STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	08/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 15, 16, 17, 18, 19 and 22, 2016 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 3 Medicaid: 31 Other: 14 Total: 48 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on August 28, 2016.	F 0000		
F 0323 SS=G Bldg. 00	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			

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

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	receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance during transfers in that a resident who required maximum assist of two for transfers sustained a fracture of the ankle while being transferred by an insufficient number of staff. The staff also failed to immediately notify the nurse when the resident got her foot caught during the transfer. This deficient practice affected 1 of 3 residents reviewed for accidents. (Resident #42) Findings include: Clinical record review for Resident #42 on 8/22/16 at 11:35 a.m., indicated the resident had diagnoses which included, but were not limited to: osteopenia, type 2 diabetes, generalized muscle weakness, abnormal posture, and lack of coordination. The most recent quarterly MDS (Minimum Data Set) assessment, dated 7/8/16, indicated Resident #42 had a BIMS (brief interview of mental status) of 13 which indicated the resident was alert and oriented. The resident required extensive assistance of two physical staff members for transfers.	F 0323	Resident #42 is now NWB to right leg and is transferred with assist of 2 and Hoyer lift Her right leg is wrapped and then elevated with pillow props Assignment sheet has been updated on #42 to reflect current transfer status Staff has been in serviced on transferring residents and reporting incidents of injury or complaints to Nurses This in-service was done on 9/2/16 For any employees not at in-services will be individual in serviced by 9/21/16 If not in-service by 9/21/16 will be removed from schedule till receives in-service The Nurse's Aide involved with this tag no longer is employed by facility All CNA assignment sheets will be reviewed and updated to reflect proper transfer status on all residents All Nursing Staff will be in-service on proper transfers of residents and reporting injuries immediately to Charge Nurse Staff advised to get help when ever not comfortable with a residents transfer status and notify therapy for a screen Staff will be monitored for correct transfers 4 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks and then monthly thereafter Will monitor and discuss results in QA meetings quarterly Documents attached	09/21/2016

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Review of Resident #42's Care Plan for ADLS (Activities of Daily Living) and Risk for Falls, date of 7/26/16, indicated "Resident requires extensive assist to total assist with ADLS..." and "...Transfer with max [maximum] assist of 2 or more, use total body life."

Review of the incident report, dated 8/13/16, indicated the following: On 8/12/16 at 2:01 p.m., Resident #42 was being transferred back to bed by one CNA (Certified Nursing Assistant) when the CNA heard the resident complain of her shoe getting caught on the carpet. Initially when the resident got her foot unstuck, she did not complain of pain but later on after dinner the resident complained of pain and it was reported to the nurse. The resident was monitored by the nursing staff and the ankle was noted to be swollen, bruised, and tender to touch. As her condition got worse, an order was obtained during the night for a "STAT X-ray" of the right ankle. The x-ray reports showed a fracture involving the distal fibula with minimal displacement being noted.

Review of the facility follow investigation, dated 8/15/16, indicated CNA involved in injury was found to have violated policy and procedure with

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	transferring and reporting injuries of a resident. During interviews on 8/22/16 at 11:45 a.m., CNA #2 and CNA #6 both indicated they would report any injury immediately to the resident's nurse and stay with the resident. During an interview on 8/22/16 at 12:00 p.m., the DON (Director of Nursing) indicated during rounds at 6:30 p.m. with the night shift CNA #5 came to the desk and said "By the way, she [Resident #42] got her foot caught earlier in the day. The CNA told us it happened at 2:00 p.m. earlier in the day, but did not explain why she waited to report it". The DON indicated Resident #42 did require extensive assistance of two physical staff and it was documented on the CNA work sheet. The resident can stand and slowly turn to ambulate but two staff must be present. On 8//22/16 at 12:10 p.m., the Director of Nursing presented a copy of the facility's current policy and procedure titled "Incident Reports". Review of this policy at this time included, but were not limited to: "...The report is to be filled out as soon after the incident as possible by the person who actually witnessed the incident or was most directly			

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	involved...All accidents, however minor, must be immediately reported to your supervisor...Lifting Policy: All employees who are transferring or lifting resident, or any heavy object, must seek assistance from another staff member...Safety Rule: Nurses and Nursing Assistants:...1. If you are unsure whether you can support a particular patient, do not attempt to lift the patient. Get assistance..." 3.1-45(a)(2)			
F 0371 SS=E Bldg. 00	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 and interview, the facility failed to store, prepare and serve food under sanitary conditions in that ceiling and ceiling vents had moderate build up of black greasy dust; floors around baseboards and under storage shelves in the kitchen and dry food storage room had a moderate build up of black debris; food equipment was soiled around and on top with food crumbs; and cabinets had spills inside from the juice and coffee machines during 3 of 3	F 0371	A1 The deficient practice of the ceiling and the vent above the clean side of the dish machine of black greasy dust will be corrected by the maintenance department The maintenance department will have cleaning completed by 9/21/2016 The maintenance supervisor or his designee will check and/or clean the ceiling and vents in the kitchen on a monthly basis by utilizing the attached QA form This will be an ongoing process A2 The deficient practice of the	09/21/2016

