

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155361	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investgation of Complaint number IN00150251</p> <p>Survey dates: June 3, 4, 5, 6, and 9, 2014</p> <p>Facility number: 000252 Provider number: 155361 Aim number: 100267780</p> <p>Survey team: Sylvia Scales RN TC Terri Walters RN Dorothy Watts RN 6/3, 6/4, 6/5, 6/9, 2014 Amy Winiger RN</p> <p>Census bed type: SNF:24 SNF/NF:34 Total:58</p> <p>Census payor type: Medicare: 12 Medicaid: 31 Other: 15 Total:58</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 6-9-2014 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 6-30-2014 We respectfully request a desk review for compliance.</p>	
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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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F000323 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 13, 2104 by Jodi Meyer, RN</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, and record review, the facility failed to ensure effective safety interventions and/or supervision were provided, in that, effective interventions were not implemented for a resident identified as having impairment that affected safety and judgment, and/or difficulty understanding and following directions and the resident experienced 4 falls for 1 of 3 residents who met the criteria for review of falls. (Resident A)</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 06/10/14 at 10:30 A.M.</p>	F000323	<p>F 323</p> <p>Resident A suffered no ill effects from the alleged deficiency.</p> <p>Completion Date 6-30-2014</p> <p>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>	06/30/2014

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	<p>Resident A was admitted to the facility on 4/4/14. The clinical record indicated the diagnoses for Resident A included, but were not limited to, total left knee replacement, diabetes type 2, depression and muscle weakness.</p> <p>The Fall Circumstance and Assessment included in the chart indicated Resident A fell on the following days:</p> <p>Fall # 1 occurred on 4/10/14 at 1515 (3:15 P.M.). Resident A fell while transferring self to the toilet. The note included Resident A's statement, "I turned it (alarm) off."</p> <p>Fall #2 occurred on 4/12/14 at 0645 (6:45 A.M.). Resident A fell while transferring to the bathroom. Resident A turned the alarm off.</p> <p>Fall #3 occurred on 4/12/14 at 2100 (9:00 P.M.). Resident A fell in room returning from the bathroom. Alarm was not turned on. The note included Resident A's statement, "I thought I could get up."</p> <p>Fall #4 occurred on 4/19/14 at 2350 (11:50 A.M.). Resident A was in her room and rolled out of bed. Injuries to her left wrist and left hand were noted.</p> <p>A Nurse's note dated 4/10/14 at 1515</p>		<p>assistance devices to prevent accidents. All residents who have fallen with in the last 30 days have been reviewed for appropriate interventions</p> <p>Completion Date 6-30-2014</p> <p>Nursing staff have been in serviced concerning fall interventions. Systemic change is campus will review entire medical record post fall to assure intervention effective.</p> <p>Completion Date 6-30-2014</p> <p>DHS /designee will monitor 3 random resident at risk for falls to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments</p> <p>Completion Date 6-30-2014</p>				

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	<p>(3:15 A.M.) read as follows: "Res(Resident) found on floor by staff...Staff states Res yelled out et (and) was found on floor. 0 (no) alarm sounded. Alarm was turned off. Res states 'I turned it off!' This nurse educated res on the importance of asking for assistance." A Nurse's note dated 4/12/14 at 0745 (7:45 A.M.) read as follows: "Res found on floor by staff. Res was trying to toilet self c (without) assistance. Call light not on, Res states she turned off alarm...Re-educated res on importance of alarm and waiting for help..." A Nurse's note dated 4/12/14 at 2100 (9:00 P.M.) read as follows: "Res found sitting on floor next to bed per this nurse. states she went to BR (bathroom) et (and) sat in floor....Res did not turn on call light et ask for assist. Alarm box turned off. Res denies turning box off although it was turned on previously...Alarm box placed under bed out of reach Res reminded to utilize call light et ask for assist..." Nurse's note dated 4/20/14 at 2430 (11:30 P.M.) read as follows: "Resident rolled out of bed. She landed on her bottom..." A Physician's Order dated 4/4/14, read as</p>			

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	<p>follows: "Percocet 5/325mg 1 po (by mouth) q (every) 4 hrs (hours) PRN (as needed) severe pain... Tramadol 50 mg 1(tablet) po q 6 hrs PRN for mild pain 1-5...Tramadol 50 mg 2 (tablets) po q 6 hrs PRN for mod (moderate) pain PRN pain...Alarm to bed and chair. check placement and func (function) q shift..."</p> <p>A Physician's Order dated 4/15/14 at 1400 read as follows: "1) Decrease Percocet 5/325mg to T.I.D.(3 times a day) PRN (as needed) Pain 2) Tramadol 50 mg T.I.D. PRN pain..."</p> <p>The Pain Medication Tracking form for the month of April 2014 indicated on 4/10/14 Resident A received the following medications: One tablet of Percocet 5/325 mg at 12:30 A.M., 6:10 A.M., 1:00 P.M. Two tablets of Tramadol 50 mg at 3:45 A.M., 10:00 A.M., 4:00 P.M.</p> <p>4/12/14 Resident A received the following medications: One tablet of Percocet 5/325 mg at 2:00 A.M., 6:30 A.M., 4:00 P.M. Two tablets of Tramadol 50 mg at 7:30 A.M., 11:15 P. M., 4:00 P.M.</p> <p>4/19/14 Resident A received the following medications: One tablet of Percocet 5/325/ mg at 8:00</p>			

