STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	07/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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. Survey dates: July 28, 29, 30, and 31, 2015 Facility number: 000563 Provider number: 155766 AIM number: 100267610 Census bed type: SNF/NF: 51 Total: 51 Census payor type: Medicare: 10 Medicaid: 32 Other: 09 Total: 51 These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1.	F 0000		
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician, in a timely manner, regarding the unavailability of a medication for 1 of 5 residents (Resident #62) reviewed for unnecessary medications. Findings include: The clinical record for Resident #62 was reviewed on 7/30/15 at 8:30 a.m.	F 0157	When nurse practitioner visited on 7/29/15 order was changed to B12 injections q 4 weeks then q 2 weeks x 2 doses then q month B12 level in 12 weeks Injections have been started with the dates given 7/30, 8/6, 8/13, 8/20/15. All MAR's from 8/1/15 are being reviewed for any unavailable/not given medications with appropriate actions being taken for any noted issues An administrative staff member will review MAR's for any	08/28/2015

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	Diagnosis included, but was not limited to, anemia. The laboratory test, dated 7/16/15 at 1:50 p.m., indicated Resident #62's iron level was 28 (normal range is 35-180). The physician order, dated 7/17/15 and untimed, included, but was not limited to, the following: "give B12 [sic] [B-12] [medication for low iron] 2000 mcg [micrograms] po [by mouth] QD [every day]...dx [diagnosis] anemia...." The pharmacy document titled, "Non-covered item", indicated the following: "Attn: DON [Director of Nursing] or Administrator...Non-Covered Item: VITAMIN B-12 1000 MCG...Directions: 2T [2 tablets] PO [by mouth] QD [everyday]...THIS ITEM IS NOT COVERED BY THE RESIDENT'S INSURANCE...." The July, 2015 Medication Administration Record (MAR) for the Vitamin B-12, between 7/18/15 - 7/29/15, was initialed by the nurses with a circle around the initials. The MAR also indicated the following on 7/18/15 at 8 a.m.: "[zero with line through it] no B12 [sic] [B-12] Tabs [tablets]. INS [Insurance] will not cover. Will cover inj's [injections]...."		unavailable/not given meds Staff inserviced (see attached) of notifying MD/NP and documenting notification when a medication is unavailable If non-covered form is received this has to be forwarded to Administrative nurse to be addressed The attached QA sheet will be used as the monitoring tool It will be completed 3x's weekly x 4 weeks then 2x's weekly x 4 weeks, then weekly x 4 weeks then biweekly x 3 months Based on results from QA it will be determined at that time, by the QA committee, if QA should continue, can be decreased further or stopped.	

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The clinical record lacked documentation of physician notification regarding non-coverage of the vitamin B-12 tablets.

During an interview on 7/30/15 at 9:15 a.m., LPN #3 indicated if a medication is not given or not available, the nurse will initial and circle their initials.

During an interview on 7/30/15 at 9:20 a.m., LPN #3 indicated she spoke with the nurse practitioner and the medication was never received from pharmacy because Resident #62's insurance would not cover it and the nurse practitioner was going to order the Vitamin B-12 injections. She indicated it was on the physician list to be looked at. She also indicated the physician or nurse practitioner comes in every Monday, Wednesday and Friday.

During an interview on 7/30/15 at 10:00 a.m., the Director of Nursing indicated she could not say whether the physician was notified regarding the unavailability of the Vitamin B-12 medication.

A policy and procedure titled, "Resident Rights - Notification of changes", was provided by medical records on 7/30/15 at 12:54 p.m. This document indicated, but was not limited to the following,

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	"...Procedure: The facility will notify the resident, family, physician and or interested family member should there be any significant changes in condition based on the notification protocol of the facility..." A written statement, provided and signed by the Director of Nursing on 7/30/15 at 2:50 p.m., included the following: "It is the intent of this facility to attempt to obtain all medications as ordered. If a medication is not available for whatever reason ie [sic]: insurance non-coverage, back order from manufacturer, pharmacy do not have stocked at order time, etc. [sic] the facility will advise physician or nurse practitioner and family of the delay in medication with new order. If new order is received, the order will be implemented. If no response is received from physician or nurse practitioner with initial notification [sic] follow will continue until a response is obtained. Documentation will occur with each notification." 3.1-5(a)(2)			