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	kitchen observations. This deficient practice affected 48 of 48 residents receiving meals from the kitchen. Findings include: A. During the initial tour on 8/15/16 between 9:25 a.m. and 9:50 a.m., the following was observed while accompanied by the Dietary Manager: 1. The ceiling and vent above the clean side of the dish machine had a build up of black greasy dust 12 inches in circumference 3/4 way around the vent/ceiling. 2. Heavy black dirt was built up 6 to 8 inches around entire kitchen baseboards and 18 inches under the pot/pan storage shelving and dry storage shelves. The floor had a moderate build up of the black dirt. 3. The Light bulb in the walk in freezer was burned out. 4. The cabinet below the coffee maker/juice machine had spills inside the shelving trays of glasses were in the cabinet sitting just behind the spills. 5. The fryer next to the convection oven had breading crumbs in the oil, sides of		black dirt built up around the entire kitchen baseboards and under the pot/pan storage shelving and dry storage shelving was corrected on 8/19/2016 by dietary staff The dietary manager or her designee will monitor the Dietary Aides to make sure cleaning is done on a daily basis The attached checklist will be the tool used to make sure this action is completed on a daily basis This will be an ongoing process A3 The deficient practice of the light bulb being out in the freezer was corrected on 8/28/16 The administrator contacted a company in Louisville, Kentucky named InterTech One of their service techs came out and looked the freezer over On 8/28/16 the service tech came in and fixed the light Maintenance will check the light monthly by utilizing the attached QA form This will be an ongoing process A4 The deficient practice of the coffee maker/juice machine spilling inside the shelving trays below them was corrected on 8/15/16 The dietary manager or her designee will monitor that this corrective action will be done on a daily basis by having the evening dietary aide clean thoroughly the coffee maker/juice machine area The attached checklist will be the tool used to make sure this action is completed on a daily basis This will be an ongoing process A5 The deficient practice of the area around the fryer not being	

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	the basket, and around the top of the machine. Cook #1 indicated the oil was too hot for staff to clean last night and the fryer was supposed to be cleaned today. B. During a kitchen observation on 8/15/16 between 11:10 a.m. and 12:35 p.m., the areas previously identified at 9:25 a.m. were observed along with new areas of concern: 1. The fryer had been cleaned out but crumbs remained along the side of the convection oven next to the fryer. 2. The top of the convection oven was heavily soiled with dried food debris. 3. The back splash to stove/flat top had a heavy build up of grease. C. During a kitchen observation on 8/22/16 between 10:20 a.m. and 11:00 a.m., the following was observed; the kitchen floor and dry storage area had black debris in the grooves. During an interview on 8/22/16 at 11:00 a.m., the Dietary Manager indicated the floors were mopped several times a day and staff were able to get some of the dirt up but not all. She further indicated the black rubber floor mats that were used to prevent the person doing dishes from		cleaned was partly corrected on 8/15/16 and the other part concerning the crumbs along the side of the convection oven was cleaned on 8/17/16 The dietary manager or her designee will monitor that the fryer will be cleaned each day that it is used and the side of the convection oven will be cleaned on a daily basis The attached checklist will be the tool used to make sure this action is completed This will be an ongoing process B1 The deficient practice of the side of the convection oven not being cleaned was corrected on 8/17/16 The dietary manager or her designee will monitor that the side of the convection oven is cleaned on a daily basis The attached checklist will be the tool used to make sure this action is completed on a daily basis This will be an ongoing process B2 The deficient practice of the top of the convection oven not being cleaned was corrected on 8/17/16 The dietary manager or her designee will monitor that the top of the convection oven is cleaned on a daily basis The attached checklist will be the tool used to make sure this action is completed on a daily basis This will be an ongoing process B3 The deficient practice of the back splash of the stove having a heavy build of grease was corrected on 8/17/16 The dietary manager or her designee will monitor that the backsplash of the	

