STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANCISCAN HEALTH ALTERNACARE	1104 E GRACE ST RENSSELAER, IN 47978

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 5, 2019 Facility number: 004199 Residential Census: 11 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/9/19.	R 0000		
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview and record review, the facility failed to ensure safe hot water temperatures were maintained for 4 of 4 rooms observed during the Environmental Tour. (Rooms 204, 205, 206, and 220) Finding includes: During the Environmental Tour on 9/5/19 at 9:46 a.m. with Lead Maintenance Technician 1, the following was observed: - Room 204's bathroom hot water temperature was 124.8 degrees Fahrenheit. There was one resident	R 0187	R 187 Water temperature was corrected immediately September 5th, day of survey. Water temperature at the boiler was turned down to 118-degree Fahrenheit and water was ran until the temperature was below 120 degrees. Starting on September 5th, the hot water tank and boiler room sink temperatures were checked daily for 1 week to ensure it stayed near 118 degrees and not to exceed	10/05/2019

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

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	who resided in this room. - Room 205's bathroom hot water temperature was 124.8 degrees Fahrenheit. There was one resident who resided in this room. - Room 206's bathroom hot water temperature was 125.7 degrees Fahrenheit. There was one resident who resided in this room. - Room 220's bathroom hot water temperature was 123.4 degrees Fahrenheit. There was one resident who resided in this room. Interview with Lead Maintenance Technician 1 on 9/5/19 at 9:46 a.m., indicated all the water temperatures on that hallway would be the same. They were all on the same boiler system and the hot water was set at 130 degrees Fahrenheit. The water temperatures were normally checked by another maintenance person. He was unaware of what the temperatures were supposed to be. Interview with Maintenance Technician 1 on 9/5/19 at 10:24 a.m., indicated the water temperatures were checked quarterly and only one room was completed due to the hallway was on the same boiler system. A policy titled, " Legionellosis Procedure," was provided by the Administrator on 9/5/19 at 2:30 p.m. This current policy indicated, "...Procedure:...B....Hot water temperature at point of use shall be between 110-120 degrees Fahrenheit.		120 degrees. Actual daily readings were 116 - 117 at the boiler room sink. This is the closest to the boiler and water cools as it goes through the lines. The hot water tank temperature is checked during daily rounds and recorded in Medimizer (computer tracking program). On September 16th the acceptable temperature range was changed to 115 – 120 degrees Fahrenheit. Monthly point – of – use tests to start in October. This test will be performed at the sink in the boiler room which is the hottest point-of-use sink in the building due to the proximity to the hot water tank. The hot water is to be allowed to run for 2 minutes prior to checking the water temperature. The reading is recorded in Medimizer. Quarterly testing in each department will be continuous. The acceptable range has been changed to 110 – 120-degree Fahrenheit in accordance with the “Legionellosis Procedure” referenced in R 187. Facilities Department Supervisor is responsible for oversight of compliance. A contractor has been contacted for a quote to replace the hot water mixing valve in the boiler room. This will allow the hot water	

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			temperature to be raised to 140-degree Fahrenheit while setting the sink temperatures to 120 degrees or below. Water temperatures have maintained below 120 degrees since the day of survey. Systemic changes will be completed by 10/5/19.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure Service Plans were completed after a resident had a change of condition, included contracted services, and a preadmission evaluation was completed before admission for 3 of 7 residents reviewed. (Residents 4, 3, and 8) Findings include: 1. Record review for Resident 4 was completed on 9/5/19 at 9:53 a.m. Diagnoses included, but were not limited to, hypertension, arthritis, fractures, and hypothyroidism. A Progress Note, dated 8/17/19, indicated the resident returned from the hospital. The resident was sent to the hospital after a fall at the facility. The resident had sustained a fractured wrist and	R 0214	**Tag #R 214** **#4 resident**: met with family on 9/19/19 to update service plan with change in condition. (See attached) **#3 resident**: met with family on 8/29/19, prior to survey, with daughter Mary present and service plan had been completed on 8/29/19. (See attached, it had not been placed in her file when surveyor reviewed record) **# 8 resident**: discharged from facility on 8/5/19, unable to complete preadmission screen form. Resident had been an inpatient in the acute care. Communication with the resident	10/05/2019

