STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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. This visit was in conjunction with the Investigation of Complaint IN00276679. Complaint IN00276679 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 16,17,18,19, 22, and 23, 2018. Facility number: 000057 Provider number: 155132 AIM number: 100266570 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 14 Medicaid: 53 Other: 32 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 30, 2018.	F 0000	Danville Regional Rehab had a recertification and state licensure survey, ID E5E911. Please accept our plan of correction enclosed. Danville Regional Rehab is requesting paper compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 0641	Facility corrected the MDS for	11/20/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded for Preadmission Screening and Resident Review (PASRR) Level II for 2 of 20 Residents reviewed for MDS assessments (Residents 7 and 72). Findings include: 1. Resident 7's record was reviewed on 10/22/18 at 2:06 p.m. Diagnoses on the resident's profile included, but were not limited to, Schizoaffective disorder, bipolar type (A mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania. bipolar type, which included episodes of mania and sometimes major depression), anxiety, and major depressive disorder (feelings of sadness, low esteem, and hopelessness). A care plan, developed on 3/9/18 and updated on 10/8/18, indicated the resident had a Level II assessment, which determined the resident was mentally ill with diagnoses of bipolar disorder and anxiety disorder. The resident received mental health services with a psychologist and a psychiatrist. A PASRR Level II evaluation, dated 5/26/16, indicated the resident was mentally ill as defined by diagnoses which included, but were not limited to, anxiety, bipolar disorder and depression. The annual MDS assessment, Section A1500, dated 1/4/18, indicated the resident was not considered to be a PASRR Level II (a screening triggered by evidence of a serious mental illness, Intellectual or Developmental Disabilities or		resident #7 and resident #72. The facility reviewed MDS coding for all residents who have a Level II. The RAI specialist educated facility MDS director and Social Service Director regarding accurate MDS coding. RAI specialist or designee will review MDS assessments weekly to ensure the MDS is accurate. To ensure compliance the RAI specialists or designee is responsible for the completion of the QAPI tool weekly x 4 weeks, monthly x 6 months and then quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. Id threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	condition related to Intellectual or Developmental Disabilities as defined by state and federal guidelines) and not to have a serious mental illness and/or intellectual disability or related condition. On 10/18/18 at 10:36 a.m., the Social Services Designee (SSD) indicated, Resident 7 did have a PASRR Level II completed and the MDS assessment section A1500 was coded incorrectly. During an interview, on 10/19/18 at 3:56 p.m., the MDS Coordinator indicated, she was not made aware Resident 7 had a PASRR Level II. She had coded the MDS assessment according to the RAI (Res Assessment Instrument) manual instructions. MDS Section A1500 and A1510, should have been completed. On 10/19/18 at 4:05 p.m., the MDS Coordinator provided a document titled, "CMS (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...A1500: Preadmission Screening and Resident Review (PASRR)...Coding Instructions...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness...and continue to A1510, Level II Preadmission Screening and Resident Review Conditions...." 2. Resident 72's medical record was reviewed on 10/22/18 at 03:14 p.m. The diagnoses included, but were not limited to bipolar disorder (a mental health condition). The Admission Minimum Data Set (MDS) assessment, dated 08/17/18, indicated, Resident 72 did not have a Preadmission Screening and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident Review (PASRR) for Level II (a federal requirement to help ensure individuals are not inappropriately placed in nursing homes for long term care). A care plan, dated 10/8/18 at 11:39 a.m., indicated, Resident 72 had been determined to be (intellectually Disabled or Mentally ill) per the PASRR Level 2 assessment. The Level 2 diagnosis was Bipolar II/ PTSD (post traumatic stress disorder). The goal indicated Resident 72 would have her mental health needs met. The interventions included, medication administration, medication monitoring, psych (mental health visit) referral if conditions were unstable, and yearly resident review required. On 10/17/18 at 03:36 p.m., during an interview, the Social Services Designee indicated, Resident 72 did have a PASRR Level II assessment, completed on 08/09/18. It was required to be done every year. It was coded wrong on the MDS assessment. It should have been entered as resident did have a Level II assessment. On 10/17/18 at 03:36 p.m., the Social Services Designee provided a copy of Resident 72's PASRR II assessment document, dated 08/09/18. This document indicated, Resident 72 had a history of bipolar II disorder/ PTSD, and required a yearly resident review. A copy of the current RAI (Resident Assessment Instrument), Version 3.0 Manual, pages A-18 through A-20. This document indicated, "... individuals who have or are suspected to have MI (mental illness) or ID (intellectual disability)/ DD (developmental disability) or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/ or specialized services provided by the State..." 