STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey This visit included a State Residential Licensure Survey. Survey dates: January 11, 12, 13, 14, and 15, 2016 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census bed type: SNF/NF: 58 Residential: 5 Total: 63 Census payor type: Medicare: 7 Medicaid: 47 Other: 4 Total: 58 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 34849 on January 22, 2016.	F 0000		

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

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F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to develop a care plan related to a non-pressure skin impairment for 1 of 14 residents reviewed for care plans. (Resident #57) Findings include:	F 0279	F279 Requires the facility to develop a care plan added to addressing her non-pressure skin impairment. 1. Resident #57 had a care plan implemented addressing her non-pressure skin impairment. 2. All residents have the potential to be affected. A skin assessment was completed on all residents. If a skin impairment was noted, a care plan was implemented. No	02/02/2016

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	During an observation on 01/13/2016 at 9:25 A.M., Resident #57's right hand had two quarter size dark blue areas and one dime size dark blue area. The resident's left hand had a blue area, 1 inch by 1/2 inch in size. During an interview on 01/13/2016 at 9:27 A.M., Resident #57 indicated she had the bruises on her right hand for over a week and bruises on her left hand for days. The resident indicated she bumps her left hand when using the toilet and her right hand on the bed side table. During an interview on 01/13/2016 at 9:29 A.M., LPN (Licensed Practical Nurse) #9 indicated the resident currently was only on an 81 mg aspirin and not on any other type of blood thinner. LPN #9 indicated Resident #57 had easily bruised since entering the facility. During an interview on 01/13/2016 at 2:19 P.M., Resident #57 indicated she just looks down and finds bruises from just bumping things and the nurses have given her lotion to rub on them in the past. During an interview on 01/13/2016 at 2:30 P.M., LPN #9 indicated there was currently no non-pressure skin assessment documents for Resident #57.		further concerns were noted. See below for corrective measures. 3. The care plan policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. A weekly skin assessment will be completed on all residents. If a skin impairment is noted, a skin sheet will be completed and a care plan initiated addressing the area of concern. If a nurse/aide notes a skin issue prior to the weekly assessment, a skin sheet is to be completed and care plan initiated addressing the area of concern. The DON or her designee will review skin sheets daily to ensure that non-pressure skin impairments are addressed with a care plan. 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 if warranted. 5. The above corrective measures will be completed on or before February 2, 2016.	

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	The resident has had bruises on her legs and hands. LPN #9 further indicated today was the first time she noticed the bruising on the resident's hands. LPN #9 indicated the last bruises she was aware of on Resident #57 were located on her legs. During an interview on 01/14/2016 at 2:24 P.M., Corporate Nurse #11 indicated when a bruise was discovered on a resident, the bruise was to be measured and documented on a skin assessment sheet. The size and condition of the bruise was to be updated weekly. Corporate Nurse #11 further indicated there should have been a skin assessment sheet completed and an at risk care plan for Resident #57. During an interview on 01/14/2016 at 2:30 P.M., RN (Registered Nurse) #10, indicated when a bruise was discovered on a resident an incident report was to be completed. RN #10 further indicated staff was to investigate and interview the resident to determine the root cause of the injury. All assessments were to be documented in the nurse's notes and on skin assessment sheets. The most recent admission MDS (Minimum Data Set) assessment, dated 11/04/2015, indicated Resident #57 had a			

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	BIMS (Brief Interview of Mental Status) of 15, which indicated the resident was alert and oriented. The MDS also indicated Resident #57 was independent with mobility. The clinical record for Resident #57 was reviewed on 01/13/2016 at 9:25 A.M. The diagnoses included, but were not limited to, Diabetes Mellitus Type 2, Atrial Fibrillation, Pulmonary Hypertension, and Diastolic Heart Failure. Resident #57's medications included but were not limited to Aspirin 81 mg daily. The clinical record lacked a care plan for a non- pressure skin impairment for Resident #57. 3.1-35(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the written plan of care related to safety precautions for 1 of 14 residents reviewed for care plans. (Resident #19)	F 0282	F282 Requires the facility to follow the written plan of care. 1. Resident #19 care plan was reviewed and no changes made. 2. All residents have the potential to be affected. Care	02/02/2016

