policy indicated, "...Situations that require hand hygiene include, but are not limited to: ...Before and after direct resident contact...before and after assisting a resident with toileting...after handling soiled or used linens, dressings, bedpans, catheters and urinals...after removing gloves...Handwashing Procedure (Duration 40-60 seconds): ...rub hands together...for at least 20 seconds...."</p> <p>The Federal tag relates to Complaint IN00201580.</p> <p>3.1-18(a) 3.1-18(l)</p>			

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to maintain accurately documented clinical records in accordance with accepted professional standards and practices for 1 of 5 residents observed for Weekly Skin assessment sheets. (Resident #C)</p> <p>Findings include:</p> <p>Record review for Resident #C on 06/29/2016 at 5:22 p.m. The diagnoses included, but were not limited to, pruritis, urinary tract infection, neuropathy, edema, and chronic obstructive pulmonary disease.</p>	F 0514	<p>F514 Requires the facility to ensure the facility to maintain accurately documented clinical records in accordance with accepted professional standards and practices.</p> <p>1.Resident #C's skin assessment documentation was completed.</p> <p>2.All residents have the potential to be affected. All resident's skin assessment documentation was reviewed ensuring accuracy. See below for corrective measures.</p> <p>3.The Skin Inspection policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure.</p>	07/05/2016

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	<p>Resident #C's Pressure Ulcer Risk Care Plan, which was initiated on 6/20/2016, indicated resident had impaired mobility, non-ambulatory, pressure ulcer, and bowel incontinence. The interventions included, but were not limited to, "head to toe skin assessment at least weekly by a licensed nurse".</p> <p>Resident #C's Alteration in Skin Care Plan, which was initiated on 7/21/2014 and revised on 6/20/2016, indicated resident had an alteration in skin. The interventions included, but were not limited to, "monitor site with weekly skin rounds".</p> <p>Review of Resident #C's "Weekly Skin Assessment" sheet dated 5/11/2016 and 5/17/2016 were blank with no assessment findings.</p> <p>During an interview on 6/30/2016 at 6:02 p.m., the Corporate Registered Nurse (CRN) #1 indicated the nursing staff were suppose to complete and sign off on the Weekly Skin Assessment sheets.</p> <p>During an interview on 6/30/2016 at 9:35 p.m., the Assistant Director of Nursing (ADON) indicated weekly skin assessments are done by the same nurse and should be initialed and dated when completed on the skin assessment sheet.</p>		<p>4. The DON or her designee will review weekly skin assessments ensuring that assessments are accurate and documented correctly. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.</p> <p>5. The above corrective measures will be completed on or before July 5, 2016.</p>	

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	The current facility policy titled, "Skin Management Program" and dated 10/2013, was provided by the ADON and reviewed at that time. The policy indicated, "...A comprehensive head to toe assessment will be completed by a licensed nurse ...at least weekly..." 3.1-50(a)(1)				