STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155126	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRINGS VALLEY MEADOWS	**457 S SR 145 FRENCH LICK, IN 47432**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications. A laxative ordered once a day was given to a resident without constipation twice in one day, resulting in loose stools for 1 of 4 resident reviewed for unnecessary medications. (Resident 70) Finding includes: During an interview on 3/4/20 at 10:41 A.M., Resident 70 indicated he had had very loose stools for the last 5 days, had told staff, and staff did not seem concerned. On 3/9/20 at 9:30 A.M., Resident 70's clinical record was reviewed. The most recent MDS (Minimal Data Set) Assessment (admission), dated 2/18/20, indicated a moderate cognitive impairment, required extensive assistance of 2 for toileting, transfers, and bed mobility, was occasionally incontinent of bladder, frequently incontinent of bowel, and [DIAGNOSES REDACTED]. An ADL (activities of daily living) care plan, dated 2/11/20, indicated Resident 70 required assistance with ADLs including toileting. A cognitive loss care plan, dated 2/18/20, indicated Resident 70 had short and long term memory deficit with impaired decision making ability. Interventions included, but were not limited to, give resident cues and repeat directions as needed. Orders included, but were not limited to, the following: [MEDICATION NAME] suppository 10 mg (milligrams) once a day as needed for constipation, dated 2/11/20. [MEDICATION NAME] powder 17 gm (grams) once a day as needed for constipation, dated 2/11/20. Resident 70's orders lacked an order related to treatment of [REDACTED]. Resident 70's output sheet indicated the following bowel movements from 2/29/20 - 3/9/20: 2/29/20 9:47 A.M. large 2/29/20 10:07 A.M. large 2/29/20 8:28 P.M. medium 3/1/20 11:38 P.M. medium 3/2/20 5:02 P.M. large 3/2/20 11:41 P.M. medium 3/3/20 9:58 A.M. large 3/4/20 1:59 A.M. medium 3/4/20 2:01 A.M. medium 3/4/20 11:03 A.M. large 3/4/20 10:13 P.M. medium 3/5/20 9:11 A.M. large 3/5/20 9:45 A.M. large 3/5/20 8:35 P.M. large 3/5/20 10:03 P.M. large 3/6/20 8:07 P.M. large 3/7/20 10:01 A.M. medium 3/7/20 2:01 P.M. large 3/8/20 10:01 A.M. medium 3/8/20 3:56 P.M. medium 3/9/20 9:33 A.M. large Resident 70's MAR (medication administration record) for March 2020 indicated a [MEDICATION NAME] suppository was administered on 3/8/20 at 11:11 A.M., with a comment it was charted late. Resident 70's February and March 2020 progress notes lacked documentation of any loose stools. During an interview on 3/9/20 at 10:45 A.M., CNA 3 indicated Resident 70 did have a loose stool this morning, and was documented in the chart as large, but staff did not document consistency. She indicated if staff were to notice a trend, the nurse would be notified. She further indicated she had not been there the last few days, so there was no way for her to notice a trend. During an interview on 3/9/20 at 11:06 A.M., LPN 1 indicated a trend of loose stool had not been noticed for Resident 70, and if it had, staff would have opened an event in the clinical record, and called the physician. LPN 1 indicated Resident 70 eats prunes and sugar free candy which could lead to loose stool, but that morning was the first she had heard of any loose stool, and did not have any knowledge of loose stools in the last few days. During an interview on 3/9/20 at 11:40 A.M., LPN 1 indicated the nurse that worked the previous night had failed to document or inform her of a [MEDICATION NAME] suppository that was given to Resident 70 at about 4:00 P.M. on 3/8/20, and staff was now watching and tracking Resident 70's bowel movements. During an interview on 3/9/20 at 12:06 P.M., the DON (Director of Nursing) indicated Resident 70 had told the nurse on 3/8/20 he didn't think he had had a bowel movement for a few days, so the nurse did a bowel assessment, and because the resident was complaining of constipation, administered a laxative. The DON further indicated the facility did not have a protocol for administration of as needed laxative suppositories, and administered to residents based on nursing judgement. On 3/11/20 at 1:00 P.M., a current Medication Pass Procedure form was provided, revised 12/2016, and indicated . Medication administration will be recorded on the MAR/EMAR or TAR after given . 