

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2016
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NAME OF PROVIDER OR SUPPLIER WINDSOR RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: May 31, 2016</p> <p>Facility Number: 004001 Provider Number: 004001 AIM Number: N/A</p> <p>Residential Census: 35</p> <p>Sample: 13</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 34233 on June 2, 2016.</p>	R 0000		
R 0119 Bldg. 00	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3)-Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility.</p>			

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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	<p>(2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interview, the facility failed to ensure employees were oriented to the facility by the department manager or designee, including documentation of the orientation by the person supervising the orientation, before performing their job duties. This deficient practice affected 4 of 6 new employee personnel files reviewed. (Director of Maintenance, QMA #1, CNA #1, and Cook #1)</p> <p>Findings include:</p> <p>Review of the Personnel files on 5/31/16 at 12:00 p.m. indicated the following staff were missing the "New Hire Orientation" to the facility and were</p>	R 0119	All employees could be affected, thus the following corrective action shall be taken: all employee files were audited and an orientation checklist was completed for all employees. as a means to ensure ongoing compliance the administrator will verify the items on the checklist are complete before any employee is release to work/ be placed on the schedule. The dept head and administrator will sign off on every new employee to ensure orientation is completed appropriately.	06/10/2016			

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R 0121 Bldg. 00	<p>allowed to work in their respective job:</p> <ol style="list-style-type: none"> 1. The Director of Maintenance was hired and began work on 2/17/16. 2. Cook #1 was hired and began work in the Dietary Department on 5/16/16. 3. Certified Nursing Assistant (CNA) #1 was hired and began work in the Nursing Department on 4/28/16. 4. Qualified Medication Aide (QMA) #1 was hired and began work in the Nursing Department on 5/4/16. <p>During an interview on 5/31/16 at 1:07 p.m., the Business Office Manager indicated she had the employee folders with their "New Hire Orientation" checklists ready, but had failed to have the new employees complete the checklist.</p> <p>At 1:47 p.m. on 5/31/16, the Administrator presented the facility's "New Hire Orientation" checklist. She indicated the orientation checklist was supposed to be completed before the employee was released to begin working their job duties.</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each</p>						

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	<p>employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the 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>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure new</p>	R 0121	All employees could be affected, thus the following corrective action shall be taken: Employee	06/10/2016			

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	<p>employees had received a physical and/or the employee files contained a copy of a first-step PPD (Tuberculin test) prior to beginning work with the residents. This deficient practice affected 2 of 6 new employee personnel files reviewed. (QMA #1 and Dietary Manager).</p> <p>Findings include:</p> <p>1. The Dietary Manager was hired and began work on 5/4/16. Review of her personnel file on 5/31/16 at 12:00 p.m., failed to locate a first-step PPD.</p> <p>During an interview on 5/31/16 at 1:55 p.m., the Administrator indicated the prior Director of Nursing had been given the copy of the first-step PPD by the Dietary Manager but they were unable to locate any document.</p> <p>2. Qualified Medication Aide (QMA #1) was hired and began working on 5/9/16. Review of her personnel file on 5/31/16 at 12:00 p.m., failed to locate a history and physical.</p> <p>During an interview on 5/31/16 at 1:55 p.m., the Administrator indicated she was unable to account as to why there was no copy of the employee's physical in the file.</p>		<p>found to have PPD/physical later than the date of hire. Employee has obtained proof of PPD from previous employer. Employee has obtained physical. In an effort to ensure compliance all employee files have been audited for compliance with Administration reading PPD before the hire date per the facility policy and per the state rule. All employee files have been audited for compliance with the state rule and facility policy regarding the employee physical examination. The administrator will be responsible to ensure no employee is permitted to work until the physical/PPD has been secured and placed in the employee file.</p>				