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	Findings include: During several observations from 01/11/2016 to 01/14/2016, Resident #19 had a bandage wrapped around the middle finger of her right hand. During an interview on 01/13/2016 at 1:57 P.M., Resident #19 indicated she told CNA (Certified Nurse Aide) #16 she wanted a soda, the CNA brought a can of soda into her room, and Resident #19 intentionally cut her finger on the can. The resident indicated, "I did it on purpose." During an interview on 01/14/2016 at 9:04 A.M., Corporate Nurse #11 indicated they had brought in a PRN (as needed) CNA to pick up a shift. Resident #19 was not present the last time CNA #16 worked and the CNA had not been aware that the resident was not supposed to have soda cans. During an interview on 01/14/2016 at 9:58 A.M., CNA #17 indicated Resident #19 had several safety precautions such as only being allowed spoons with meals and not leaving sharp items, like cans, near her. The CNA further indicated that these precautions had been in place for a long time.		plans were reviewed to ensure ways to manage said risk factors are present and communicated to staff. No further concerns were noted. See below for corrective measures. 3. The care plan policy and procedure was reviewed with no changes made. (See attachment A) Staff was also inserviced on reviewing care plans on ways to manage said risk behaviors. The staff was inserviced on the above procedure. 4. The DON or her designee will conduct rounds to ensure staff is managing said risk behaviors according to the plan of care. The DON or her designee will also review care plans to ensure ways to manage said risk behaviors are clearly addressed on the care plan. 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 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 if warranted. 5. The above corrective measures will be completed on or before February 2, 2016.	

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During an interview on 01/13/2016 at 3:12 P.M., CNA #18 indicated CNA's receive "pocket papers" every day which had information about resident needs in case the leaving staff forgot to include certain information during hand-off and that when changes are made the information on those papers will reflect those changes. The CNA further indicated the information that stated Resident #19 could not have cans had been on the assignment sheets for as long as she had been there, which was five months.

During an interview on 01/14/2016 at 1:50 P.M., CNA #16 indicated Resident #19 had asked for a coke and she had brought her one to her room. The CNA indicated she had poured most of the coke into a cup for the resident, but that she had also left the can on the bedside table. CNA #16 also indicated she worked PRN, hadn't worked in the facility in a while, and didn't know Resident #19 couldn't have cans. The CNA responded to the resident's call light and the resident told the CNA she had cut her finger on the can.

Record review was conducted for Resident #19 on 01/13/2016 at 10:35 A.M. Resident #19's care plan for a

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	history of self injury indicated the resident had no safety awareness and acts impulsively. The interventions included, but were not limited to, no plastic utensils, metal spoon for meals, do not sit resident next to wall and ensure no unsafe items in room such as pens, soda cans, and scissors. Resident #19's care plan for a non-pressure related skin condition indicated the resident had lacerations to the right middle finger. The interventions included, but were not limited to, treatment as ordered, monitor for signs and symptoms of infections, and pressure dressing per order. The nurse's note, dated 01/11/2016 at 11:50 P.M., indicated the resident asked the CNA for a soda, which the CNA took to the resident and left on the bedside table. The resident used the soda can to cut three different areas on the right middle finger. A pressure dressing was applied to help stop the bleeding and the resident would be monitored. The Incident and Accident Report and Investigation form indicated CNA #16 was unaware of Resident #19 not being allowed to have soda cans due to prior self injury. The CNA left the soda can in the resident's room and the resident cut			

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	three different areas on her right middle finger. The Wing 4 CNA Assignment Sheet was provided by Corporate Nurse #11 on 01/13/2016 at 3:04 P.M. and was reviewed at that time. The Assignment sheet indicated Resident #19 is not to have cans. The Behavioral Healthcare Management consult sheets were provided by the Administrator on 01/14/2016 at 11:21 A.M. and were reviewed at that time. The behavioral consult sheet, dated 01/12/2016, indicated Resident #19 had chronic self mutilating behaviors and the resident indicated she cut her finger intentionally because she wanted attention. The behavioral consult sheet, dated 12/08/2016, indicated Resident #19 had ongoing issues with self mutilating behaviors. The current facility policy titled, "Care Plan Development and Review" and dated 10/2014, was provided by the Administrator on 01/14/2016 at 8:48 A.M. and was reviewed at that time. The policy indicated, "...The comprehensive care plan is designed to...incorporate risk factors associated with identified problems and ways to manage said risk factors..." and "...Care plans are a part of			

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	the clinical record and should be accessible to all personnel..." 3.1-35(g)(2)			
F 0323 SS=E 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 receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to maintain a safe and hazard free environment for the residents related to unsafe water temperatures for 2 of 7 resident sinks tested (Sinks in room 15 and in adjoining rooms 25/27), improperly disposed of sharps and unsecured chemicals for 1 of 3 shower rooms observed (Wing 3), exposed batteries in equipment for 1 of 5 medication carts observed (Wing 3, Medication cart #1), unlocked supply rooms for 2 of 2 supply rooms on Wing 3, unsecured personal care items for 1 of 3 shower rooms observed (Wing 4), and unsecured sharps containers for 2 of 3 medication/treatment carts on Wing 3. Findings include:	F 0323	F323 Requires the facility to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Water temps were tested and immediately turned down until the water tested at correct range. Unsecured sharps containers and hazardous chemicals were removed from areas immediately. Wing 3 medication cart was repaired to ensure no batteries were exposed. Supply rooms had automatic locks placed on the doors. Chemical in shower room was removed. Razors disposed of properly 2. All residents have the potential to be affected. A complete round of the facility was conducted ensuring all sharps containers were properly secured, hazardous	02/02/2016

