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		A. BUILDING 00 B. WING	05/31/2019

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HAMILTON PLACE	2116 BUTLER RD FORT WAYNE, IN 46815

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 30 and 31, 2019 Facility number: 004686 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 4, 2019.	R 0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure sanitation practices were followed in the facility kitchen. This had the potential to affect the 29 of 29 residents who ate their meals prepared by facility staff. Findings include:	R 0273	1. Chef 1 was re-trained on 6/11/2019 by Executive Director on the policy regarding Infection Control and DNH Dress Code. CNA 2 was re-trained on 6/11/2019 by the Executive Director on policy regarding Infection Control and DNH Dress	07/12/2019

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

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	During an observation of the main kitchen on 5-30-2019, the following was observed: At 10:09 a.m., Chef 1 was observed in the kitchen preparing the noon meal. Chef 1 was observed with a hair restraint and a beard restraint. The beard restraint was observed not to cover the upper parts of the beard on each side of his face and the mustache. At 11:59 a.m., CNA 2 (Certified Nurse Aide) was observed to be placing the clean dishwashing racks on a shelf. CNA 2 left the kitchen and returned to the kitchen when she began rinsing dirty dishes and running them through the dishwasher. CNA 2 was not observed to have donned a hair net. Chef 1 was observed at this time finishing the noon meal preparation. Chef 1 was not observed to have a beard restraint on to cover his full beard and mustache. At 12:10 p.m., Chef 1 began plating the food for the noon meal and was not observed to have the beard restraint on to cover his full beard and mustache. At 12:12 p.m., the CSM (Case Services Manager) entered the kitchen and went to the handwashing sink to wash her hands. The hand washing sink was located on the other side of the prep table where Chef 1 was plating the food and putting the plates on a tray near the CSM. The CSM was not observed to have a hair restraint to cover her long hair. An observation in the main kitchen on 5-31-2019 at 9:29 a.m., indicated Chef 1 was observed with a hair restraint		Code. CSM was re-trained on 6/11/2019 by Executive Director on the policy regarding Infection Control and DNH Dress Code. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Staff were re-trained on Infection Control and DNH Dress Code by the Executive Director on 6/12/2019. 4. The Executive Director and/or designee is responsible for sustained compliance. Executive Director and/or designee will monitor weekly to ensure ongoing compliance. Weekly audits reports to be reviewed at monthly QI meetings for 3 months. Ongoing QI review will be based on 3 months of sustained compliance.	

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	which covered the hair on his head, but a beard restraint was not observed to cover Chef 1's full beard and mustache. An interview with Chef 1 on 5-31-2019 at 9:29 a.m., indicated for staff who entered the kitchen beyond the black strip on the floor, a hair restraint was required to cover their hair. The black strip on the kitchen floor was observed to separate the dishwashing side of the kitchen from the refrigerator/freezer/food prep/cooking side of the kitchen. Chef 1 was interviewed regarding the lack of the beard restraint to cover his full beard and mustache. Chef 1 indicated he was not sure of the facility policy for facial hair. Chef 1 indicated the facility had beard restraints available. Chef 1 obtained the policy which pertained to hair restraints and indicated staff with facial hair must wear beard/mustache restraints in the kitchen. Further interview with Chef 1, indicated staff could rinse and place dishes in the dishwasher without a hair restraint to cover their hair, but would need to don a hair restraint to handle any clean dishes. A current policy, "Infection Control and DNH Dress Code" dated 4-17-2017, was provided by the Executive Director on 5-31-2019 at 9:40 a.m. The policy indicated "...Hair restraints will be worn in the food preparation area at all times...restraints must cover all hair...there may not be any hair on the outside of the restraint...employees with facial hair must wear beard/mustache restraints...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication			

