STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. BUILDING 00 B. WING	01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING MEADOWS HEALTH CARE CENTER	604 RENNAKER ST LA FONTAINE, IN 46940

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 2, 3, 4, 5, and 8, 2024 Facility number: 0000447 Provider number: 155551 AIM number: 100289950 Census Bed Type: SNF/NF: 88 Total: 88 Census Payor Type: Medicare: 6 Medicaid: 59 Other: 23 Total: 88 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 16, 2024.	F 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance. ="" p="">	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jaime Sevier	RN, RDQA	01/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility			

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	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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation and interview, the facility staff failed to sanitize a multi-use blood glucose meter according to manufacturer's instruction, and failed to ensure staff handled medications in a sanitary manner and performed hand hygiene during a medication administration observation. Findings include: 1. During a random observation on the 100 hall on 1/4/24 at 10:48 a.m., LPN 2 returned to her medication cart with a multi-use blood glucose meter. She used a sanitizing cloth to wipe the device and placed it in a basket on top of lancets (used to obtain blood sample). During an interview at the time of the observation, LPN 2 indicated the device would be ready to re-use	F 0880	1. No residents have had any adverse reactions related to this deficient practice. All residents residing in the facility that require a blood glucose check by multi-use blood glucose meter have been reviewed to ensure appropriate glucose meter cleaning and disinfection occurs. The facility policy and procedure for Glucose Meter Cleaning and Testing was reviewed and no changes were indicated. Nursing staff were re-inserviced by the Director of Nursing regarding the facility policy and procedure for Glucose Meter Cleaning and	01/29/2024

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	after she completed her charting. She did not know what the "wet time" for sanitizing the device was. She indicated the device was wet when she wiped it down and would be ready to re-use after it dried. Following approximately 45 seconds, the nurse indicated the device was dry and ready for use. During an interview on 1/4/24 at 1:50 p.m., the DON indicated the blood glucose meter should be sanitized per the manufacturer's instructions with a wet time of two minutes. A current facility policy, revised 2/2022, titled, "Glucose Meter Cleaning & Testing," provided by the Corporate Nurse Consultant on 1/4/24 at 10:55 a.m., indicated the following: "...Procedure:...5. Wipe entire external surface of the blood glucose meter with germicidal wipe. Ensure meter stays wet for 2 minute time period. 6. Place cleaned meter on paper towel, in plastic cup or clean barrier...." 2. During a medication administration observation on 1/5/24 at 2:46 p.m., when LPN 4 administered medications to Residents 44, 12, 2, and 61, hand hygiene was not completed before or after the administrations. She placed a pill directly into her bare hand before placing it into a medication cup, and administered the medication to Resident 44. She dropped a tablet into the narcotic box, retrieved it from the box with bare hands, placed it in a medication cup, and administered it to Resident 12. During an interview on 1/5/24 at 3:29 p.m., LPN 4 indicated she was unaware she shouldn't have retrieved the pill, since it had not fallen on the floor. Her practice was to put medications directly into a medication cup, never into her hand. She indicated she had washed her hands with soap		Testing. The DON and/or designee will complete the Glucometer Disinfection Review. The random audit will occur weekly for four weeks, every other week for four weeks, then monthly thereafter. Monitoring will continue until 100% compliance is achieved for a period of three consecutive months as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Glucometer Disinfection Review form to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up. The DON report of monitoring will be forwarded to the Administrator for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. 2. No residents were negatively affected by this deficient practice. The nurse identified (LPN #4) was immediately in-serviced on proper hand hygiene procedures. All residents residing in the facility have the potential to be affected by this deficient practice. Facility personnel were inserviced by the Director of Nursing regarding the facilities policy and procedure for Hand Hygiene. The DON and/or designee will complete the random Hand Hygiene Validation Checklist	

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	and water at the beginning of the medication pass and it was not her practice to perform hand hygiene in between residents. During an interview on 1/5/24 at 3:45 p.m., the DON indicated LPN 4 should not have picked up the pill from the narcotic drawer and administered the medication. The medication should have been discarded. LPN 4 should have been performing hand hygiene before preparing medications to be administered and again following administration to a resident. A current facility policy, dated 2023, titled "Medication Administration", and provided by the Corporate Nurse Consultant on 1/5/24 at 3:35 p.m., indicated the following: "...4. Wash hands prior to administering medication per facility protocol and product...13. Remove medication from source, taking care not to touch medication with bare hand...16. Wash hands using facility protocol and product...." 3.1-18(a)(l)		weekly for four weeks, every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the DON and/or designee will randomly complete the Hand Hygiene Validation Checklist to ascertain continued compliance at least biannually. The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	