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	slipping on the wet floor, tended to put black dirt onto the floor when walked across. 3.1-21(i)(2) 3.1-21(i)(3)		stove is cleaned on a daily basis The attached checklist will be the tool used to make sure this action is completed on a daily basis This will be an ongoing process C The deficient practice of having black debris in the grooves was corrected on 8/19/16 The dietary manager or her designee will monitor that the floor in the kitchen is cleaned on a daily basis The attached checklist will be the tool used to make sure this action is completed on a daily basis This will be an ongoing process In addition to the daily cleaning of kitchen floor a weekly deep cleaning will be completed as well with any equipment that can be moved, moved for cleaning underneath This will be completed by the dietary staff with the dietary manager or designee monitoring for completion by use of the attached QA This will be an ongoing process	
F 0441 SS=E Bldg. 00	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;			

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	(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. Based on observation, interview and record review, the facility failed to perform proper hand hygiene during 2 of 2 wound treatments, and 3 of 3 incontinence care observations. (Resident's # 29, # 45, # 5, and # 32). Findings include: 1. On 08/17/16 at 9:22 a.m., Resident # 29 was observed for incontinence care by CNA #1 and CNA #2. CNA #1 performed handwashing by rubbing hands for 22 seconds, with a total	F 0441	Nursing Staff in-service on Hand washing and the new WHO guidelines have been reviewed and implemented into policy. Nursing will be monitored and educated with treatment and incontinent care for proper hand washing techniques before and after care. In-service refresher given on incontinent care and proper technique. Nursing staff will be monitored by management staff with attached updated QA form Monitoring will be done 4 times a week for 4 weeks, then 3 times a	09/21/2016

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	handwashing time of 35 seconds. CNA #2 applied gloves and sprayed cleansing body lotion onto wet wipes and handed them to CNA #1. CNA #1 cleaned under the fold of the abdomen using the wipes first with the assistance of CNA #2. Then CNA #1 wiped the crease to the right of the labia, the left crease, then the labial area. The CNA #1 cleaned with individual wipes for each swipe. CNA #2 removed her gloves and performed handwashing per CDC guidelines, and applied gloves. CNA #2 obtained dry wipes and dried the labial area. The resident was rolled onto the left side and wet wipes with no spray were used to clean the rectal area with a front to back motion. A clean brief was placed under the resident. The resident was rolled back onto the brief and it was fastened. CNA #1 removed her gloves and performed handwashing per CDC guidelines. CNA #1 left the room and LPN #1 entered the room and asked CNA #2 if the abdomen had been dried. LPN #1 applied Nystatin to the folds of the abdomen without handwashing. LPN #1, performed handwashing per CDC guidelines. CNA #2 removed her gloves and performed handwashing per CDC guidelines. 2. On 08/17/16 at 11:04 a.m., LPN #1 provided skin tear treatment to Resident		week for 4 weeks, weekly for 3 months Monitoring will then be done monthly afterward and as needed Monitoring and discussion will be discussed in quarterly QA meeting with end date decided in QA Copies Attached	

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	#45. LPN #1 entered the room and laid the supplies on the bedside table. No handwashing was observed. She removed the resident's jacket and peeled off the bandage without applying gloves. LPN #1 cut a strip of tape and opened the gauze, kerlix, zeroform, two saline syringes packaging and obtained dry wipes. She applied gloves and cleaned the skin tear with normal saline from a syringe. A dry gauze was held under the resident's arm to catch the saline run off. The moistened wipe was used to pat the skin tear, folding the wipe with each pat. LPN #1 obtained a dry wipe and patted dry the skin tear. She applied the zeroform and placed a gauze over it. LPN #1 then wrapped the narrow kerlex around the gauze and arm and trimmed the end. She applied tape at the end to hold it in place. LPN #1 removed her gloves, dated and initialed the tape. She then placed protective sleeves on the resident's arms. The skin tear was observed on the right forearm and was in the shape of a c (size of a fingernail). The wound was closed and had no redness. LPN #1 gathered the packaging and placed it into the trash bag. The LPN then performed handwashing per CDC guidelines. 3. On 08/18/16 at 9:38 a.m., Resident #5 received incontinence care by CNA #3.			

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	CNA #3 entered Resident #5's room and performed handwashing, rubbing her hands together for 10 seconds with a total handwashing time of 15 seconds. The resident entered the bathroom and the CNA pulled down the resident's briefs and pants then assisted the resident to sit down on the toilet. The CNA applied gloves and removed the resident's brief from around the resident's ankles. The CNA obtained a wipe and moistened it under the faucet and applied spray body lotion. Using one area of the wipe, the CNA cleaned the tip of the penis with a 4 circular motions, using one area of the wipe. CNA #5 asked the resident to stand and obtained another wipe and applied the cleansing spray. The CNA cleaned the resident's rectal area with one area of the wipe, swiping front to back twice. CNA #5 removed her gloves and walked the resident to the bed. She then applied clean gloves, gathered the trash bag from the trash can, removed her gloves, and performed handwashing per CDC guidelines. 4. On 08/18/16 at 9:35 a.m., Resident #32 was observed receiving incontinence care by CNA #3 and CNA #4. CNA #3 entered the bathroom and performed handwashing, rubbing her hands together for 22 seconds, with a total handwashing time of 30 seconds. CNA #4 entered the			