3.1-48(a)(3) 3.1-48(a)(4)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained for 2 of 5 Residents observed for incontinence care. (Resident 51, Resident 22) Findings Include: 1. On 3/9/20 at 12:00 P.M., incontinence care was observed for Resident 51. Upon entering the resident's room, CNA 4 completed hand hygiene for 35 seconds and CNA 5 completed hand hygiene for 22 seconds and both donned gloves. CNA 4 then removed gloves and left the room to obtain wipes for incontinence care. Hand hygiene was not performed when leaving room. CNA 4 returned and completed hand hygiene for 25 seconds. CNA 5 removed the blanket from Resident 51 and pulled Resident 51's pants and brief down, tucking the brief under Resident 51. CNA 5 then wiped Resident 51's peri area and inner thighs using a disposable wipe. CNA 4 donned gloves, hand hygiene was not performed prior to applying gloves and applied barrier cream to Resident 51's peri area and inner thighs. CNA 5 rolled Resident 51 to her left side and removed the brief. CNA 5 wiped Resident 51's buttocks with a new disposable wipe and barrier cream was then applied by CNA 4. At that time, CNA 4 and CNA 5 removed their gloves. Hand hygiene was not performed and new gloves were not applied. A clean brief was positioned under Resident 51 per CNA 4 and Resident 51 was rolled to her back. CNA 4 then secured the brief. CNA 5 pulled up Resident 51's pants and Resident 51 was sat up onto the side of the bed. CNA 4 applied a gait belt to Resident 51 and CNA 4 and CNA 5 assisted Resident 51 into a wheelchair. CNA 4 removed the gait belt and CNA 5 obtained a comb from the dresser drawer. CNA 5 combed Resident 51's hair and returned the comb to the drawer. CNA 4 bagged up the trash containing the soiled brief and sat it on the bedside table while placing a new liner inside the trash can. CNA 4 then made Resident 51's bed. Resident 51 was pushed in the wheelchair to the doorway where CNA 5 utilized hand sanitizer. CNA 4 retrieved the bag of trash from the bedside table and utilized hand sanitizer at the doorway before exiting. The table top was not sanitized after the bag of soiled items was removed from the room. On 3/9/20 at 10:10 A.M. Resident 51's clinical record was reviewed, including the most recent Annual MDS (Minimum Data Set), dated 1/22/20. [DIAGNOSES REDACTED]. Resident 51 was identified with severely impaired cognition and required extensive assistance for bed mobility, transfers, and toileting. During an interview on 3/11/20 at 10:00 A.M., CNA 2 indicated that gloves should be changed and hands sanitized between dirty and clean tasks while performing care and that gloves should always be worn for the entire task of incontinence care. On 3/11/20 at 10:08 A.M., CNA 3 indicated that gloves are always to be worn when providing direct resident care and that gloves should be changed and hand hygiene performed between clean and dirty tasks. 2. On 3/9/20 at 10:50 A.M., CNA 3 was observed to perform pericare for Resident 22. After assisting to change Resident 22's brief, CNA 3 removed her gloves, gathered the garbage bag from the can, tied the bag, took it to the soiled linen room, then walked to the sink by the common area on the North Hall and washed her hands for 5 seconds. During an interview on 3/11/20 at 10:45 A.M., CNA 2 indicated that when performing hand hygiene, hands should be washed for a minimum of 20 seconds. On 3/11/20 at 10:35 A.M., a policy dated 3/2018 and titled Hand Hygiene Policy was provided and reviewed. The policy stated that handwashing is indicated after contact with bodily fluids or excretions and hand rubbing is indicated .when moving from a contaminated body site to a clean body site during resident care and after removing glove On 3/11/20 at 10:35 A.M. a policy dated 3/2012 and titled Gloves was reviewed. The policy states that after gloves have been removed and disposed of, one must wash hands. On 3/11/20 at 11:00 A.M. a policy dated 3/2012 and titled Perineal Care was reviewed. The

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) policy indicated that after perineal care had been completed one must remove gloves then wash hands On 3/11/20 at 10:40 A.M. the policy dated 3/2018 and titled Hand Hygiene Policy was reviewed. The policy indicated that the duration of the handwashing procedure should be 40-60 seconds 3.1-18(b) 3.1-18(l)