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	1. During an observation with the Housekeeping Supervisor on 01/11/2016 at 3:55 P.M., the water in the bathroom sink of connecting rooms 25 and 27 had a temperature of 122 degrees Fahrenheit. During an interview on 01/11/2016 at 4:10 P.M., LPN (Licensed Practical Nurse) #14 indicated no burns from hot water had been reported on the unit. During an observation and interview with the Maintenance Supervisor on 01/11/2016 at 4:31 P. M., the water in the bathroom sink connecting rooms 27 and 25 had a temperature of 128 degrees Fahrenheit and the sink in room 15 had a temperature of 125 degrees Fahrenheit. He indicated he had replaced a mixing regulator a month ago. He further indicated he had turned up the water temperature prior to replacing the regulator due to low water temperatures and failed to turn it back down after the regulator was replaced. During an observation and interview with Corporate Nurse #11 on 01/11/2016 at 4:35 P.M., she placed her hand under the running water in room 15 and indicated it was too hot and could not keep her hand in the running water.		chemical are stored correctly, razors disposed of properly, water temps are within the correct range and medication carts do not have batteries exposed. No further concerns were noted. See below for corrective measures. 3. The water policy and procedure was reviewed with no changes made. (See attachment C) The maintenance supervisor was inserviced regarding this policy and procedure. The Storage and Security of Items Potentially Hazardous to Residents policy and procedure was reviewed. (Attachment D) The Sharps Disposal policy was reviewed with no changes made. (See attachment D2). The staff was inserviced on the above procedure. 4. The DON or her designee will conduct rounds to ensure that sharps containers are properly secured, razors are disposed of properly, shower rooms are free of hazardous chemicals, batteries on medication carts are covered, doors properly locked with hazardous supplies, hazardous chemicals/supplies are properly placed and locked. 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 to ensure residents remain free of safety hazards as possible. (See attachment B) The maintenance	

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	The "Weekly Water Temps Common Bathing/Shower Rooms" log was provided by the Maintenance Supervisor on 01/11/2016 at 4:45 P.M. and reviewed at that time. The logs indicated the shower rooms in Wings #1, #2, #3, and #4 had been tested from January 2015 to present with no excessive water temperatures noted. The Maintenance Supervisor indicated random rooms were selected to be tested but he did not record which rooms. He further indicated if he turned down the water temperature the residents would be complaining about cold water temperatures in the showers. A blank form entitled, Weekly Random Resident Room Water Temps, was also provided. The form indicated temperatures were to be between 100-120 degrees Fahrenheit. The form also had a place for the "Wing/Unit" to be identified. No completed forms were provided. During an interview on 01/12/2016 at 9:15 A.M., QMA (Qualified Medication Aide) #13 indicated of the 19 residents living in the Alzheimer unit, 13 were mobile and could get themselves in and out of their rooms without assistance either on foot or in their wheelchairs. The current "Preventative Maintenance Program" policy was provided by the		supervisor will conduct water temps on each unit daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure proper water temps are being maintained. (See attachment E) The audits will be ongoing until 100% compliance is obtained and maintained. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before February 2, 2016.	

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	Administrator on 01/14/2016 at 8:48 A.M. and reviewed at that time. The policy stated, "...resident room water temps are assessed on at least a quarterly basis... at least 3 random rooms from each hall shall be taken and logged on a weekly basis." The current "Excessive Water Temperature" policy was provided by Corporate Nurse #11 on 01/14/2016 at 10:30 A.M. and reviewed at that time. The policy stated, "This facility shall monitor water temperatures to ensure temperature is maintained between 100-120 degrees Fahrenheit." 2. During an observation on 01/11/2016 at 11:14 A.M., CNA (Certified Nursing Assistant) #23 was observed cleaning Wing 3's shower room. CNA #23 picked up the soiled towels and gown then left the room leaving a used razor in the trash can. During an observation on 01/11/2016 at 11:32 A.M., Wing 3's shower room had a trash can with two used razors and an unlocked cabinet with a bottle of cleanser containing bleach. During an observation on 01/11/2016 at 11:44 A.M., Wing 3's shower room had a trash can with three used razors and an			

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	unlocked cabinet with a bottle of cleanser containing bleach. During an observation on 01/11/2016 at 12:51 A.M., Wing 3's shower room had an unlocked cabinet with a bottle of cleanser containing bleach. During an interview on 01/11/2016 at 11:53 A.M., CNA #23 indicated all used razors were to be placed in a sharps container. During an interview on 01/11/2016 at 11:54 A.M., CNA #4 indicated all disposable razors, after use, were to be placed in a sharps container and not in the garbage can. During an interview on 01/11/2016 at 11:58 A.M., the Administrator indicated all disposable razors were to be placed in a sharps container and not placed in a garbage can. 3. During a continuous observation on 01/13/2016 from 9:48 A.M. to 10:02 A.M., Wing 3's medication cart #1 was observed unattended. The medication cart had a battery pack located on the side with no safety cover and four D size batteries exposed. On top of the medication cart was a blood pressure cuff with no safety cover and 2 triple A			