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F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to provide the sanitary handling of food during meal preparation and service for 12 of 51 residents who received their meals from the facility kitchen. (Residents #12, #13, #22, #26, #28, #29, #30, #44, #47, #51, #52, and #59) Findings include: 1. During an interview on 7/28/15 at 9:30 a.m. the Morning Cook #1 indicated that hand washing was to be done for 15-20 seconds when preparing or handling food. On 07/28/15 between 11:55 a.m. and 12:45 p.m., lunch service was observed in the Main Dining Room with 35 residents present. The following was observed: Registered Nurse (RN) #1 was observed to wash her hands for 13 seconds and serve the lunch tray to Resident # 30.	F 0371	#1,2 & 4 - No further action can be done at this time for this occurrence only monitoring from this point forward. #3 Both of these residents are now out of isolation Therefore no further corrective action can be taken There were no adverse effects noted with any residents related to #1,2,3,4 #1 Timers have been purchased (see attached) and will be placed at every sink in facility to ensure hands are being washed the correct amount of time Handwashing in dining room will be monitored by utilizing the attached QA (see attached) This will be completed 2x/day M-F x 4weeks then 2x/day 3 days/week x 4 weeks, then 1xday 3 days/week x 4 weeks then 1 meal/week x 3 months Based on results from QA at the end of this time a decision will be made by QA committee as to whether QA should continue, be decreased further or stopped #2 New ice scoops have been purchased (see attached) with safety caddy that prevent scoop from touching hand and the caddy stores the scoop when not in use Hospitality	08/28/2015

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	Certified Nursing Assistant (CNA) #1 was observed to wash her hands for 9 seconds and serve lunch trays to several unknown residents sitting in the Main Dining Room. Licensed Practical Nurse (LPN) #1 was observed to wash her hands for 6 seconds and serve the lunch tray to Resident # 47. LPN # 2 was observed to wash her hands for 12 seconds and serve the lunch tray to Resident # 12. On 07/29/15 between 11:55 a.m., and 12:25 p.m., the lunch service was observed in the Main Dining Room. The following was observed: CNA # 2 was observed to wash her hands for 15 seconds and serve the lunch tray to Resident # 12. RCNA # 3 (Restorative CNA) was observed to wash her hands for 15 seconds and then serve the lunch tray to Resident # 52. 2. During an observation of the main dining room meal service, on 7/28/15 at 12:00 p.m., Cook #1 was observed to serve drinks to the residents. While scooping the ice, the ice scoop handle		staff member will be observed during the beverage cart service at either lunch or supper for 30 days (see attached QA) #3 Inservice held on 8/18/15 (see attached) reviewing proper procedures when entering/while in/when exiting a contact isolation room as well as proper handwashing procedure When a resident is in isolation with trays being delivered to their room, an administrative nurse will accompany staff to deliver tray to monitor for appropriate procedure by utilizing the attached QA This QA will be completed 2x day at least 5 days/week while resident is in isolation QA committee will determine at April 2016 meeting if QA should continue or can be stopped #4Dietary Manager has conducted 3 inservices: Handwashing, Gloves and Cross Contamination (see attached) A cook will be observed (1 meal a day) during meal service for 30 days to ensure safety measures are met Monitoring will be done monthly after that (see attached QA)	

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	was placed directly back into the ice bucket, directly on the ice. During the observation Cook #1 was not observed to use hand sanitizer, wash her hands, or use gloves during this service. She was observed to serve Resident #51, Resident #59, Resident #44, Resident #13, and Resident #26 in this manner. 3. During initial tour with Registered Nurse (RN) #1 on 7/28/15 at 10:30 a.m., RN #1 indicated Resident #28 and Resident #29 were both in contact precautions for Methicillin-resistant Staphylococcus aureus (MRSA), which is a bacterial infection. During an observation of hallway meal pass, on 7/28/15 at 12:25 p.m., CNA #1 was observed to enter Resident # 28's room with no gloves and touched the resident empty glasses and personal items with her bare hands. CNA #1 was then observed to exit the room without washing her hands. CNA #1 then walked down the hall to a common area and washed her hands for ten seconds. During an observation of hallway meal pass, on 7/29/15 at 12:35 p.m., with Licensed Practical Nurse (LPN) #1. LPN #1 was observed exiting Resident #29's room without washing her hands. LPN #1 then walked to common wash station			

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	in the dining room and washed her hands for three seconds. LPN #1 then delivered a tray to Resident #28's room and did not wash her hands before exiting. LPN #1 then washed her hands in a common area behind the nurses station for ten seconds. LPN #1 then delivered a food tray to Resident #22's room. 4. During an observation on 7/30/15 at 10:20 a.m., the Morning Cook #2 removed fish from the oven wearing pot holders (oven mitts). He was observed to remove pot holders and proceeded to get parchment paper and a larger pan to place the fish in. Cook #2 was not wearing gloves and did not wash his hands. He was observed to place parchment paper inside a deeper pan, using his bare hands and pressed parchment paper down inside the pan, also with bare hands. He was observed to place the fish from the oven directly on top of the parchment paper and placed this pan into the oven. During an interview on 7/30/15 at 2:30 p.m., the Administrator indicated the facility was training a new dietary manager and things were improving in the kitchen. He also indicated staff would follow policy and procedure and wear gloves and observe proper hand washing when handling food.			