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	assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview, and record review, the facility failed to ensure 2 of 14 medications were administered correctly for 2 of 7 residents who received the medications. (Resident 6 and Resident 5) Findings include: 1. A review of Resident 6's records on 5/31/19 at 9:05 a.m., indicated the following, diagnoses included, but were not limited to, diabetes. Review of Resident 6's Physician orders indicated the admission orders were dated 5/25/19 for Humalog (a fast acting insulin) 100 U (Units, a measurement)/ml (milliliter, a measurement), inject 24 units 3 times a day before meals, at 8:00 a.m., 12:00 p.m., and 5:00 p.m. Review of Resident 6's MAR (Medication Administration Record) for May 2019 indicated, Humalog 24 Units was to be administered at 8:00 a.m., 12:00 p.m., and 5:00 p.m. During Resident 6's medication administration by Nurse 3, the following was observed: After Nurse 3 tested Resident 6's blood sugar with a glucometer (a device to test blood sugar level with a drop of blood), the Nurse prepared the Humalog KwikPen (a prefilled insulin syringe) to administer the routine 24 Units of insulin. The nurse was observed to don gloves, cleaned the rubber stopper of the insulin pen and attached the needle to the pen. She dialed the pen to 2 units and pushed the plunger knob to discard the 2 units to prime the insulin pen and needle. She then dialed the Humalog KwikPen to 24 units. The Nurse	R 0296	1. Nurse 3 was re-trained on 6/11/2019 by Care Services Manager on Basaglar KwikPen manufacturer's instructions to include specifics on holding the needle in place. Nurse 4 was re-trained on 6/11/2019 by Care Services Manager on the policy regarding Medication Administration. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. The Care Services Manager will reeducate nursing staff on Basaglar KwikPen manufacturer's instructions to include specifics on holding the needle in place, and also on the policy regarding Medication Administration on 6/12/2019. 4. The Care Services Manager and/or designee is responsible for sustained compliance. The Executive Director and/or designee will review to ensure ongoing compliance. Care Services Manager or designee will complete quarterly medication competency on staff and this is to be reviewed at monthly QI meetings for 6 months. Ongoing QI review will be based on 6 months of sustained compliance.	07/12/2019

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	then cleaned the Resident 6's left abdomen with an alcohol prep pad, pinched up the skin and injected the needle into the skin, depressed the plunger knob and removed the needle immediately. The nurse was not observed to hold the needle in place for the recommended 5 seconds before removing the needle from the skin. The Humalog insulin was administered at 11:54 a.m. Resident 6 left their apartment for the dining room at 11:55 a.m. Lunch services were scheduled for 12:00 p.m. An interview with Nurse 3 on 5/30/19 at 11:55 a.m., indicated only 1 resident had an insulin pen in the facility. Nurse 3 indicated she was not aware of the need to hold the insulin pen needle in place in the skin after injecting the insulin. She indicated she she only started working full time at the facility last week. 2. A review of Resident 5's records on 5/31/19 at 9:25 a.m., indicated the following, diagnoses included, but were not limited to osteoporosis and Vitamin D deficiency. Review of Resident 5's Physician's orders indicated a medication order dated 2/27/18 for Calcium 600 mg (milligram, a measurement) with Vitamin D 400 IU (International Units, a measurement). The prescription instructions were to give 1 tablet by mouth 2 times a day with food. Review of Resident 5's MAR (Medication Administration Record) for May 2019 indicated, Calcium 600 mg with Vitamin D was scheduled to be given at 8:00 a.m. and 4:00 p.m. During Resident 5's medication administration by Nurse 4 the following was observed, at 3:13 p.m., Nurse 4 removed Resident 5's medications from			

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	the medication cart, and poured the medications for administration. Nurse 4 was observed to don gloves, broke a scored Calcium 600 mg with Vitamin D 400 IU tablet into 2 halves and put the medication into the medication cup. Nurse 4 indicated Resident 5 had trouble swallowing the large tablet and wanted the Calcium broke in half. Nurse 4 was observed to administer Resident 5's Calcium with Vitamin D at 3:15 p.m. Nurse 5 was not observed to offer nor remind Resident 5 to eat some food with the medication. An interview with the Case Services Manager (CSM) on 5/31/19 at 10:48 a.m., indicated she had talked with the facility pharmacy about the insulin pen. She indicated when administering an insulin pen, the needle needed to be held in place after the insulin was injected. She indicated the amount of time the needle needed to be held in place varied from 5 to 10 seconds. An interview with the CSM on 5/31/19 at 10:52 a.m., indicated Resident 5's Calcium with Vitamin D tablet should have been given with food. She indicated the residents had food in their apartments they could eat at anytime. The CSM did not indicate the nurse should have reminded the resident to eat some food when the medication was given. She indicated the medication administration time should be change to be administered at 5:00 p.m., which would be closer to meal time. Evening dinner time was scheduled for 5:00 p.m. Review of document faxed to the facility by the Pharmacy on 5/31/19 at 9:32 a.m., titled, Insulin Glargine, was provided by the CSM on 5/31/19 at 10:48 a.m., indicated, "...for administration using the Basaglar KwikPen, push the dose knob all the way in. Continue to hold the dose knob in and			