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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	batteries exposed. Multiple residents were observed walking past the medication cart. 4a. During an observation on 01/11/2016 at 11:51 A.M., the Wing 3 supply room door was propped open by a box of alcohol pads. Supplies inside the room included, but were not limited to, needles, tube feeding accessories, and urinary catheter supplies. During an interview on 01/11/2016 at 11:51 A.M., LPN #2 indicated the supply room should never be left propped open and the door locks automatically. During an interview on 01/11/2016 at 11:54 A.M., QMA #13 indicated only nurses and management had keys to the supply room and the room was never left unlocked. During an interview on 01/12/2016 at 11:02 A.M., LPN #19 indicated the supply room should be kept locked because of all the nursing supplies that are kept inside. She further indicated nothing should be used to prop the door open. 4b. An observation of the Wing 3 shower room was conducted on 01/12/2016 at 11:18 A.M. The supply			

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	room located inside the shower room to the right was left unlocked. The following were located on the bottom shelf: a plastic tub containing partially used bottles of lotion, "SILK", and other personal hygiene supplies, none of which were labeled with resident names, an empty "Maxi Pad" bag, and four bottles of perineal wash. The following were located on the third shelf: an open bag of disposable BIC razors, three empty disposable razor bags, a used can of shaving cream, a set of nail clippers, and two tubs of "Micro-Kill" disinfecting wipes. The following were located on the top shelf: a used, unlabeled can of shaving cream and a used, unlabeled bottle of "Berry Flirt" body spray. The following were located on the floor: an unlabeled deodorant, a disposable nail file, an empty "Maxi Pad" bag, and a cardboard box containing a denture cup, empty denture cleaner box, and a bottle of perineal wash. 5. An observation of the Wing 4 shower room was conducted on 01/11/2016 at 12:00 P.M. The shower room door was unlocked. Behind a curtain, inside the door and to the left, were a set of plastic shelving units. Supplies stacked on the shelves included, but were not limited to, denture cleanser, lotion, toothpaste, boxes of gloves, tissues, briefs, and			

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	gauze. Inside the shower area there was a used bottle of shampoo and a used bottle of cleansing gel on the floor, 11 clothes hangers, including three wire hangers, hanging on the shower curtain rods, a used lotion bottle on the floor, a used lotion bottle on top of an open glove box, and a stick of antiperspirant sitting on a shower chair. During interviews on 01/11/2016 at 12:05 P.M. and 2:50 P.M., LPN #19 indicated that the Wing 4 shower room had not yet been used their shift (Day Shift). She indicated the shower room door cannot be locked and that personal items and linens are not to be left out. LPN #19 further indicated Residents' personal hygiene bottles should be kept in their rooms and were to be labeled. 6. During an observation 01/11/2016 at 12:30 P.M., two medication carts located by the nurse's station on Wing 3 had sharps containers attached to the outside of them. The locking mechanism, used to ensure the disposable sharps liners could not be removed, were both unlocked so that the boxes could be removed without a key. During an interview on 01/11/2016 at 1:00 P.M., the DON (Director of Nursing) indicated that sharps containers			

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	should be kept locked at all times, not left unlocked. She further indicated that bleach should always be locked up. The current facility policy titled, "Storage and Security of Items Potentially Hazardous to Resident" and dated 1/2016, was provided by Corporate Nurse #11 on 01/14/2016 at 11:17 A.M. and was reviewed at that time. The policy indicated, "...Areas of the facility and/or storage carts which must be restricted from resident access due to contents (i.e., medication rooms, medication/treatment carts, storage rooms housing chemicals, etc.) must be secured or attended...when unsecured...Chemicals must be secured..." The current facility policy titled, "Personal Care Items/Medications Maintained by the Resident" and dated 10/2014, was provided by Corporate Nurse #11 on 01/14/2016 at 11:17 A.M. and was reviewed at that time. The policy indicated, "...Facility personnel will monitor individual rooms to ensure that personal care items are maintained in a manner so as not to cause potential hazards to resident or other residents of the facility...Facility assistance shall be offered to maintain personal care items/medications in a manner...to ensure the health and safety of confused			

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	residents of the facility who could have potential access to those items...The facility shall...encourage storage of the personal care items in an effort to safeguard all residents of the facility..." The current facility policy titled, "Sharps Disposal" and dated 10/2014, was provided by the Administrator on 01/14/2016 at 8:48 A.M. and was reviewed at that time. The policy indicated, "...Needles/sharps disposable containers will be located in the medication room and/or on the medication carts as needed...will be sealed properly as indicated and disposed in a biohazard box...Place all used needles and syringes in needles/sharps disposable container after use...place the sealed needles/sharps disposable container in the designated locked area for storage of biohazardous waste..." 3.1-19(r)(1) 3.1-19(r)(2) 3.1-45(a)(1)			
F 0353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER			