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	During an interview on 7/31/15 at 10:50 a.m., with Infection Control Nurse #1 and Infection Control Nurse (ICN) #2, both ICN's indicated that gloves should be worn anytime a staff member enters a room with a resident that has Methicillin-resistant Staphylococcus aureus (MRSA). Both ICN's indicated that before exiting the room the staff member should wash their hands in the resident's room. Both ICN's indicated staff should wash their hands for a minimum of 30 seconds. On 7/30/15 at 12:54 p.m., Medical Records provided a copy of the facility's current policy, titled "Handwashing". The policy indicated, when washing hands, there must be at least 20 seconds of friction. The current policy and procedure, dated August of 2012 and titled, "Contact Precautions", was provided by Medical Records on 7/30/2015 at 12:54 p.m. and reviewed at that time. The policy indicated that gloves should be worn in a residents room that is on contact precautions. The policy also indicated to remove gloves and perform hand hygiene before leaving a room with a resident that is on contact precautions. On 07/31/15 at 11:30 a.m., the Dietary			

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	Manager provided a copy of the kitchen handwashing policy. The policy indicated, but was not limited to, "Keeping hands clean through improved hand hygiene is one of the most important steps we can take to avoid getting sick and spreading germs to others. Many diseases and conditions are spread by not washing hands with soap and clean, running water. If clean, running water is not accessible, as is common in many parts of the world, use soap and available water. If soap and water are unavailable, use an alcohol-based hand sanitizer that contains at least 60% to clean hands." The policy also indicated, but was not limited to, "Wash hands: Before, during, and after preparing foods; Before eating food; Before and after caring for someone who is sick; Before and after treating a cut or wound; After using the toilet; After blowing your nose, coughing, or sneezing; and After touching garbage." The policy also indicated the "right way to wash your hands", included but was not limited to: "Wet your hands with clean, running water (warm or cold) and apply soap. Rub your hands together to make a lather and scrub them well; be sure to scrub the backs of your hands, between your fingers, and under your nails. Continue			

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	rubbing your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. Rinse your hands well under running water. Dry your hands using a clean towel or air dry them." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program			

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	determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure proper handwashing by staff when providing dressing changes for 1 of 2 residents observed for dressing changes (Resident #58) and failed to properly store a soiled bed side commode on the 100 Hallway. 1. During an observation of Licensed Practical Nurse (LPN) #3 while performing a pressure ulcer wound dressing change on 7/30/15 at 10:40 a.m., LPN #3 washed her hands for five seconds before the dressing change and again for 5 seconds, during the pressure ulcer wound dressing change, for Resident #58. During an interview on 7/31/15 at 9:32	F 0441	#1 Inservicing being provided on proper handwashing during wound dressing changes There are no wound infections in facility therefore other than inservicing and monitoring no other corrective actions are needed at this time Inservice held on 8/18/15 (see attached) to include proper handwashing procedures during dressing changes Timers are being placed at each sink in facility and set for 25 seconds to ensure hands are being washed the appropriate length of time The attached QA will be utilized by an administrative nurse to check off each nurse monthly on proper handwashing during dressing changes This QA will be done monthly until QA meeting April 2016, at which time the QA committee will determine if QA needs to continue or can be stopped based on proficiency	08/28/2015

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MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

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	a.m., Licensed Practical Nurse (LPN) #1, indicated the proper hand washing time for the facility is two minutes. During an interview on 7/31/15 at 9:44 a.m., Certified Nursing Assistant (CNA) #1, indicated the proper hand washing time for the facility is 30 seconds. During an interview on 7/31/15 at 10:50 a.m., with Infection Control Nurse #1 and Infection Control Nurse (ICN) #2, both ICN's indicated staff should wash their hands for a minimum of 30 seconds. On 7/30/15 at 12:54 p.m., Medical Records provided a copy of the facility's current policy, titled "Handwashing". The policy indicated, but was not limited to, "when washing hands, there must be at least 20 seconds of friction". 2. During an observation on 7/28/15 between the times of 11:38 a.m. and 2:00 p.m., a bedside commode was observed in the hallway across from Resident #2's room. Inside the bedside commode were four dark brown streaks running across the bottom of the commode and an empty candy bar wrapper. During an interview with the Infection Control Nurse (ICN) #1 on 7/28/15 at 2:02 p.m., the ICN #1 indicated the		shown during this time #2 Commode was removed, cleaned and placed in storage on 7/28/15 There are no other bedside commodes sitting in hallway Bedside commodes will remain in rooms until housekeeping cleans and removes from room to place in storage An Administrative staff member will check hallways to ensure no bedside commodes are in hallway by utilizing the attached QA This QA will be completed 4x's weekly x 4weeks then 3x's weekly x 4 weeks then 2x's weekly x 4 weeks then weekly x 3 months Based on results from QA at the end of this time a decision will be made by QA committee as to whether QA should continue, can be decreased further or stopped	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	07/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	policy for the facility is to bring a soiled bedside commode directly to the soiled utility room and not to leave it in the hallway. ICN #1 also indicated she had seen both the dark brown streaks and empty candy bar wrapper in the bedside commode. During an interview on 7/28/15 at 2:09 p.m., CNA #1, indicated she had seen the bedside commode in the hallway the previous day. During an interview on 7/28/15 at 5:15 p.m., Resident #2's family member indicated the bedside commode had been in the hallway for over a week, and it was from Resident #2's room. 3.1-18(l)			