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	<p>A.M., 11:15 P.M.</p> <p>The facility's guidelines for pain assessment were as follows: "1-2 mild pain, 3-5 moderate pain, 6-8 severe, 9-10 excruciating"</p> <p>The Nursing 2014 Drug Handbook 34th edition page1384 indicated, "Tramadol...ADVERSE REACTION...CNS:... dizziness, confusion,coordination disturbance...page 1045...Percocet...ADVERSE REACTION...CNS (central nervous system):..lethargy, mental impairment, confusion, agitation, dizziness..."</p> <p>Admission MDS (Minimum Data Set Assessment) dated 4/11/14 indicated Resident A had a BIMS (Brief Interview for Mental Status) score of 15 which indicated Resident A experienced no cognitive impairment. Resident A needed the assistance of 1 person with walking, transferring and toileting. Balance during transfer and walking was not steady and resident was only able to stabilize with human assistance.</p> <p>MDS 30 day assessment dated 5/2/14 indicated Resident A had a BIMS score of 9 which indicated a moderate cognitive impairment.</p> <p>A Care Plan for falls dated 04/5/14 read</p>			

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	<p>as follows: "...Interventions...Monitor for side effects of any drug that can cause gait disturbance, weakness, sedation, change in mental status...Provide resident/family teaching to include: Safety measures to reduce fall risk... 4/10/14 Educate to call for assistance. 4-12-14 (1st fall on 4/12/14 at 6:45 A.M.) Awaken at 6 am and offer toilet. 4/12/14 (2nd fall on 4/12/14 at 9:00 P.M.)- place alarm box under bed in mesh bag and out of residents reach. 4/15/14 MD reviewed medication regimen feels pain medication maybe causing falls. Medication decreased. 4/20/14 Bed in lowest position. 4/21/14 Define perimeter mattress medication review, pain medications decreased."</p> <p>PT - Therapist Progress notes (summation of the last 5 skilled treatments) dated 4/18/14 were reviewed on 6/9/14 at 3:28 P.M. and read as follows: "Analysis of Functional Outcome/Clinical Impression...frequently rates pain as 8 or 9 out of 10. Pt (patient) continues to be somewhat confused, very agitated...Impact on Burden of Care/Daily Life Complicating factors, including pt's varying cognitive status prevent the patient from achieving all established goals. Precautions Fall risk."</p>			

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	<p>During an interview on 6/9/14 at 3:28 P.M., PTA #1 (Physical Therapy Assistant) indicated Resident A started physical therapy on 4/7/14. PTA #1 further indicated Resident A's therapy progress was slow at first due to the cognitive impairment Resident A experienced as a result of her pain medication, but after the week of 4/18/14 her therapy progression started improving.</p> <p>On 6/9/14 at 2:30 P.M., the DON (Director of Nursing) provided the "Falls Management Program Guidelines" policy. The policy indicated, "...Implement preventive measures...PROCEDURE...3. Should the resident experience a fall the attending nurse shall...identify possible contributing factors, interventions to reduce risk of repeat episode..."</p> <p>During an interview with the DON on 6/9/14 at 4:00 P.M., the DON indicated no documentation could be provided to indicate effective interventions were implemented after the fall on 4/10/14 and the 2 subsequent falls on 4/12/14 to ensure the safety of Resident A. The DON further indicated Resident A's Physician decreased Resident A's pain medication on 4/15/14.</p>			