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Bldg. 00	CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to ensure adequate staffing was provided related to call lights being answered in a timely manner and residents having to wait long periods for assistance for 5 of 23 residents and/or family members interviewed, (Resident #10, #30, #38, #54, and #85) and 6 of 6 staff interviewed (Staff #40, #41, #42, #43, #44 and Corporate Nurse #11). Findings include: 1. During an interview on 01/12/2016 at	F 0353	F353 Requires the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. It is the goal of the facility to provide services to its residents to allow the resident to attain or maintain their highest practicable physical and psychosocial well-being. b. Resident #10, #30, #38, #54,	02/02/2016

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	9:39 A.M., Resident #10 indicated she has had to wait as long as 20 minutes to have her call light answered. She further indicated that around meal times was when she had to wait the longest. During an interview on 01/12/2016 at 1:55 P.M., Resident #30 indicated not having enough staff was a problem. She indicated a lot of staff have quit. During an interview on 01/11/2016 at 3:33 P.M., Resident #85 indicated she has had to wait as long as 30 to 40 minutes and still didn't get assistance to go to the restroom. She indicated she took herself to the restroom. Record review of the admission MDS (Minimum Data Set) assessment dated 12/04/2015, indicated Resident #85 was a two person assist for transfers. During an interview 01/12/2016 at 2:17 P.M., a family member for Resident #54 indicated the resident didn't get all of his personal care done due to not having enough staff. During an interview on 01/12/2016 at 12:56 P.M., a family member for Resident #38 indicated the facility needed more help especially in the dementia unit.		#85 identified during survey was reviewed and corrective action plans initiated regarding call light response time, assistance for personal care and assistance with toileting. 2. To identify other residents who have the potential to be affected by the alleged deficient practice. a. All residents have the potential to be affected. b. The DON and/or Designee will observe all residents during routine daily rounds on scheduled days of work to ensure resident personal care provided timely for residents, call lights are answered timely, and residents are also toileted timely . Any noncompliance noted will be immediately corrected and/or employee disciplined as appropriate. c. Staff scheduling will be reviewed each shift according to resident needs by the DON and/or Designee. Adjustments will be made to ensure resident needs are met. *3. The facility has placed ads in local paper contacted local colleges and started their own CNA class to recruit staff in an effort to reduce the amount of overtime and possible staff burnout. Administration and nursing administration have met to review current acuity and staffing patterns in an effort to ensure staff are best utilized in response to residents' plans of care. Nursing management has been re-educated on assessing the need for a sufficient amount*	

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	During a confidential interview on 01/13/2016, Staff #44 indicated the DON (Director of Nursing) has had to work as a CNA (Certified Nursing Assistant) some evenings. Staff #44 also indicated on 3rd shift there was only two nurses and two CNAs for the whole building most of the time. Staff #44 indicated the nurse on unit four was scheduled to cover unit two as well. During a confidential interview on 01/15/2016 Staff #40 indicated frequently one CNA had to work alone on Hall 3 with 26 residents. 2. During an interview on 01/15/2016 at 9:09 A.M., Corporate Nurse (CN) #11 indicated the corporate nurses had been working in the evenings during the survey to assist staff. CN #11 further indicated after the corporate nurses leave, the DON would manage staffing and if the facility was short of staff next week, the corporate nurses would be back to assist. During a confidential interview on 01/13/2016 at 2:22 P.M., Staff #42 indicated more staff was needed in the Alzheimer's unit. During a confidential interview on		*of staff to care for the residents. Nursing staff shall be addressed in regard to ensuring the correct number of caregivers are present as per plan of care, timely response to call lights toileting and personal care and of the need to notify administration should unexpected staffing vacancies be such to prohibit the meeting of resident needs per plan of care. 4. As a means of quality assurance, and in an effort to ensure a sufficient amount of staff is present, the DON or designee will complete the staffing schedule reviews daily for 4 weeks, then weekly for four weeks, monthly times two and then quarterly until compliance with ensuring sufficient nursing staff is maintained. (See attachment B). Daily rounds on scheduled days of work will be conducted in an effort to assess sufficiency of staff as evidenced by ability to care for the residents according to their careplans and provide timely response to resident needs. Results of the rounds, staffing schedule reviews and any additional corrective action taken shall be reported to the Quality Assurance Committee during quarterly meetings and the plan revised (e.g., extended if concerns persist), if warranted. 5. The above corrective action will be completed on or before February 2, 2016.*	

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	01/14/2016 at 10:20 A.M., Staff #42 indicated staffing had been short for at least 2 years and Wing 3 had one CNA and one nurse on all shifts. Staff #42 further indicated on third shift there was usually one nurse who worked both Wing 4 and the Alzheimer's Unit. During a confidential interview on 01/14/2016 at 2:31 P.M., Staff #43 indicated there was not enough housekeeping personnel. He/she further indicated staff were not following protocol with dirty linens. He/she indicated that masses of fecal matter were being left in bedding/towels and sent to the laundry. He/She indicated that the administration had been made aware of the issue several months ago to no avail. Review of the daily staffing sheets, on 01/14/2016 at 2:15 P.M., indicated the following: On 3rd shift (10 P.M. to 6 A.M.) there was scheduled one CNA for Wing 2, one nurse and one CNA for Wing 3, and one nurse for Wing 4 for 11 out of the 13 daily schedules reviewed. Wing 2 had one nurse and two CNAs, Wing 3 had one nurse and two CNAs, and Wing 4 had one nurse and one CNA for day shift (6 A.M. to 2 P.M.). Wing 2 had one nurse and two CNAs until after dinner, Wing 3 had one nurse and two CNAs, and Wing 4 had one nurse and			