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	hip. The resident returned to the facility with a Foley catheter. A Semi-Annual Evaluation, dated 5/23/19, indicated the resident required some assistance for mobility and transfers and had occasional incontinent episodes. A BI-Weekly Summary, dated 8/29/19, indicated the resident did not ambulate, used a Gerichair and required transfer assistance of 2 people. The resident also had a Foley catheter. The record lacked any documentation an updated Service Plan had been completed after the resident had a change in condition related to the fall with fractures. Interview with the Director of Nursing (DON) on 9/5/19 at 1:15 p.m., indicated she should have completed an updated Service Plan on the resident because she had a change of condition. She further indicated they did not have a specific policy on Service Plans and they would have to look in to putting better policies in place.2. Resident 3's record was reviewed on 9/5/19 at 9:49 a.m. Diagnoses included, but were not limited to, hypertension and metastatic breast cancer. The resident was admitted to the facility on 8/19/19 with hospice services. A Semi-Annual Evaluation, dated 8/19/19, lacked documentation of the resident receiving hospice services. Interview with the DON on 9/5/19 at 10:49 a.m., indicated she had been using the Semi-Annual Evaluation forms as the Service Plan. The Nurse who completed the evaluation should have		and staff had occurred prior to admission but was not documented. Reviewed all other resident medical records and all residents had completed service plans on admission and with a change of condition. Admission checklist and 24- hour chart review (see attached form) with all new admissions has been implemented to ensure accurate documentation. Review on daily rounds for change in condition (see attached change of condition form and CQI tool) and service plan meetings with resident/family to update service plan will be scheduled as needed. This will be a continuous process. Department Manager responsible for oversight of compliance. Education inservice with Nurses for Admission process, Service plans, Preadmission assessment/screening process, 24- hour chart review process, and daily rounds with use of CQI tool process began 9/20/19 with one to one education and department inservice scheduled 9/23/19 and 9/25/19. Admission checklist and 24- hour chart review with all new admissions has been implemented to ensure accurate documentation. Systemic changes will be completed by 10/5/19.	

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	documented the resident received hospice services as the resident was actually admitted to the facility with hospice services. 3. The closed record for Resident 8 was reviewed on 9/5/19 at 1:45 p.m. Diagnoses included, but were not limited to, falls and hip fracture. The resident was admitted on 4/24/19 for therapy following surgery for a fractured hip. The record lacked documentation a Pre-Admission Evaluation had been completed prior to admission. The Admission Checklist, dated 4/24/19, lacked indication the Pre-Admission Evaluation had been completed. Interview with the DON on 9/5/19 at 2:25 p.m., indicated a Pre-Admission Evaluation had not been completed. The facility did not have a policy on completing Pre-Admission Evaluations.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.			

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	(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident and/or their responsible party for 1 of 7 records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 9/5/19 at 9:49 a.m. Diagnoses included, but were not limited to, hypertension and metastatic breast cancer. The resident was admitted to the facility on 8/19/19 with hospice services. A Semi-Annual Evaluation was completed on 8/19/19. There was no signature noted of the resident and or responsible party to indicate the Service Plan had been reviewed and accepted. Interview with the DON on 9/5/19 at 10:49 a.m., indicated she had been using the Semi-Annual Evaluation forms as the Service Plan. The Nurse who completed the evaluation should have had the family or responsible party review and sign the form.	R 0217	**Tag #R217** **#3 resident:** Met with family on 8/29/19 and completed Service plan (had not placed updated service plan in chart prior to survey). (see attached Service plan 8/29/19) Reviewed all other service plans and found all service plans had been signed. Inservice nurses on service plans initiated with one on one education and department inservice scheduled 9/23/19 and 9/25/19. Service plan form updated with signature line for responsible party/family and **"other box"** added to include contracted services such as Hospice or Home Health (see attached updated Service plan) Monitoring will be completed by 24- hour chart review to ensure Service plan completed on admission with responsible party/family signatures. This will be a continuous process.	10/05/2019