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F000371 SS=F	<p>3.1-45(a)(2)</p> <p>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 ensure floors in the dietary department were free of soilage, kitchen equipment and supplies were clean, and dietary staff had hair and beards completely contained to prevent contact of exposed food for 3 of 3 dietary tours. This had the potential to affect 57 of 58 residents, who resided in the facility.</p>	F000371	<p>F 371</p> <p>Residents 57 out of 58 suffered no ill effects</p> <p>from the alleged deficiency.</p> <p>Completion Date 6-30-2014</p> <p>All other residents are at risk to be</p>	06/30/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> On 6/3/14 at 9:35 A.M., the dry storage area of the kitchen was toured with the Food Service Manager (FSM). The floor of the pantry area had areas of missing 12 x 12 vinyl floor tiles and/or pieces of missing tiles with soil noted in tile crevices and exposed flooring. The food storage area 7 plastic drawer containers were observed to contain food condiments. The plastic container lids had a large amount of soilage of dry food particles and dust. Two large plastic containers which stored flour, rice, and oatmeal were observed to have lids that were heavily soiled with a white powder. On 6/5/14 at 10:30 A.M., the edges of the flooring and baseboards in the kitchen including under equipment had black soilage. Four of six metal shelves on a storage unit which contained clean kitchen utensils and dishes had rusted areas of approximately 6 to 10 inches in length. On 6/5/14 at 10:40 A.M., the FSM was assisting staff in meal preparation and was observed wearing a beanie style hat with her bangs on one side extruding out of her hat. Dietary Cook #1 was preparing the pureed diets for the noon meal. She was wearing a beanie style hat 		<p>affected by the alleged deficiency and through alterations, processes, and in-servicing the campus will ensure proper storage, preparation, and distribution of food under sanitary conditions.</p> <p>Completion Date 6-30-2014</p> <p>Dietary Staff have been in-serviced on proper floor maintenance. The dietary staff will follow a deep clean floor schedule to ensure proper floor maintenance is being done daily and deep cleaned weekly. The dietary cleaning schedule has been revised to reflect the proper cleaning schedule.</p> <p>Completion Date 6-30-2014</p> <p>Dietary Staff have been in-serviced</p>	
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	<p>with hair not contained under her hat on both sides. Dietary Cook #1 indicated Regional Dietary Staff #2 had already measured amounts of water and margarine in measuring cups for preparation of the pureed spaghetti. Regional Dietary staff #2 was observed in the kitchen area assisting staff wearing a baseball cap with his beard and mustache uncovered.</p> <p>A small metal table next to the reach-in refrigerator was also observed at that time to have a large amount of black debris build up on 1 section of the table top and on the metal plate area of 2 of the 4 legs of the table.</p> <p>4. On 6/5/14 at 11:22 A.M., Regional Dietary Staff #2 was observed pouring ice into the salad bar table and preparing the salad bar table for delivery into the main dining room. Regional Dietary Staff #2 was wearing a baseball cap and his mustache and beard remained uncovered.</p> <p>5. On 6/5/14 at 11:42 A.M., the FSM provided a facility policy entitled, "Dietary Hair Restraint Policy and Procedures (undated)." The policy included but was not limited to, "...Trilogy has chosen Baseball, Floppy Chef, or Beanie style caps with the Trilogy Logo for our restraint policy and</p>		<p>regarding proper maintain of storage bins and lids. Dietary staff will clean bins and lids daily as they become soiled or dusty.</p> <p>Completion Date 6-30-2014</p> <p>A dish storage unit was discovered to have rust four of the six shelves. A new unit with epoxy coding has been ordered to replace the rusted shelving.</p> <p>Completion Date 6-30-2014</p> <p>A metal table was observed to have a large amount of black debris build up. That metal table is not in use and has been removed from the kitchen.</p> <p>Completion Date 6-30-2014</p>	

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	<p>to meet our designed uniform code. This hat will be worn to effectively keep hair from contacting exposed food. Those employees that have hair that extrudes out of the cap will be required to have hair wrapped into a bun style or tucked under hat. A neutral colored hair net will need to be worn under hat if hair cannot be contained by the ball cap..."</p> <p>6. On 6/6/14 at 10:10 A.M., the FSM was made aware of the soiled floor areas of the kitchen. A paper towel was wiped across the floor area underneath the steam table cabinet. A mixture of dirt and dust was observed. During interview at that time the FSM agreed the flooring was soiled. She indicated she had 2 staff on the day and evening shifts. She indicated staff on the day shift swept the kitchen floors and on the evening shift staff mopped the floors. She indicated staff does not clean daily around the edges and baseboards of the floor. She indicated staff would clean along the edges of the floor and baseboards, "...maybe monthly." She also indicated at that time dietary staff members with a beard were suppose to wear a beard net when working in the kitchen food preparation area. She indicated the soiled black debris build up on metal table next to the walk-in fridge was a grease build up due to previously being used next to a</p>		<p>Staff were observed to not have their hair properly restrained while in the food preparation area. All dietary staff have been in-serviced in regards to the policy and procedure of proper hair restraints.</p> <p>Completion Date 6-30-2014</p> <p>The floor and pantry area was observed to have missing 12x12 tiles. Those tiles have been replaced. Staff will continue to maintain floors according to our daily/weekly cleaning schedule.</p> <p>Completion Date 6-30-2014</p> <p>DFS/designee will monitor dietary staff observing and</p>	

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	<p>fryer in the kitchen. She indicated the table was no longer in use and should have already been removed from the kitchen.</p> <p>7. During interview with the FSM on 6/9/14 at 10:45 A.M., she indicated she usually tried to have a thorough cleaning of the kitchen floors once a month. She indicated there was no set day scheduled monthly for the thorough cleaning of the kitchen floor. She indicated during the thorough cleaning staff would scrub the edges of flooring and not just sweep and mop as staff did daily. She indicated the months of April and May 2014 the kitchen floors had been lacking of a thorough cleaning.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>following best practice protocol</p> <p>and policy for preparing,</p> <p>storing, and distributing</p> <p>food under sanitary conditions.</p> <p>5x a week for a month, then</p> <p>3x a week for a month, with</p> <p>results forwarded to QA committee</p> <p>monthly x 6 months and</p> <p>quarterly thereafter for</p> <p>review and further suggestions</p> <p>or comments.</p> <p>Completion Date 6-30-2014</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155361	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567
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(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