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	one CNA for 2nd shift (2 P.M. to 10 P.M.). During an interview on 01/15/2016 at 1:43 P.M., Corporate Nurse #12 indicated there were no policies for staffing, state and federal guidelines were followed. 3.1-17(a)			
F 0364 SS=D Bldg. 00	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on interview and observation, the facility failed to ensure residents received food that was palatable with acceptable flavor and was served at an appropriate temperature. This affected 3 of 14 residents interviewed for food quality. (Resident #49, 57, and 90) During an interview on 01/11/2016 at 10:19 A.M., Resident #49 indicated the food often had no flavor and was served cold.	F 0364	F 364 It is the practice of this facility to provide food that is of high quality nutritive value, palatable in both taste and appearance and at the proper temperature. 1.Upon discovery, the dietary staff was instructed to use the attached “Season Your Foods Without Salt” from the USDA. This guideline gives tips for using herbs and seasonings to add flavor to the food. (Attachment F). The pellet warmer was fixed and used immediately thereafter	02/02/2016

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	During an interview on 01/11/2016 at 3:13 P.M., Resident #57 indicated the food does not taste good and was not always served hot. She further indicated the breakfast trays were always cold. During an interview on 01/12/2016 at 2:43 P.M., Resident #90 indicated the food was bad and that he had his wife bring him food rather than eat what was served on many days. The resident further indicated the food was cold a lot of the time and it seemed like the staff put no effort into making the food taste or look good. During an observation on 01/12/2016 a 12:33 P.M., a test tray was used for the performance of a taste test. The last tray from the Wing 4 cart was taste tested. The mashed potatoes tasted like water, with no flavor. During an interview, after tasting the mashed potatoes, the Dietary Consultant indicated the potatoes are instant mashed potatoes and are not seasoned. She further indicated that she would not enjoy them without the gravy. During an interview on 01/12/2016 at 12:45 P.M., the Dietary Consultant indicated the hotplate machine, used to keep food on the units warm, was being repaired.		on 1/13/16. 2.All residents have the potential to be affected. 3.The “Food Appearance”, “Standardized Recipes”, “Holding Hot & Cold Foods on Service Line” and “Food Temperatures on Service Line” policies were reviewed and no changes made. (Attachment G – I). All Dietary Staff were educated on the policies on 1/29/16. 4.A dietary designee will be responsible for completing a monitoring sheet at least five times weekly until compliance is maintained (See Attachment J). Each meal (Breakfast, Lunch. Supper) will need to be observed at least one time per week The audits will be reviewed during the facilities quality assurance meeting and issues addressed and the above plan will be altered accordingly. 5.The above plan was completed on 2/2/16.	

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	During an interview on 01/12/2016 at 1:56 P.M., the Dietary Consultant indicated the hotplate machine had been out of service for approximately two weeks and had just been fixed that day. 3.1-21(a)(1) 3.1-21(a)(2)			
F 0441 SS=D 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; (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			

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	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 ensure proper infection control measures were followed by staff related to proper handwashing, transportation of linens, glove use, and cleaning of medication supplies for 4 of 7 direct care observations (Resident #19, #16, #30 and #63) in that handwashing was not done for the required length of time, gloves not changed appropriately, faucets turned off with bare hands, and linens were not handled properly. (CNA #4,CNA #17, QMA #13, RT#5,) Findings include: 1. During an observation on 01/12/2016 at 11:05 A.M., RT (Respiratory Therapist) #5 washed her hands for 6 seconds then turned off the water faucet with her bare hand. After assessing Resident #30's pulse and oxygen	F 0441	F441 Requires the facility to ensure proper infection control measures were followed by staff related to proper handwashing, transportation of linens, glove use and cleaning of medication supplies. 1. Residents #19, #16, #30 and #63 were not harmed. Resident #30's medication cup was immediately cleaned. 2. All residents have the potential to be affected. An inservice was immediately completed regarding infection control. See below for corrective measures. 3. The policies and procedures for handwashing (See Attachment K), linen handling (See Attachment L) and glove use (See Attachment M) were reviewed with no changes made. Staff was also inserviced on properly cleaning medication cups. The staff was inserviced on the above procedures. 4. The DON or herdesignee will conduct rounds to ensure staff is handling linens correctly,conducting handwashing and glove use per	02/02/2016