3.1-31(c)(7)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for isolation procedures, and head lice for 1 of 1 residents reviewed for transmission based precautions (Resident 252). Findings include: On 10/17/18 at 09:56 a.m., Resident 252 was observed in her room, with the door open. A sign on the left of the door indicated, "Stop please see nurse". Certified Nurse Aid (CNA) 18 was observed weighing the resident on a chair scale. CNA 18 was not wearing any personal protective equipment (gown or gloves) while working with the resident. On 10/17/18 at 10:00 a.m., during an interview, outside Resident 252's room, during the observation, Registered Nurse (RN) 22 indicated, Resident 252 was in contact isolation for head lice, but they were not active. On 10/17/18 at 10:08 a.m., CNA 18 was observed leaving Resident 252's room without washing her hands. She brought the chair scale out of the	F 0656	Resident #252 no longer has lice nor on isolation. No other residents have lice or are on isolation. Staff to be educated on isolation policy and procedure. To ensure compliance the Clinical Education Coordinator or designee is responsible for the completion of the QAPI tool weekly x 4 weeks, monthly x 6 months then quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	11/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	room, into the hallway. During an interview, she indicated she did not come in contact with the resident. She had just weighed her with the chair scale. She did not need to wear protective equipment in the room if she did not touch the resident. She didn't think the resident had any live bugs anyway, just eggs. She did not have any disinfectant, with her, to clean the chair scale. She was going to take it to the soiled utility room, for cleaning. On 10/17/18 at 11:30 a.m., Resident 252's medical record was reviewed. A physician's order, dated 10/17/18 at 9:05 a.m., indicated, Rid (lice shampoo) Kit x 1. "Resident is in isolation due to having an active infection with highly transmittable or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Type of Isolation: Contact, Related to: pediculosis capitus, until course of treatment is completed, and nit free. Special instructions: all services provided in room." A nursing progress note, dated 10/17/18 at 9:05 a.m., indicated Resident 252 had complained of itchy scalp, upon assessment noted to have small firm apparent nits in hair. DON (Director of Nurses) and unit manager completed full hair assessment. Found no active parasites, but nits throughout the hair. NP (Nurse Practitioner) called and order to treat received. Family notified. Resident placed in isolation with all activity in room. Pharmacy called for stat order delivery. Housekeeping ordered to clean room. All bedding and clothing bagged and taken to the laundry. On 10/17/18 at 11:02 a.m., a nursing progress note indicated, pharmacy delivered treatment for hair. Resident placed in shower and treatment as ordered, applied. Resident tolerated lengthy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	procedure well. All belongings and bedding taken to laundry for treatment. A review of all of Resident 252's careplans on 10/17/18 at 11:30 a.m., did not provide documentation of a care plan for isolation, or head lice. A second review of Resident 252's care plans was conducted on 10/22/18 at 10:00 a.m., there was no additional documentation. On 10/22/18 at 11:09 a.m., during an interview, the Executive Director (ED) indicated, she didn't think the resident needed a care plan for head lice or isolation. The staff had talked to the resident, and explained the procedure for treatment and isolation. Nothing additional was required. On 10/22/18 at 11:28 a.m., the Executive Director (Ed) provided a current policy, dated 11/17, titled, "IDT (interdisciplinary team) Comprehensive Care Plan Review". This policy indicated, "...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment...Care plan problems, goals and interventions will be updated based on changes in resident assessment/ condition, resident preferences or family input." 3.1-35(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to properly assess a resident following dialysis, 1 of 1 residents reviewed for dialysis (Resident 250) . Findings include: On 10/19/18 at 03:39 p.m., Resident 250's medical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease, and dependence on renal dialysis. The physician's orders included, but were not limited to, Dialysis (name and address of the facility) Monday, Wednesday, and Friday. Chair time was 6:30 a.m., (name of provider) stretcher transport. An admission skin assessment, dated 10/2/18 at 9:36 a.m., indicated, the resident had a well healed pink surgical chest incision. A right subclavian double lumen dialysis port, with dressing C/D/I (clean, dry, and intact) had no signs of infection. A Post Dialysis Assessment, dated 10/19/18, indicated, "... Date and time of returned from dialysis 10/19/18 at 11:35 a.m...Return paperwork was reviewed... B/P (blood pressure) was 116/72, Bruit was present (a audible blood flow through a fistuala, the access created surgically, in an arm for dialysis treatment), Thrill (palpable blood flow though a fistula) was present. Bleeding was absent. Edema (swelling) was absent. Warmth, redness, and drainage were marked absent..." A Post Dialysis Assessment, dated 10/12/18, indicated "...Date and time returned from dialysis 10/19/18 