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			Department Manager responsible for oversight of compliance. Systemic changes will be completed by 10/5/19.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was carried out as ordered for 1 of 7 residents reviewed. (Resident 2) Finding includes: On 9/5/19 at 10:30 a.m. Resident 2 was observed lying in bed with his eyes closed. The record for Resident 2 was reviewed on 9/5/19 at 10:15 a.m. Diagnoses included, but were not limited to, end of life. The resident was admitted to the facility for a hospice respite stay. A Physician's Order, dated 9/1/19, indicated scopolamine (used to treat secretions) 1 milligram transdermal patch every 72 hours. The Medication Administration Record, dated 9/2019, lacked documentation the patch had been initiated. Interview with the Director of Nursing (DON) on 9/5/19 at 10:43 a.m., indicated the patch had been delivered by hospice but had never been initiated.	R 0241	**Tag #R241** **#2 resident:** Resident passed away day of survey without need for Scopolamine prior to death. Met with Hospice 9/13/19 and discussed Scopolamine order written. Hospice educated on 9/13/19 that PRN orders need to be written as such. Met with nurse on 9/13/19 that took orders off, educated 9/13/19 that orders are to be transcribed as written and are to be followed. Reviewed all records for new orders 9/14/19 and found 1 order not transcribed to MAR. Record was corrected immediately. Educated nurse 9/15/19. Inservice all nurses on accurate received and transcribed orders initiated with one to one education and department inservice scheduled 9/23/19 and 9/25/19. All new orders will be reviewed by night shift nurse with 24-hour chart	10/05/2019

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	She indicated the resident did not currently have any patch on.		review to ensure orders have been transcribed to MAR/TAR. This will be a continuous process. Department Manager responsible for oversight of compliance. Systemic changes will be completed by 10/5/19.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure the resident's clinical record was complete and accurate related to the lack of a Physician's Order for a Foley catheter for 1 of 7 residents reviewed. (Resident 4) Finding includes: On 9/5/19 at 11:09 a.m., Resident 4 was observed lying in bed with her eyes closed. A catheter bag was attached to the side of the bed. The bag had visible urine in it and was touching the floor. On 9/5/19 at 1:12 p.m., the resident was still observed lying in bed. The catheter bag was attached to the side of the bed. The bag had visible urine in it and was still touching the floor. Record review for Resident 4 was completed on	R 0349	**Tag #R349** **#4 resident:** Faxed MD on 9/5/19 for orders for Foley Catheter. Order received on 9/06/19 (see attached copy of order). Reviewed all residents, no Foley catheters. Inservice Nurses on appropriate orders for Foley catheters and that orders are on chart. Inservice nurses and CNAs on proper placement of foley catheter bag on bed frame and that foley catheter bag is covered with dignity bag. One on one education began 9/20 and department inservice scheduled 9/23/19 and 9/25/19. Initiated 24 hr chart review and CQI tool to identify any catheters to ensure orders are on chart. This	10/05/2019

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	9/5/19 at 9:53 a.m. Diagnoses included, but were not limited to, hypertension, arthritis, fractures, and hypothyroidism. Progress notes, dated 8/17/19 - to current date, indicated the resident had a Foley catheter. A Bi-Weekly Summary, dated 8/29/19, indicated the resident had a Foley catheter. The record lacked any documentation a Physician's Order for the catheter had been obtained. Interview with the Director of Nursing (DON) on 9/5/19 at 11:29 a.m., indicated the resident came back from the hospital with a catheter related to her hip fracture. They should have gotten an order from the Physician for the catheter. Staff had been providing care every day for the catheter.		will be a continuous process. Department Manager responsible for oversight of compliance. Systemic changes will be completed by 10/5/19.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.			

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	(6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure a current emergency file was available for review for 2 of 5 residents reviewed. (Residents 3 and 2) Findings include: 1. Resident 3's record was reviewed on 9/5/19 at 9:49 a.m. Diagnoses included, but were not limited to, hypertension and metastatic breast cancer. The Emergency File Binder was reviewed on 9/5/19 at 10:45 a.m. There was no photograph for the resident in the Emergency File. Interview with the Director of Nursing (DON) on 9/5/19 at 2:02 p.m., indicated she had the photograph on her desk in her office and would put it in the file. 2. The record for Resident 2 was reviewed on 9/5/19 at 10:15 a.m. Diagnoses included, but were not limited to, end of life. The resident was admitted to the facility for a hospice respite stay. The Emergency File Binder was reviewed on 9/5/19 at 10:45 a.m. There was no photograph for the resident in the Emergency File. Interview with the Director of Nursing (DON) on 9/5/19 at 2:02 p.m., indicated the file was not complete. The resident had passed away this afternoon.	R 0356	**Tag #356** **#3 resident and #2 resident:** Nursing manager had pictures on her desk. Pictures were immediately placed in emergency file binder on 9/05/19 Reviewed all residents, no missing pictures. Inservice all nurses regarding pictures for emergency file binder began on 9/20 with one on one training and department inservice scheduled 9/23/19 and 9/25/19. A 24-hour chart review form has been initiated. Will monitor all new admissions with 24 hr chart review that pictures are placed in emergency file binder. This will be a continuous process. Department Manager responsible for oversight of compliance. Systemic changes will be completed by 10/5/19.	10/05/2019
R 0406	410 IAC 16.2-5-12(a) Infection Control - Offense			