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	saturation, RT #5 washed her hands for 7 seconds and turned off the water faucet with her bare hand. After completing the breathing treatment and reassessing the resident's pulse and oxygen saturation, RT #5 placed the used medication cup and mask, without rinsing or drying, back into a plastic bag and placed it on the resident's bedside stand. RT #5 washed her hands for 7 seconds and turned off the water faucet with her bare hand. During an observation on 01/13/2016 at 11:14 A.M., RT #5 washed her hands for 8 seconds then turned the water off with her bare hand. After assessing Resident #16's pulse and oxygen saturation, RT #5 washed her hands for 6 seconds and turned off the water faucet with her bare hand. After completing the breathing treatment and reassessing the resident's pulse and oxygen saturation, RT #5 rinsed the medication cup with normal saline and placed the cup in a plastic bag while the cup was wet. RT #5 then placed the bag on the resident's bedside stand. RT #5 washed her hands for 7 seconds and turned off the water faucet with her bare hand. During an interview on 01/13/2016 at 11:35 A.M., RT #5 indicated she rinsed the medication cup and did not shake or		policy and cleaning medication cups,as warranted. The DON or her designee will utilize thenursing monitoring tool daily times four weeks, then weekly times four weeks,then every two weeks times two months, then quarterly until 100% compliance isobtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly qualityassurance meetings and the plan of correction will be adjusted accordingly ifwarranted. 5. The above corrective measures will becompleted on or before February 2, 2016.	

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	dry the cup prior to placing the cup in a plastic bag. RT #5 further indicated the proper protocol after completing the breathing treatment was for the cup and mask to go back in the bag. Proper handwashing included using soap and water for 30 seconds to a minute and then turning the water off using paper towels. During an interview on 01/13/2016 at 11:44 A.M., the Respiratory Manager (RM), indicated proper handwashing included washing hands for 20 to 30 seconds, turning the water off using a paper towel and rinsing medication cups after use with normal saline or sterile water then shaking dry. Sterile water and normal saline was distributed daily. 2. During an observation on 01/12/2016 at 9:30 A.M., CNA (Certified Nursing Assistant) #4 was observed with three towels and a bed chuck (pad) held against her uniform top and bare arm. CNA #4 walked into Resident #58's room then out of Resident #58's room and into Resident #14's room and provided morning care to Resident #14. During a continuous observation on 01/13/2016 from 9:57 A.M. to 10:15 A.M., CNA #4 walked out of Resident #27's room with a bundle of wash cloths held up against her shirt. The wash			

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	cloths were held directly on her skin and uniform, between her elbow and side. The CNA walked into the soiled linen closet and then walked out of the closet with the bundle still under her arm. CNA #4 walked into Resident #63's room and provided bathing assistance using the wash cloths. During an observation on 01/14/2016 at 2:05 P.M., the clean linen cart was left uncovered sitting in the hallway by the shower room on Wing #3. CNA #7 walked up to the linen cart 13 minutes later and pulled several linens off the cart. CNA #7 then covered the cart when she walked away. During a confidential interview on 01/14/2016 at 2:31 P.M., Staff #43 indicated there was not enough housekeeping personnel. He/she further indicated staff was not following protocol with dirty linens. 3. During an observation on 01/14/2016 at 1:50 P.M., CNA #17 and QMA (Qualified Medication Aide) #13 gathered supplies for incontinence care for Resident #19. CNA #17 and QMA #13 washed their hands appropriately and donned gloves. The CNA and QMA used the hoyer lift to place the resident in bed and moved the hoyer lift away from the			

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	bed. The CNA wet several washcloths, the QMA and CNA assisted the resident to turn left and right and pulled down the resident's pants. CNA #17 pulled down the resident's brief, sprayed cleanser on a wet washcloth, wiped the resident from front to back, and dried the resident. QMA #13 assisted the resident to roll to the right, CNA #17 sprayed cleanser on a wet washcloth, wiped the resident from front to back, and dried the resident. The CNA then removed the soiled brief, placed a clean brief under the resident, and the QMA and CNA secured the brief and pulled up the resident's pants. Without changing or removing her gloves, CNA #17 pulled the hoyer lift into position, attached the lift pad, and used the hoyer to move the resident into her wheelchair, touching the remote and handles with her gloved hands. The CNA unattached the lift pad, moved the hoyer out of the way, put Resident #19's feet into the leg rests, unlocked the wheelchair, and then removed her gloves. The CNA and QMA washed their hands appropriately and CNA #17 took the resident out of the room. QMA #13 removed the hoyer lift and bagged linen from the room, disposed of the bagged linen in the soiled utility room, used hand sanitizer, and plugged the hoyer lift in to charge in an alcove partway down the			

