

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/23/2014
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: December 22 and 23, 2014</p> <p>Facility number: 012940 Provider number: 012940 AIM number: N/A</p> <p>Survey team: Julie Ferguson, RN, TC Caitlyn Doyle, RN Heather Hite, RN Jennifer Redlin, RN (12/23/14)</p> <p>Census bed type: Residential: 25 Total: 25</p> <p>Census payor type: Other: 25 Total: 25</p> <p>Residential Sample: 9</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on December 28, 2014, by Janelyn Kulik, RN.</p>	R000000		
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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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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to conduct the required number of fire drills in 2014. This had the potential to affect the 25 residents who reside in the facility.</p> <p>Finding includes:</p> <p>The Fire Drill Log book was reviewed on 12/22/14 at 1:30 p.m. Records indicated fire drills were conducted on the following dates:</p>	R000092	No residents were negatively affected by this delinquent practice, although potential for harm did exist. · Director and Maintenance Coordinator re-educated on need for the prescribed number of fire drills each year. · Fire drill schedule will be discussed and planned for up-coming quarter, with Director and Maintenance Coordinator, at quarterly Safety Meetings. · Fire drills to be held monthly on rotating shifts and records kept in Survey Manual · Divisional	01/09/2015			

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R000216	<p>1/27/14 - 4:00 p.m. 2/15/14 - 4:15 a.m. 3/18/14 - 8:20 a.m. 4/9/14 - 3:40 p.m. 5/10/14 - 4:30 a.m. 7/31/14 - 1:05 p.m. 8/24/14 - 6:10 p.m. 9/16/14 - 6:13 a.m. 10/31/14 - 2:53 p.m. 11/25/14 - 7:32 p.m. 12/15/14 4:29 a.m.</p> <p>The record lacked documentation indicating a fire drill was conducted in June 2014.</p> <p>Interview with the Executive Director (ED) on 12/22/14 at 2:00 p.m., indicated she did not find documentation of a June 2014 fire drill in the log book, however she would check with the Maintenance Director.</p> <p>Follow up interview with the ED on 12/23/14 at 11:10 a.m., indicated no record was found to indicate a fire drill was conducted in June 2014.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance</p>		Director of Operations will review of Drill Records at least twice a year for compliance. Date of compliance 01.09.15 and on-going				

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	<p>(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to record the residents weight upon admission for 1 of 7 residents records reviewed. (Resident #4)</p> <p>Finding includes:</p> <p>Resident #4's record was reviewed on 12/22/14 at 10:00 a.m. The resident was admitted on 04/30/14 and diagnoses include, but were not limited to, dementia, Diabetes Mellitus and hypertension (high blood pressure).</p> <p>There was lack of documentation in the record to indicate the resident 's weight had been obtained upon admission.</p> <p>Interview with the RN (Registered Nurse) Coordinator on 12/23/14 at 10:55 a.m., indicated a lack of documentation for the resident's weight upon admission to the</p>	R000216	No residents were negatively affected by this delinquent practice. Additional review of thinned chart was conducted for Resident #4. Weight record on admission was located and added to the current records. An audit was conducted of all active records on 12/23/14 and 12/24/14. All admission weight records were present. RNC and all Licensed nursing staff were re-educated on need for weight measurement to be done on day of move in. Admission weight to be recorded on initial Nursing Assessment form, as well as, monthly Vitals Record. Nursing Assessment form has been revised since the admission of Resident #4 to include this parameter. RNC to audit records of each resident within one week of move-in to ensure a complete record is in place. Vitals/weights record to re reviewed by the Divisional twice a year for	01/09/2015

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R000241	<p>facility. She indicated the resident should have been weighed.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure Physician's orders were followed as written for blood pressures and blood sugars outside the ordered parameters for 1 of 7 records reviewed. (Resident #4)</p> <p>Finding includes:</p> <p>The record for Resident #4 was reviewed on 12/22/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia, Diabetes Mellitus and hypertension (high blood pressure).</p> <p>Review of the resident's Physician Orders for November and December 2014 indicated midodrine (a medication for blood pressure) 5 mg (Milligrams), give one tablet by mouth three times daily with meals.</p>	R000241	<p>compliance. Date of compliance 01.09.15</p> <p>No residents were negatively affected by this delinquent practice, although potential harm did exist. Physician for Resident #4 was contacted and parameters for Blood Sugar and Blood Pressure were reviewed. Current parameters remain in place. All resident records will be reviewed by the RNC to ensure medications with parameters for follow up are triggered/flagged in electronic medication record. RNC and Licensed nursing staff re-educated on the importance of follow-through with the identified medications. Communication confirmation with physician to be maintained as part of medical record, either through fax communication or phone with documentation in care notes. RNC to audit administration and follow up on weekly medication in care notes. Review of weekly audits by Divisional with</p>	01/09/2015			