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Bldg. 00	(a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, record review, and interview the facility failed to ensure an infection control program was maintained related to a resident's catheter bag touching the ground for 1 of 1 residents observed for catheters (Resident 4) Finding includes: On 9/5/19 at 11:09 a.m., Resident 4 was observed lying in bed with her eyes closed. A catheter bag was attached to the side of the bed. The bag had visible urine in it and was touching the floor. On 9/5/19 at 1:12 p.m., the resident was still observed lying in bed. The catheter bag was attached to the side of the bed. The bag had visible urine in it and was still touching the floor. Record review for Resident 4 was completed on 9/5/19 at 9:53 a.m. Diagnoses included, but were not limited to, hypertension, arthritis, fractures, and hypothyroidism. Progress notes, dated 8/17/19 - to current, indicated the resident had a Foley catheter. A Bi-Weekly Summary, dated 8/29/19, indicated the resident had a Foley catheter. Interview with the Director of Nursing (DON) on 9/5/19 at 1:15 p.m., indicated the resident's catheter bag should not touch the ground. A Best Practice titled, "Preventing Catheter	R 0406	Tag #406 #4 resident: Director of Nursing (DON) corrected foley catheter bag touching the floor and had no dignity cover on 9/05/19 when surveyor spoke with DON at 1:15pm. DON repositioned foley catheter bag and placed a dignity cover on foley catheter bag at 1:25pm on 9/05/19 Reviewed all residents, no other residents with foley catheter. Inservice to nurses and cnas **began on 9/20 with one on one education.** Department inservice scheduled 9/23/19 and 9/25/19**.** "Cauti playbook" (provided during survey) and Mosby's skills "Urinary Catheter" (see attached) used as resources for training. Will monitor with daily (CQI tool) to ensure proper placement on bed frame and dignity cover in place. This will be a continuous process. Department Manager responsible for oversight of compliance. Systemic changes will be completed by 10/5/19.	10/05/2019

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	Associated Urinary Tract Infections" and received as current from the facility, indicated, "...Do not place Foley bag on the floor...."			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure there was a complete infection control program which tracked and monitored all infections. This had the potential to affect the 11 residents who resided in the facility. Finding includes: Interview with the Director of Nursing (DON) on 9/5/19 at 2:10 p.m., indicated she did not keep any logs or listings of infections for the facility. They had an in house system that kept track of any cultures or labs and would notify them of infections. For infections that didn't require labs or cultures, she would just remember and keep track of in her head. She did not have any specific tracking or trending system. A facility policy, titled "Infection Control Plan", indicated "...The Infection Control Plan will provide a system of monitoring and controlling	R 0407	**Tag #407** Continue hospital surveillance for infections with cultures. New infection log form created on 9/13/19 (see attached) and put in place for infections for residents (that do not require cultures) Reviewed all residents, no current non-cultured infections. No current infections identified by Infection Control Department for cultured infections. CQI tool used to monitor for non-cultured infections and when identified they will be documented on the Infection Log. If trends identified, will work with Infection control specialist to develop plan. Inservice to nurses and cnas on new Infection Log form beginning with one on one education on 9/20	10/05/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FRANCISCAN HEALTH ALTERNACARE	1104 E GRACE ST RENSSELAER, IN 47978

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	infectious processes that may affect...patients, staff, volunteers and/or visitors..."		and department inservice scheduled 9/23/19 and 9/25/19. Will monitor with daily (CQI tool) to identify non-cultured infections, if present will record on infection log under appropriate category. This will be a continuous process. Department Manager responsible for oversight of compliance. Systemic changes will be completed by 10/5/19.	