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	slowly count to 5 before withdrawing the needle from the skin to ensure that the full dose is delivered...." 410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure adequate hand hygiene at appropriate times.This had the potential to affect 29 of 29 residents residing in the facility. Findings include: An observation of blood glucose testing by Nurse 3 on 5/30/19 at 11:40 a.m., indicated the following: Nurse 3 pushed the medication cart down the hallway, near the resident's room. Nurse 3 was not observed to perform hand hygiene (hand washing or use of hand sanitizer) after she pushed the medication cart nor before retrieving an insulin pen and glucometer (device which measures the blood sugar) from the medication cart. The nurse also retrieved a lancet (a pricking needle used to obtain a drop of blood), alcohol prep pads and tissues. She closed the drawer and locked the medication cart. The Nurse knocked on the resident's room door, touched the door knob and entered the resident's room. The nurse donned gloves, opened an alcohol prep pad and cleaned the resident's finger with an alcohol prep pad. Nurse 3 was not observed to perform hand hygiene after locking the medication cart, after knocking on the door, touching the door handle, and before donning gloves. After testing the resident's blood sugar, the nurse removed the			
R 0414 Bldg. 00		R 0414	1. Nurse 3 was re-trained on 6/11/2019 by Care Services Manager on the policy regarding Handwashing. Nurse 4 was re-trained on 6/11/2019 by Care Services Manager on the policy regarding Handwashing. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. The Care Services Manager will reeducate nursing staff on the policy regarding Handwashing on 6/12/2019. CSM or designee will make spot checks weekly to ensure staff are performing handwashing according to the policy. 4. The Care Services Manager and/or designee is responsible for sustained compliance. The Executive Director and/or designee will review at monthly QI meeting to ensure ongoing compliance. Further review will be based on 6 months of sustained compliance.	07/12/2019

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	gloves and discarded them in the trash. She then donned a clean pair of gloves, prepared the insulin pen, cleaned the resident's skin with an alcohol prep pad and administered insulin to the resident. The nurse was not observed to perform hand hygiene after removing the gloves nor prior to donning the clean gloves. After the nurse administrated the insulin, the nurse was observed to remove one of the gloves. The nurse placed the insulin pen, the used lancet, and trash in the gloved hand and left the room. She returned to the medication cart, discarded the trash in the waste container on the side of the medication cart, discarded the needles in the sharps container on the side of the cart, removed the remaining glove and threw it away. Nurse 3 then performed hand hygiene with hand gel sanitizer. On 5/30/19 at 12:04 p.m., Nurse 3 was observed to perform hand hygiene with hand gel sanitizer. Nurse 3 was observed to touch her uniform, then reached into her pocket to retrieve keys, opened the medication cart, put the keys back into her pocket, then pushed her hair away from her face. She opened the medication cart drawer and retrieved a glucometer, lancet, alcohol prep pads, closed the drawer, retrieved gloves and tissues. She then knocked on the door, opened the door touching the door knob and entered the resident's room, without performing hand hygiene after touching the uniform, keys, medication cart, hair, and door knob before performing the blood glucose test. On 5/30/19 at 12:06 p.m., Nurse 3 was observed to perform hand washing with soap and water in the kitchenette sink. She was observed to move her hands in and out of the running water while she lathered her hands for 30 seconds. After she dried her hands with clean paper towel, she			