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	hall on Wing 4. During an interview on 01/14/2016 at 9:59 A.M., QMA #13 indicated gloves are to be changed after care and before touching "clean" items like the new brief and that the hoyer lift should not have been handled with dirty gloves. She further indicated she was not sure how often the hoyer lift was cleaned and that two people on Wing 4 required the use of a hoyer lift. During an interview on 01/14/2016 at 10:29 A.M., CNA #17 indicated gloves should have been changed after removing the dirty brief and before putting on the clean brief. The current facility policy titled, "Hand Held Nebulizer" and dated 10/15, was provided by Corporate Nurse #11 on 01/12/2016 at 1:12 P.M. The policy indicated, "...5. Wash hands per facility policy...15. Upon completion of the treatment, rinse nebulizer cup with sterile water, shake dry and place device in a bag (labeled with resident's name and date) to be maintained at bedside. 16. Wash hands per facility policy..." The current facility policy titled, "Handwashing/Hand Hygiene" and dated 10/2015, was provided by the			

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	Administrator on 01/14/2016 at 8:47 A.M. and was reviewed at that time. The policy indicated, "...Before and after direct resident contact...Before and after assisting a resident with personal care...After handling soiled or used linens, dressings bedpans, catheters and urinals...Rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers...Use towel to turn off faucet and discard towel..." The current facility policy titled, "Linen, Handling" and dated 12/2015, was provided by the Administrator on 01/14/2016 at 8:47 A.M. and was reviewed at that time. The policy indicated, "...Linen will not be carried against the body... When changing soiled linen, the soiled linen will not be placed on the floor..." The current facility policy titled, "Incontinent Brief Application" and dated 10/2014, was provided by Corporate Nurse #12 on 01/14/2016 at 3:05 P.M. and was reviewed at that time. The policy indicated, "...Provide perineal care as indicated...Remove gloves and wash hands..." 3.1-18(a) 3.1-18(l)			

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	3.1-19(g)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to maintain a sanitary environment for residents related to cleaning shower rooms after use and properly disposing of used linens. This affected 2 of 3 shower rooms observed. (Wing 3 and Wing 4 shower rooms) Findings include: During an observation on 01/11/2016 at 11:05 A.M., the Wing 3 shower room trash can contained no liner. Observed in the trash can was a razor and used gloves. On the floor, there were three used towels, four used washcloths, and one used gown. An observation of the Wing 4 shower room was conducted on 01/11/2016 at 12:00 P.M. The shower room door was	F 0465	F465 Requires the facility to maintain a sanitaryenvironment for residents relating to cleaning shower rooms after use and properly disposing of used linens. 1. The Shower rooms on wings 3 and 4 were cleaned and used linens were disposed ofproperly. 2. All Shower rooms were reviewed for cleanliness. See below for corrective measures 3.The policy related to personal care items/medications maintained by the resident (See Attachment N) was reviewed with no changes made. Staff was inserviced on the aforementioned policy. 4.The DON or her designee will conduct rounds to ensure shower room cleanliness is maintained and used linens are disposed of properly. 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	02/02/2016

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	unlocked. Inside the shower area there was a clean towel sitting on a shower chair, a chair cushion sitting on the floor, a used bottle of shampoo and a used bottle of cleansing gel on the floor, 11 clothes hangers, including three wire hangers, hanging on the shower curtain rods, a stack of clean washcloths on a shower bench, a used lotion bottle on the floor, a used lotion bottle on top of an open glove box, and a stick of antiperspirant sitting on a shower chair. The shower room had a strong, feces odor and there was a brown smear, 1 inch x 1 inch, on the trash can lid. None of the used bottles of shampoo, lotion, or cleansing gel had labels with resident identifiers. During interviews on 01/11/2016 at 12:05 P.M. and 2:50 P.M., LPN #19 indicated that the Wing 4 shower room had not yet been used their shift (Day Shift). She indicated the shower room door cannot be locked and that personal items and linens are not to be left out. LPN #19 further indicated residents' personal hygiene bottles should be kept in their rooms and are to be labeled. During an observation on 01/12/2016, a clean washcloth was left sitting on a shower chair in the Wing 4 shower room.		until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during thefacility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5.The above corrective actions will be completed on or before February 2, 2016.	

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	During an observation on 01/13/2016 at 2:02 P.M., a trash bag containing dirty linen was left on a shower chair in the Wing 3 shower room. A stack of clean towels and a used bottle of shampoo were left sitting on a shelf. During an interview on 01/13/2016 at 2:05 P.M., CNA #20 indicated the last shower was given by the hospice nurse right before lunch. When shown the shower room, the CNA immediately donned gloves to remove the dirty linens. The current facility policy titled, "Personal Care Items/Medications Maintained by the Resident" and dated 10/2014, was provided by Corporate Nurse #11 on 01/14/2016 at 11:17 A.M. and was reviewed at that time. The policy indicated, "...Facility personnel will monitor individual rooms to ensure that personal care items are maintained in a manner so as not to cause potential hazards to resident or other residents of the facility...Facility assistance shall be offered to maintain personal care items/medications in a manner...to ensure the health and safety of confused residents of the facility who could have potential access to those items...The facility shall...encourage storage of the personal care items in an effort to safeguard all residents of the facility..."			

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	3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 5 Sample: 5 Hanover Nursing Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000		