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	<p>Take BP (Blood Pressure) before meals and before bed. Call Dr. with systolic (top number of blood pressure reading) was greater than 170 or less than 100.</p> <p>The November and December's blood pressure's recorded indicated the following: 11/24/14 at 8:00 p.m.-176/80; 11/29/14 at 8:44 a.m.- 178/88; 12/13/14 at 8:58 a.m.-176/88; 12/13/14 at 8:58 a.m.-176/88; 12/14/14 at 8:53 a.m. -176/86 and 12/23/14 at 7:46 a.m. -176/78.</p> <p>There was lack of documentation in the record to indicate the Physician had been notified of the blood pressures outside of the parameters ordered.</p> <p>Interview with the RN (Registered Nurse) Coordinator, on 12/23/14 at 11:30 a.m., indicated the November's and December's blood pressures were outside the ordered parameters and the Physician should have been notified.</p> <p>Review of the resident's Physician Orders for November and December 2014 indicated blood sugar test three times a day before meals and to call MD with blood sugars less than 60 or greater than 300.</p>		<p>medication room audit twice a year. Date of compliance 01.09.15</p>				

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R000273	<p>The November and December's MAR (Medication Administration Record) sheet indicated the following blood sugar readings at 5:00 p.m.: 11/6/14-53; 11/12/14-48; 11/20/14-53; 11/22/14-36; 12/1/14-326 and 12/10/14-50.</p> <p>There was lack of documentation in the record to indicate the Physician had been notified of the blood sugars outside of the parameter ordered.</p> <p>Interview with the RN Coordinator, on 12/23/14 at 10:55 a.m., indicated the November's and December's blood sugars were outside the ordered parameters and the Physician should have been notified.</p> <p>At the time of the exit conference on 12/23/14 at 1:40 p.m., the Divisional Director of Resident Services confirmed there was not a policy for following Physician's Orders.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas</p>						

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	<p>(excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to establish and maintain infection control practice for 1 of 2 dining rooms observed. This had the potential to affect 10 of the 11 residents in the Mary B dining room. (Mary B Dining room)</p> <p>Finding includes:</p> <p>The following was observed on 12/22/14 from 11:55 a.m. until 12:37 p.m. in the Mary B Dining Room:</p> <p>At 12:10 p.m., CNA #1 was observed to have pushed a three tiered cart down the hallway from the kitchen, through a door into the Mary B Unit and into the Mary B dining room. Salads, to which 10 residents were served and consumed, were located on the second tier of the cart uncovered.</p> <p>CNA #2 was observed to serve the salads from the second tier of the cart to 10 residents. At this time, CNA #2 was interviewed and indicated it was normal practice to receive food from the kitchen uncovered on this cart.</p> <p>Interview with the RN Coordinator</p>	R000273	<p>No residents were negatively affected by this delinquent practice, although potential harm did exist. Kitchen staff re-educated on proper procedures for food leaving the kitchen area. Dining service, for both dining rooms, to be audited at least monthly by Director to assure the deficient practice does not reoccur. Dining service, for both dining rooms, to be audited by Divisional twice a year. Date of compliance 01.09.15</p>	01/09/2015

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R000410	<p>(RNC) on 12/22/14 at 12:45 p.m., indicated all food should be covered when leaving the kitchen. She also indicated the facility lacked a policy on dining services.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure a resident had a documented two step Mantoux (test for tuberculosis) completed upon admission into the facility for 1 of 7 residents reviewed for Mantoux's in a total sample of 7. (Resident #2)</p>	R000410	No resident was negatively affected by this delinquent practice. Resident #4 was restarted on the TB 2 step process. 1st step was administered 12/23/14 and read 12/26/14 with negative results. 2nd step was administered 1/13/15 and read 1/16/15 with	01/09/2015

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	<p>Finding includes:</p> <p>Resident #2's record was reviewed on 12/22/14 at 10:35 a.m. The resident's diagnoses included, but were not limited to dementia and coronary artery disease.</p> <p>The resident was admitted to the facility on 11/16/14.</p> <p>The resident had a Mantoux administered on 11/12/14 and read on 11/14/14 prior to admission to the facility.</p> <p>There was a lack of documentation to indicate the resident had a second step Mantoux completed one to three weeks after the first step.</p> <p>During an interview on 12/22/14 at 11:20 a.m., the RN Coordinator (RN-C) indicated the second step Mantoux had not been completed.</p>		<p>negative results. 100% audit was conducted 12/24/14 on all active residents. Any resident affected by this deficient practice has completed an new 2 step TB process with negative readings. · RNC was re-educated on the requirement to follow up on admission TB screening. · Mantoux testing to be scheduled into resident profile in electronic medication record upon admission. · RNC to audit records of each resident within one week of admission to ensure a complete record is in place. · TB screening to be audited by Divisional twice a year. Date of compliance 01.09.15</p>				