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	bathroom and performed handwashing per CDC guidelines. CNA #4 & CNA #3 applied gloves and assisted Resident #32 from the recliner to the wheelchair. The resident was wheeled into the bathroom and assisted onto toilet. The brief was removed and placed into the trash bag. The resident laid the colostomy bag down toward the toilet. CNA #4 indicated the adhesive around the stoma had opened and needed to be replaced. She removed her gloves and performed handwashing per CDC guidelines. CNA #3 emptied the colostomy bag into the measuring canister. She then removed her gloves and performed handwashing per CDC guidelines. She applied gloves and poured water into the colostomy bag and let it drain out into the canister. CNA #4 returned to the bathroom after notifying the nurse of the opened colostomy and performed handwashing per CDC guidelines. The LPN #2 entered the room and applied gloves. LPN #2 indicated she washed her hands outside of the room. She then removed the soiled colostomy ring from around the stoma, asked CNA #4 to moisten the wipes, and applied the spray cleanser and cleaned the stool from the around the stoma. CNA #4 removed her gloves and left the room. The LPN removed her gloves and applied clean gloves. She dried the abdomen and used an adhesive remover on the area			

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	around the stoma. LPN #2 removed her glove, applied clean gloves, and opened the colostomy ring's package. The LPN then attached the bag to the adhesive ring and applied the ring with bag to the abdomen around the stoma. LPN #2 removed her gloves and applied clean gloves. She obtained wet wipes and proceeded to clean the labial area. The LPN #2 wiped the crease to the right of the labia, then the left crease and then the labia folding the wipe between swipes. The LPN dried the resident with the same procedure and the LPN applied powder to creases on both sides of the labia. The resident's shirt was changed and she was assisted off of the toilet. CNA #3 applied clean gloves, moistened a stack of wipes, and washed the rectal area, and swiped twice with the same area of one wipe, then twice with another wipe on the rectal area. The resident's brief and pants were put in place and the resident was wheeled out of the bathroom. CNA #3 removed her gloves and performed handwashing per CDC guidelines. The LPN performed handwashing, rubbing her hands together for 13 seconds, with a total handwashing time of 30 seconds. During an interview on 08/18/16 at 9:45 a.m., CNA #3 indicated for handwashing she would turn on the water, rinse her hands, and rub her hands together for 20			

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	155766	A. BUILDING 00 B. WING	08/22/2016

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	seconds. The CNA further indicated she would make sure to get between the fingers and the nails, then rinse her hands, and get a paper towel to dry her hands. CNA #3 indicated she would not use the same towel to dry both hands. CNA #3 indicated when performing perineal care on a male, she would pull back the foreskin and wash the tip, then wash between the penis and scrotum, and then wash the buttocks from front to back. CNA #3 indicated when the wipes were moistened with no rinse cleansing cream, the resident was not dried since the cream helps prevent dryness. During an interview with the DON on 08/22/16 at 11:48 a.m., she indicated the proper time for handwashing was 20-25 seconds, from time the water was turned on and the actual hand washing. The facility policy indicated 20-25 seconds for the total procedure. Staff should hand wash before patient care, after patient care, and when hands are soiled. The DON indicated for incontinence care on males staff should clean the penis in a circular motion using separate wipes with each swipe. The DON indicated for females the staff should clean the labia area first then the creases to each side. On 08/17/16 at 8:10 a.m., the DON provided a copy of the current			

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	Handwashing Policy and Procedure, which included but were not limited to, "...It is the policy of this facility to provide the best infection control possible through thorough handwashing. The chance of spreading infection is reduced when hands are washed: 1. Before and after contact with each resident, even if gloves are worn....Procedure:....3. Vigorously rub hands together, between fingers, under nails and two inches above wrist for one full minute..." and "Incontinent Care...to provide incontinent care in a manner that will prevent irritation, infection, odor, and skin breakdown...Separate Labia. Wash Urethral Area First...Wash Between And Outside Labia In Downward Strokes, Alternating From Side To Side And Washing Outward To Thighs. Use Different Part Of Washcloth Or Disposable Wipe For Each Stroke...Pull Back Foreskin If Male Is Uncircumcised. Wash And Rinse The Tip Of Penis Using Circular Motion Beginning At Urethra...continue Washing Down The Penis To The Scrotum and Inner Thighs...Gently Pat Area Dry In Same Direction As When Washing..." 3.1-18(l)			