This visit was for a Post Survey Revisit to the Recertification and State Licensure survey completed on 12/3/18.

This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00280522 completed on 12/3/18.

This visit was in conjunction with the Investigation of Complaint IN00283773.

Complaint IN00280522 - Corrected.

Survey dates: January 10, 2019.

Facility number: 000129
Provider number: 155224
AIM number: 100266780

Census Bed Type:
SNF/NF: 112
Total: 112

Census Payor Type:
Medicare: 3
Medicaid: 98
Other: 11
Total: 112

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on January 10, 2019.

The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.
Bldg. 00

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Based on observation, interview, and record review, the facility failed to ensure medications were not stored or used up to 28 days past the open dates of the vials in 2 medication rooms. (Second floor Medication Room, First floor Medication Room)

Findings include:

On 1/10/19 at 8:55 a.m., in the second floor medication room, a vial of influenza vaccine was observed to have an opened date of 12/6/18. RN 2
indicated she was unsure of how long the vaccine was good for and would have to find out.

On 1/10/19 at 11:47 a.m., the first floor medication was observed to have a vial of Tubersol with an opened date of 12/4/18. RN 1 indicated she would tell the nurse manager to have destroyed.

On 1/10/19 at 11:56 a.m., the audits were reviewed for expired medications. The audits for the second floor medication refrigerator was marked as no expired medications for 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10/19, signed by a nurse. The audits for the first floor medication refrigerator was marked as no expired medications for 1/4, 1/7, 1/8, 1/9, and 1/10/19, with no marks for 1/5 and 1/6/19.

On 1/10/19 at 2:28 p.m., the Director of Nursing indicated the night shift nurses had completed the audits for the refrigerator and expired medications.

On 1/10/19 at 2:30 p.m., the RN Consultant indicated she believed the influenza vaccine was good for 30 days.

On 1/10/19 at 3:15 p.m., the World Health Organization recommended that opened vials of influenza vaccinations was to be kept up to a maximum of 28 days.

On 1/10/19 at 4:40 p.m., the Administrator provided the current facility policy, Disposal/Destruction of Expired or Discontinued Medications, revised date 1/1/13. The Policy indicated, but was not limited to, the "facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction".
This deficiency was cited on 12/3/18. The facility failed to implement a systemic plan of correction to prevent recurrence.

3.1-25(j)

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?
· The DNS/designee will be responsible for the completion of a Medication Storage QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.

Date of Compliance 01/27/2019

F880 Infection Prevention
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<td>155224</td>
<td>the development and transmission of communicable diseases and infections.</td>
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<td>§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:</td>
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<td>§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;</td>
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<td>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident</td>
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(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, record review, and interview, the facility failed to ensure proper hand hygiene and glove use during care for 1 of 5 residents observed for care and treatments. Staff failed to perform hand hygiene prior to donning gloves, when removing and donning new gloves, and after touching the resident or resident's environment. (Resident A)

Findings include:

During an observation on 1/10/19 at 11:10 a.m. the following was observed:

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| F 0880 | F | 880 | Infection Prevention and Control | 01/27/2019 | 9PRR12 | 000129 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

· Proper infection control practice regarding hand hygiene and glove use during care for Resident A.

· Staff involved were re-in-serviced by January 25th regarding proper infection control practice regarding handwashing.
RN 1 entered Resident A's room. CNA 1 was already in the room. RN 1 placed wound supplies on the bedside table and donned gloves without performing hand hygiene. CNA 1 left the room. RN 1 removed her gloves and left the room to obtain additional supplies.

RN 1 reentered Resident A's room and donned gloves without performing hand hygiene.

CNA 1 reentered the room with gloved hands. She approached Resident A in her wheelchair and held her catheter bag. She assisted Resident A from her wheelchair to her bed, and handed Resident A the bed remote with her gloved hand. She hung the catheter bag on the bed. RN 1 removed her gloves and left the room. She did not perform hand hygiene.

The Physical Therapist entered the room. CNA 1 assisted Resident A to her left side, and adjusted the draw sheet. CNA 1 pulled down Resident A's brief.

The Physical Therapist donned gloves without performing hand hygiene.

CNA 1 removed her gloves and performed hand hygiene.

RN 1 rolled the bedside table to the bedside with her gloved hands.

RN 1 removed her gloves and donned new gloves without performing hand hygiene.

RN 1 peeled off Resident A's dressing from the coccyx area and tossed it into a trash bin. She sprayed normal saline onto the wound and wiped it with a gauze pad.

The Physical Therapist measured the wound. RN 1 applied Santyl (a wound treatment) to the open wound, opened packages of foam dressings with her same gloved hands, and applied the foam dressing to the open area.

The Physical Therapist walked to the other side of Resident A's bed and assisted in holding Resident A's body over to her left side.

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<tr>
<td>RN 1</td>
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<tr>
<td>CNA 1</td>
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- A re-inservice was conducted by the DNS/designee to all licensed nursing staff regarding hand hygiene and donning of gloves while wound care.

- An in-service was conducted by the DNS/designee to all therapy staff regarding hand hygiene and donning of gloves.

**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**

- All residents that require assistance with personal care have the potential to be affected by the alleged deficient practice.

- All residents that require wound care have the potential to be affected by the alleged deficient practice.

- On January 24th and 25th, skills validations for proper hand hygiene and donning gloves was completed by DNS/designee for all nursing and therapy staff.

- RN1, C.N.A.1 and the Physical Therapist have received one on one re-education and will receive weekly skills validation weekly for four weeks.

**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**

- RN1, C.N.A.1 and the Physical Therapist have received one on one re-education and will receive weekly skills validation weekly for four weeks.
The Physical Therapist was still wearing her same gloves. RN 1 removed her gloves and left the room without performing hand hygiene. CNA 1 and the Physical Therapist were observed to remove gloves and perform hand hygiene prior to exiting the room.

During an interview with RN 1 on 1/10/19 at 2:29 p.m., she indicated staff should perform hand hygiene upon entering a room, before procedures, before donning and after removing gloves, and prior to exiting a resident room.

During a review of the current policy, "Hand Hygiene," revised 2/2010, provided by the Administrator on 1/10/19 at 4:12 p.m., it indicated, "...Five moments for Hand Hygiene before touching, before clean/Aseptic procedure, after body fluid exposure risk, after touching a patient, after touching patient surroundings."

This Federal tag relates to Complaint IN00283773.

This deficiency was cited on 12/3/18. The facility failed to implement a systemic plan of correction to prevent recurrence.

3.1-18(b)(1)
3.1-18(l)

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<td>· An in-service will be completed by DNS/designee for all staff to include regarding proper infection control practice of handwashing and gloving.</td>
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<tr>
<td>· On January 24th and 25th Skills validations for proper hand hygiene and donning gloves was completed by DNS/designee for all nursing staff.</td>
</tr>
<tr>
<td>· Observational rounds will be completed twice daily by DNS/designee to ensure that proper infection control practice regarding handwashing and gloving are followed by staff during personal and wound care.</td>
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**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**

- The DNS/designee will be responsible for the completion of Infection Control QA Tool and skills validation for glucometer disinfection weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible
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<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
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<th>X3) DATE SURVEY COMPLETED</th>
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**NAME OF PROVIDER OR SUPPLIER**

COLUMBIA HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

621 W COLUMBIA ST
EVANSVILLE, IN 47710

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<td>employee. Date of Compliance 01/27/2019</td>
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<td>This was cleared at the time of the revisit.</td>
<td>01/10/2019</td>
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