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	donned gloves, tested the resident's blood sugar, gathered the trash, left the room with the gloves on her hand, discarded the lancet in the sharps container, put the trash in in the waste container, removed the gloves, threw them away, then performed hand hygiene. She then touched her uniform, retrieved the keys from her uniform pocket, unlocked the medication cart, put the keys back in her pocket, opened the drawer, retrieved a vial of insulin, insulin syringe, alcohol prep pad, then closed the drawer and locked the medication cart. She retrieved gloves, donned the gloves and picked up the supplies. She knocked on the resident's door, opened the door by touching the knob with the gloved hand. Nurse 3 was observed to touch her uniform, then opened the alcohol prep pad, cleaned the top of the insulin vial, opened the insulin syringe and withdrew the insulin from the vial. The nurse was not observed to perform hand hygiene nor change the gloves after she touched contaminated surfaces. The nurse was stopped prior to administering the insulin and interviewed about hand hygiene. On 5/30/19 at 12:15 p.m., Nurse 3 was interviewed and indicated she had touched door and her uniform and would need to change her gloves. On 5/30/19 at 12:16 p.m., Nurse 3 was observed to remove her gloves and indicated she did not have additional gloves. She gathered the supplies and left the room to retrieve additional supplies. She returned to the room and washed her hands with soap and water. She lathered her hands for 25 seconds and was observed to move her hands in and out of the water one time while lathering her hands. After drying her hands, she donned gloves and realized she needed another alcohol prep pad. She removed the gloves and went to the medication cart to retrieve an alcohol prep			

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	pad. Nurse 3 returned to the room, washed her hands with soap and water, lathering her hands for 20 seconds, and moved her hands in and out of the water while lathering her hands. The nurse then donned gloves, and administered the insulin to the resident. On 5/30/19 at 12:23 p.m., Nurse 3 removed the gloves after administering insulin, discarded the gloves and washed her hands with soap and water. She lathered her hands for 15 seconds and moved her hands in and out of the water one time while she lathered her hands. On 5/30/19 at 3:13 p.m., Nurse 4 was observed to push the medication cart up the hallway, stopped by a resident's room, opened the medication cart drawer, and retrieved medication cards. She was not observed to perform hand hygiene after pushing the medication cart nor before she touched the medication cards. She poured the medications, then donned gloves and broke the 2 large tablet in half with her gloved hands. She was not observed to perform hand hygiene prior to donning the gloves. On 5/30/19 at 3:25 p.m., Nurse 4 was observed to push the medication cart up the hallway, stopping between 2 resident rooms. She retrieved the keys from her uniform pocket, unlocked the medication cart, opened the drawer and removed the medication cards for a resident. Nurse 4 was not observed to perform hand hygiene prior to pouring the resident's medications. An interview with the Case Services Manager (CSM) on 5/31/19 at 9:45 p.m., indicated the Nurse should wash her hands before pouring the medication. Hand hygiene should be done after touching a resident, the medication cart, doors or			

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	handles. She indicated the keys to open the medication cart were considered dirty. Hand hygiene should be done after opening the medication cart and before touching the medications. She also indicated hand washing should be done when the hands were visibility soiled, otherwise an alcohol based hand sanitizer could be used for hand hygiene. The CSM indicated she would provide the facility policy for hand hygiene. Review of the current facility policy, titled, HANDWASHING, with an Effective date: 9/1/2016, was provided by the Executive Director on 5/31/19 at 10:06 a.m. The policy indicated, "...Handwashing is the single most effective means to prevent the spread of infection...Hands should be washed before:...Administering medication...Hands should be washed when soiled and after:...Resident care...Any clinical procedure...removing gloves...General procedure for proper hand washing: Completely wet your hands...Apply soap...Work up a good lather. Spread it over the entire area of you hands and wrists. Get soap under your nails and between your fingers. Use "friction" as you work the soap onto your hands. Clean for at least 20 seconds (using "friction") and rub vigorously...If you are washing your hands in a room with the door closed, the door should be opened with a paper towel and the paper towel disposed of, as door handles are a prime place for germs to collect...A hand sanitizer is not to be used in place of proper hand washing; however, it should be readily available for staff to use in situations where hand washing facilities or supplies are not immediately available (e.g. in resident's apartment)...When a hand sanitizer is used, hands must be washed with soap and water as soon as feasible, and/or in accordance with manufacturer instructions...."			

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