at 11:21 a.m... Return paperwork was	F 0698	Resident #250 incorrect assessments updated/corrected. No other residents are on dialysis, therefore, no further potential to be affected. DNS or designee to review dialysis assessments the next business day to ensure accuracy of assessment and provide education to nurses as needed. Education provided to the nurse who completed inaccurate assessment. To ensure compliance the DNS or designee is responsible for the completion of the QAPI tool weekly x 4 weeks, monthly x 6 months then quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	11/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	reviewed... B/P (blood pressure) was 123/65, Bruit was present (a audible blood flow through a fistuala, the access created surgically, in an arm for dialysis treatment), Thrill (palpable blood flow though a fistula) was present. Bleeding was absent. Edema (swelling) was absent. Warmth, redness, and drainage were marked marked absent..." A care plan, indicated, Resident 250 was receiving hemodialysis and was at risk for complications, related to hemodialysis, which included a risk for complications, such as fluid imbalance,and bleeding or infection (site: right chest port). The goal indicated Resident 250 would have no complications related to hemodialysis. Interventions included, assess dialysis access site every shift for excessive bleeding, drainage, swelling, redness, or warmth. Documented abnormal findings were reported abnormal to the physician and the Dialysis clinic/ center (name, address, and phone number). Dialysis days were Monday, Wednesday, and Friday, with chair time at 6:30 a.m. Diet as ordered. Resident had right chest port for dialysis. If minor bleeding occurred at access, applied pressure would have been maintained until bleeding stopped. If bleeding was severe, with applied pressure, 911 should have been called. Physician and Dialysis center notified of problems. Labs as ordered. Fluid intake monitored. No blood pressure/ venipuncture would be obtained from effected extremity. On 10/22/18 at 01:51 p.m., during an interview the Director of Nursing Services (DNS), indicated, one nurse was completing the assessment improperly. The nurse could not have assessed for a bruit and thrill on a right subclavian double lumen, chest port.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 10/22/18 at 1:55 p.m., the DNS provided copies of Resident 250's "Dialysis Appointment Assessment" documents for 10/08/18 through 10/22/18. She indicated, it was the policy, of the facility, for the assessment to have been completed on all dialysis days, before and after the scheduled appointment. A separate policy was not provided. 3.1-37(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure medications were clinically indicated after being alerted by pharmacy recommendations were addressed for 1 of 5 Residents reviewed for unnecessary medications (Resident 28). Findings include: Resident 28's record was reviewed, on 10/22/18 at 10:35 a.m., diagnoses included, but were not limited to depression and anxiety disorder. A care plan, initiated on 8/21/17 and revised on 9/1/18, indicated the resident was at risk for adverse side effects related to use of psychotropic, antidepressant, antianxiety, and antipsychotic medications with interventions	F 0758	Diagnosis clarification completed when survey was in progress. All other residents have the potential to be affected by the deficient practice. Nurses to be educated on placing accurate diagnosis when medications entered into EMAR. Nurse management to check new orders entered the following business day to ensure correct diagnosis is input on the new medication orders. To ensure compliance the DNS or designee is responsible for the completion of the QAPI tool weekly x 4 weeks, monthly x 6 months then quarterly until compliance is maintained for 2	11/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	included, but not limited to, administer medications as ordered and the pharmacist to review medications routinely. An active physician's order, started on 9/8/17, indicated the resident received olanzapine (an antipsychotic medication, which can treat mental disorders, including schizophrenia and bipolar disorder) at bedtime for the diagnosis of, "Anxiety disorder, unspecified." An active physician's order, started on 9/8/17, indicated the resident received lamotrigine (an anticonvulsant medication, which can treat seizures and bipolar disorder [depression]) twice daily for the diagnosis of, "Encounter for other specified aftercare." A pharmacy consultation report, dated 11/13/17, indicated Resident 28's medication record listed potentially inappropriate supporting diagnoses for the following medications: "...1. 'Anxiety disorder' is listed for use of olanzapine and 2. 'Encounter for other specified aftercare' is listed for use of lamotrigine with the recommendation for the facility to clarify the appropriate supporting diagnoses for these medications and have the medical record updated accordingly...." A pharmacy consultation report, dated 1/10/18, indicated repeated recommendation from 11/13/17."...Please respond promptly to assure the facility compliance with Federal regulations...." Resident 28's medication record listed potentially inappropriate supporting diagnoses for the following medications: "...1. 'Anxiety disorder' is listed for use of olanzapine and 2. 