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R 0123 Bldg. 00	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.</p> <p>Based on record review and interview, the facility failed to ensure new employees were oriented to their Job Description, Specific Job Skills, Resident Rights and Abuse before beginning their job duties. This deficient practice affected 4 of 6 personnel files reviewed. (Director of Maintenance, QMA #1, CNA #1, and Cook #1)</p> <p>Findings include:</p> <p>Review of the Personnel files on 5/31/16 at 12::00 p.m., indicated the following</p>	R 0123	All employees could be affected, therefore the following information has been taken: All employee files have been audited and an employee checklist has been completed for all employees. This checklist includes Job description, job specific skills, resident rights/abuse. Administrator will ensure that all employees have completed orientation and checklist before being permitted to be placed on the schedule to work.	06/10/2016			

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	<p>staff were missing their Job Description, Job Specific Orientation, Inservices on Resident Rights and Abuse and were allowed to work in their respective job:</p> <ol style="list-style-type: none"> 1. The Director of Maintenance was hired and began work on 2/17/16. 2. Cook #1 was hired and began work in the Dietary Department on 5/16/16. 3. Certified Nursing Assistant (CNA) #1 was hired and began work in the Nursing Department on 4/28/16. 4. Qualified Medication Aide (QMA) #1 was hired and began work in the Nursing Department on 5/4/16. <p>During an interview on 5/31/16 at 1:07 p.m., the Business Office Manager indicated she had the employee folders with the blank employee orientation forms on Resident Rights, Abuse, Job Description and Job Specific Orientation, but had failed to have the new employees complete the individual checklists.</p> <p>At 1:47 p.m. on 5/31/16, the Administrator presented the facility's "New Hire Orientation" checklist. She indicated that this orientation checklist was supposed to be completed before the employee was released to begin working</p>			

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R 0356 Bldg. 00	<p>their job duties. Review of this Orientation checklist included the employee being oriented to Resident Rights and Job Description.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure every resident's Emergency File was complete with a resident photo and/or listed a hospital preference. This deficient practice affected 7 of 35 Resident Emergency files reviewed. (Resident R#1, R#6, R#7, R#8, R#9, R#10, and R#14.)</p> <p>Findings include:</p>	R 0356	Necessary information has been secured and the deficient emergency files updated. All residents can be affected, the following corrective action shall be taken: In an effort to ensure ongoing compliance an audit shall be conducted of all resident emergency files and any deficient information secured to ensure each emergency files is accurate and complete. As a means to ensure quality assurance, the admin/DON shall be responsible	06/01/2016

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	<p>Review of the Resident Emergency Files on 5/31/16 at 10:00 a.m., indicated the following information was missing:</p> <ol style="list-style-type: none"> 1. Resident R#1 was admitted to the facility on 5/6/16. No hospital preference was listed in the resident's Emergency File. 2. Resident R#6 was admitted to the facility on 4/13/16. No photo identification of the resident was found in the resident's Emergency File. 3. Resident R#7 was admitted to the facility on 4/12/16. No hospital preference was listed in the resident's Emergency File. 4. Resident R#8 was admitted to the facility on 6/15/15. No photo identification of the resident was found in the resident's Emergency File. 5. Resident R#9 was admitted to the facility on 5/25/16. No Emergency file could be located for the resident. 6. Resident R#10 was admitted to the facility on 5/25/16. No Emergency file could be located for the resident. 7. Resident R#14 was admitted to the 		<p>to ensure the informaiton is obtained from the newly admitted resident to complete the emergency files in accordance with the state rule and the facility policy as part of the admission process and audited again within 72 hours to confirm completion. There after the emergency files will be audited monthly to confirm continued compliance.</p>	

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	<p>facility on 5/29/16. No Emergency file could be located for the resident.</p> <p>During an interview on 5/31/16 at 10:15 a.m., the Administrator indicated the Emergency Files had just been recently updated to reflect the current status of the residents.</p> <p>During a second interview on 5/31/16 at 11:59 a.m., the Administrator indicated the initial Emergency File information was placed in the resident's binder on the next business day after a new admission.</p>				