STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155532	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON NURSING AND REHABILITATION CENTER	120 E MILLER DR BLOOMINGTON, IN 47401

(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
F000000	. This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on June 03, 2013. This visit was in conjunction to the investigation of Complaint IN00132260. Survey dates: July 22, 23, 24, and 25, 2013 Facility number: 000460 Provider number: 155532 AIM number: 100290620 Survey team: Susan Worsham, RN-TC Cheryl Mabry, RN Melissa GIllis, RN Census bed type: SNF/NF: 36 Total: 36 Census payor type: Medicare: 4 Medicaid: 28 Other: 4 Total: 36	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on August 06, 2013; by Kimberly Perigo, RN.			

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F000323 SS=D	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.	F000323	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. F323 483.25(h) FREE OF ACCIDENT HAZARDS Bloomington Nursing and Rehabilitation Center does ensure the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents. I. Resident A has been discharged from facility. II. All residents were reassessed for elopement risk and those at high risk were identified. Care plans updated to reflect interventions and supervision needs for those resident at high risk. III. The	08/26/2013

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			facility's Elopement policy was reviewed and revised to include changing of door alarm codes weekly and as needed and change in posting of alarm codes. All staff will be provided with directed in-service training on the facility policy and procedures for ensuring adequate supervision for cognitively impaired residents with wandering behaviors. This training will be held on August 21 st . No employee will be permitted to work following the final session if he/she has not attended the training until that employee has received the necessary education. IV. In addition to the process noted above, Elopement drills will be conducted under the supervision of the Administrator weekly until 100% compliance for 60 days is achieved then monthly thereafter. Elopement risk assessments will be reviewed and updated no less frequently than quarterly and with any significant change in condition according to the RAI schedule. These assessments will be reviewed by the IDT and care plans will be maintained to address risk factors and individualized interventions. The Maintenance Director will maintain a log indicating date/time of door code changes. These logs will be reviewed weekly by the Administrator until 100% compliance is achieved for 60 days and monthly thereafter.	

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	Based on observation, record review, and interview, the facility failed to ensure adequate supervision for a cognitively impaired resident, for 1 of 1 residents reviewed for wandering behaviors. (Resident # A) Findings Include: Resident #A's clinical records were reviewed on 7/22/13 at 10:10 a.m. Resident#A's diagnosis included, but were not limited to Traumatic Brain Injury. The current Minimum Data Set Assessment dated 07/08/13, indicated Resident #A was ambulatory with rollinator (rolling walker), alert, and oriented. A Brief Interview of Mental Status (BIMS) score measured 8, which indicated Resident #A required cues and supervision of daily decision making. Physician order dated July 2013, lacked documentation to indicate Resident #A could be outside without staff's supervision.		Results of all audits will be presented in Quality Assurance Meeting monthly.	

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	Elopement Risk Assessment dated 07/07/13, lacked documentation to indicate resident left facility on 7/7/13 without letting anyone know to go to the gas station. A facility incident report dated July 07, 2013, indicated "Resident found by Dietary Manager (DM) walking down the road [was walking from a gas station and returning to the facility] with RES #A walker, and was brought back to facility by car." Review of social service notes dated July 07, 2013; indicated Resident #A left the building without notifying staff or being sent out by an appropriate person. On 7/24/13, interview with Social Service Director (SSD), indicated it was not known how resident got out, just that Resident #A was not let out by a staff member. On 7/24/13 at 11:20 a.m., Resident #A was observed coming in the front door, with his rolling walker and no staff around. When Resident #A was asked how he got out the door. He indicated he knew the code. On 7/24/13 at 11:35 a.m., interview with LPN #1 indicated no resident was to be outside without supervision.			

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	LPN #1 indicated Resident #A had a mind of his own and "wanted to do what he wanted to." Interview with ADM and DON on 7/24/13,at 11:50 a.m., indicated after being asked if either knew how Resident #A gets out of the building, the ADM stated that Resident #A probably figured out the code. The ADM was then asked how often was the code changed, and the ADM indicated the code was changed every month and when needed. When asked if the code was changed after Resident #A eloped on July 07, 2013, he indicated yes, and thought Resident #A had left around 6/28/13. The DON in the room, indicated it was 7/7/13. On 7/25/13 at 1:30 p.m., Res #A was observed coming out the front door and sitting on porch, with no staff member present. Overheard the Minimum Data Set (MDS) person indicate she changed the codes. She was then was asked at what time. She indicated that it was in the past 5-10 minutes. Interview with Resident #A's guardian (mother) indicated she had concerns about him being other places outside, "other than on smoking breaks"			