'Encounter for other specified aftercare' is listed for use of lamotrigine with the recommendation for the facility to clarify the appropriate supporting		consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Reason for IDR: Per 483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The resident listed in the deficiency has the diagnosis that clinically supports the medications listed in the deficiency. The diagnoses are listed in the EMR, has been documented by the physicians and NPs and is also care planned for the resident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	diagnoses for these medications and have the medical record updated accordingly...." On 10/22/18 at 12:28 p.m., the Social Services Designee (SSD) indicated, he addressed the psychotropic medications and the Director of Nursing Services (DNS) addressed all other pharmacy recommendations. He was not sure why the pharmacy recommendations were not completed. The pharmacy indicated the medical record listed potentially inappropriate supporting diagnoses for the following medications: Anxiety disorder was listed for use of olanzapine and "Encounter for other specified aftercare" was listed for use of lamotrigine. The inappropriate diagnoses were not addressed, because the diagnoses were still the same at this time on the Resident's medical record. The Executive Director (ED), on 10/23/18 at 2:45 p.m., provided and identified as a current facility policy, dated 11/17, titled "Pharmacy Recommendations." The policy indicated, "...Purpose: It is the policy of ASC (American Senior Communities) that the facility maintains the residents highest practicable level of physical, mental, and psychosocial wellbeing and prevents or minimizes adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed Pharmacist, Attending Physician, Medical Director, and Director of Nursing...Policy: The pharmacist will review each resident's medication regimen at least once a month...." 3.1-48(a)(4)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to provide a sanitary environment during meal service for 24 of 24 residents consuming meals in the Main Dining room by contaminating ice and drinking cups with improper handling, and failed to perform proper hand hygiene while assisting residents with meals for 2 of 20 residents dining in the Memory Care Dining Room (Residents 35 and 199). Findings include: 1. On 10/16/18 at 12:04 p.m., during a dining observation, in the main dining room, 24 residents were observed in the main dining room for lunch service. On 10/16/18 at 12:14 p.m., Housekeeping	F 0812	Staff members listed in deficiency educated on infection control practices. All other resident have the potential to be affected by the deficient practice. All staff to be educated on infection control practices, especially as it relates to dining services. To ensure compliance the Clinical Education Coordinator or designee is responsible for the completion of dining observation and ensuring proper hand hygiene weekly x 4 weeks, monthly x 6 months then quarterly until compliance is maintained for 2 consecutive	11/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Supervisor 14 was observed, as she served drinks to all of the residents in the Main Dining Room. She rolled a cart around the room, to each table. The top of the cart transported several pitchers containing drinks and a large plastic pitcher, without a lid, contained ice. Housekeeping Supervisor 14 was observed transferring ice into glasses, for resident drinks, using her left hand, directly touching the ice, with her bare hand, to control the amount transferred into glasses, as she poured ice from the pitcher. She filled glasses with drinks then picked them up, with her hand over the top of the glasses, with fingers on the brims, and placed them on the tables, for the residents. On 10/16/18 at 12:21 p.m., while serving drinks, Housekeeping Supervisor 14 was observed as she adjusted her garments, at the shoulder. She placed her right hand under sweater, to make an adjustment, then rubbed her chin, and served drinks to 4 residents. She did not perform hand hygiene. Housekeeping Supervisor 14 served 16 glasses of drinks with ice, and 11 glasses of milk to 24 unidentified residents in the Main Dining Room. On 10/16/18 at 12:27 p.m., during an interview Housekeeping Supervisor 14 indicated, ice should not be touched with bare hands, and the brims of glasses, where the residents' mouths made contact, should not have been touched, with her fingers. She indicated, she thought she had washed her hands three times that day. On 10/17/18 at 02:37 p.m., the Director of Nursing Services (DNS) indicated, there was not a specific policy for passing or serving drinks in the dining		quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	room or handling ice. When passing drinks in the dining room the employee should never touch the ice, with their hands, or put their fingers on the brims of the glasses, where it makes contact with the resident's mouth. On 10/17/18 at 4:40 p.m., the DNS provided a current policy, dated 3/2018, titled, "Hand Hygiene Policy". This policy indicated,"... the purpose was to provide a standardized approach to hand hygiene to reduce or minimize the transmission of infection from potential microorganism on the hands of all employees... (name of organization) will follow the Centers for Disease and Prevention (CDC) hand hygiene and World Health Organization (WHO) guidelines for the standards of hand hygiene..."2. During an observation, on 10/16/18 at 12:22 p.m., the Memory Care Support Specialist was holding the wheelchair handles for Resident 35 to assist him to sit closer to the dining table. She