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	unsupervised due to his diagnosis of TBI (Traumatic Brain Injury). Review of MD orders on 7/24/13 at 1:50 p.m., indicated there was no order for resident to be outside without supervision. At 2:55 p.m. on 7/24/13, a return phone call from Resident #A's Medical Doctor, indicated he had a concern about Resident #A being outside of the building, without supervision due to his TBI. Interviews with Resident #A on 7/22/13 at 10:30 a.m., 7/23/13 at 10:30 a.m., and 7/24/13 at 11:20 a.m., Res #A indicated all three times he knew the code to get out. This Federal tag relates to Complaint IN00132260. 3.1-45(a)(2)			

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F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview, and record review, the facility failed to maintain proper temperature in the freezer. This had the potential to affect 41 of 41 residents served from the kitchen. Findings include: During observation on 7/24/13 at 12:20 p.m., ice cream and orange juice in the freezer were observed to be thawing out. The thermometer read 20 degrees Fahrenheit. Interview with the Dietary Manager (DM) indicated, "Not hard like it should be, I noticed when the door opened in freezer that it doesn't take long for it to start defrosting." Retail Food Establishment Sanitation Requirements, on site at the facility, indicated; "Time and temperature control of frozen food. Stored frozen foods shall be maintained frozen and should be stored at zero (0) degrees Fahrenheit."	F000371	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY Bloomington Nursing & Rehabilitation Center does (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. I. Food items in freezer were discarded. Freezer	08/26/2013

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	This deficiency was cited on June 03, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-21(i)(2)		was inspected by Maintenance Director and is fully operational. Freezer temperatures are monitored and have been at or below 0 degrees Fahrenheit. II. All residents have the potential to be affected. III. The facility's policy and procedure for maintaining proper temperatures for frozen food was reviewed by QA and found to be appropriate. Freezer temperatures will be logged twice times daily to assure proper maintenance of temperatures. All dietary employees will be provided with directed in-service training on facility policy and procedures for maintaining proper temperatures for frozen food. This training will be held on August 21 st . No employee will be permitted to work following the final session if he/she has not attended the training until that employee has received the necessary education. IV. In addition to the process noted above, the Dietary Manager will review freezer temperature logs daily to assure maintenance of temperatures at or below 0 degrees Fahrenheit. Results will be presented in Quality Assurance Meeting monthly.	

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F000441	By submitting the enclosed	08/26/2013

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			material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS Bloomington Nursing & Rehabilitation Center has established and does 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. I. LPN #1 and LPN #2 were reeducated on effective handwashing. Residents #58, #6, #32 and #3 were assessed and are free of s/s infection. II. All residents who are dependent upon nurses to administer medications were identified through review of physician's orders and have the potential to be affected. No	

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			resident was identified as having an infectious process related to improper handwashing during medication administration. I. The facility's policy and procedure for handwashing was reviewed by QA and found to be appropriate. All employees will be provided with directed in-service training on facility policy and procedures for hand washing including but not limited to when passing medication. This training will be held on August 21 st . No employee will be permitted to work following the final session if he/she has not attended the training until that employee has received the necessary education. III. In addition to the process noted above, the DON or designee will audit handwashing during medication pass daily for two weeks, then weekly until 100% compliance is achieved for 60 days and monthly thereafter. Results will be presented in Quality Assurance Meeting monthly.	
	Based on observation, interview, and record review, the facility failed to ensure staff washed their hands between residents as indicated by the facility policy and procedure when passing medication for 4 of 4			

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	residents observed. (Resident #3, #32, #58, and #61) (LPN #1, and #2) Finding include: 1. During observation on 7/25/13 at 8:50 a.m., LPN #1 (Licensed Practical Nurse) was observed to pass medication to Resident #32. After having passed the medication LPN#1 washed her hands for 5 seconds before leaving the room. LPN #1 then entered Resident #58's room without washing her hands before or after the administration of medication. LPN #1 was then observed using hand sanitizer and then wiped hands on her scrub (top) before entering Resident #6's room. LPN #1 was then observed handwashing for 8 seconds before exiting Resident #6's room. LPN #1 indicated when asked how long should you handwash, "2-3 minutes." When asked how should hand sanitizer be used, LPN #1 indicated, "It should dry first." She also indicated that she didn't not realized she wiped her hands on her scrub (top) after applying the hand sanitizer. 2. During a second observation on			

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	7/25/13 at 9:10 a.m., LPN #2 was observed handwashing for 5 seconds before and after administering insulin to Resident #3. LPN #2 indicated when asked how long should you handwash, replied, "20 seconds." Review of the facility's undated policy, provided during the June 03, 2013 survey, titled "Handwashing" indicated staff are wash hands between residents for 20 seconds. This deficiency was cited on June 04, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(l)			