washed her hands for 14 seconds, then assisted Resident 199 with eating. While assisting Resident 199 with eating, she picked up the resident's soft taco with her bare hand, put it back on the plate, cut it up and with a fork, and fed it to him. During an interview, on 10/22/18 at 2:03 p.m., the Executive Director (ED) indicated staff should have washed their hands 45-60 seconds and should not have touched resident food with their bare hands. A current policy, titled, "Hand Hygiene Policy," dated 3/2018, was provided by the Executive Director, on 10/22/18 at 2:59 p.m. A review of the policy indicated, " ...Hand washing - the vigorous, brief rubbing together of all surfaces of hands with soap and water, followed by rinsing under a stream of water ...Handwashing Technique -			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Duration of the entire procedure: 40-60 seconds ...." 3.1-21(i)(3)			
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. §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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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 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, interview, and record review, the facility failed to follow policy for	F 0880	Staff member listed in deficiency has been re-educated on isolation policy.	11/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	isolation procedures, when providing care for 1 of 1 residents reviewed for transmission based precautions (Resident 252). Findings include: On 10/17/18 at 09:56 a.m., Resident 252 was observed in her room, with the door open. A sign on the left of the door indicated, "Stop please see nurse". Certified Nurse Aid (CNA) 18 was observed weighing the resident on a chair scale. CNA 18 was not wearing any personal protective equipment (gown or gloves) while working with the resident. On 10/17/18 at 10:00 a.m., during an interview, outside Resident 252's room, during the observation, Registered Nurse (RN) 22 indicated, Resident 252 was in contact isolation for head lice, but they were not active. On 10/17/18 at 10:08 a.m., CNA 18 was observed leaving Resident 252's room without washing her hands. She brought the chair scale out of the room, into the hallway. During an interview, she indicated she did not come in contact with the resident. She had just weighed her with the chair scale. She did not need to wear protective equipment in the room if she did not touch the resident. She didn't think the resident had any live bugs anyway, just eggs. She did not have any disinfectant, with her, to clean the chair scale. She was going to take it to the soiled utility room, for cleaning. On 10/17/18 at 11:30 p.m., Resident 252's medical record was reviewed. A physician's order, dated 10/17/18 at 9:05 a.m., indicated, Rid (lice shampoo) Kit x 1. "Resident is in isolation due to having an active infection with highly transmittable or		All residents have the potential to be affected by the deficient practice. All staff to be re-educated on the infection control policy and practice. To ensure compliance the Clinical Education Coordinator or designee is responsible for the completion QAPI tool weekly x 4 weeks, monthly x 6 months then quarterly until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Type of Isolation: Contact, Related to: pediculosis capitus, until course of treatment is completed, and nit free. Special instructions: all services provided in room." A nursing progress note, dated 10/17/18 at 9:05 a.m., indicated Resident 252 had complained of itchy scalp, upon assessment noted to have small firm apparent nits in hair. DON (Director of Nurses) and unit manager completed full hair assessment. Found no active parasites, but nits throughout the hair. NP (Nurse Practitioner) called and order to treat received. Family notified. Resident placed in isolation with all activity in room. Pharmacy called for stat order delivery. Housekeeping ordered to clean room. All bedding and clothing bagged and taken to the laundry. On 10/17/18 at 11:02 a.m., a nursing progress note indicated, pharmacy delivered treatment for hair. Resident placed in shower and treatment as ordered, applied. Resident tolerated lengthy procedure well. All belongings and bedding taken to laundry for treatment. On 10/22/18 at 11:09 a.m., during an interview, the Executive Director (ED) indicated, she had read the policy, and staff should have been wearing PPE in the room when caring for the resident. On 10/17/18 at 2:40 p.m., the Director of Nursing Services provided a current policy, dated March 2018, titled, "Isolation Transmission-Based Precautions". This policy indicated, "...Use of Personal Protective Equipment - Gown and Gloves: Applies to anyone entering the room who may touch the resident or objects in the room should wear PPE...perform hand hygiene prior to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155132	A. BUILDING 00 B. WING	10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	entering the room and before leaving the room..wear gloves whenever touching the resident's skin or surfaces close to the resident..." On 0/17/18 at 3:28 p.m., the Social Service Designee provided a current undated policy, titled, "Lice (Pediculosis)". This policy indicated, "...Gloves must be put on before entering room and worn by all staff during care. Gloves should be removed when leaving the resident's room. Hand washing should be done after removing gloves...Gowns should be put on before or immediately upon entry to the room/ cubicle..." 3.1-18(b)(2)			