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
	155725		07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	1750 LINDBERG RD WEST LAFAYETTE, IN 47906

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00177503. Complaint # IN00177503 - Substantiated. Federal and State deficiencies related to the allegations are cited at F157 and F314. Survey dates: July 20, 21, 22, 23 and 24, 2015 Facility number : 003673 Provider number: 155725 AIM number: 200450890 Census bed type: SNF: 17 SNF/NF: 7 Residential: 42 Total: 66 Census payor type: Medicare: 17 Medicaid: 1 Other: 6 Total: 24 These deficiencies reflect state findings cited in accordance with 410 IAC	F 0000	UniversityPlace ("the Provider") submits this Plan of Correction ("POC") in accordancewith specific regulatory requirements. This POC should not be construed as an admission of any all allegeddeficiency cited. The Provider submitsthe POC with the intention that it be inadmissible by any third party in anycivil or criminal against the Provider or any employee, agent, officer,director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of thissurvey if at any time the provider determines that the disputed findings, (1)are relied upon to adversely influence or serve as a basis, in any way, for theselection and/or imposition of future remedies, whether such remedies areimposed by the Centers for Medicare and Medicaid Services ("CMS") the State ofIndiana or any other entity; or (2) to serve, in any way, to facilitate orpromote action by any third party against the Provider. Any changes to Provider policy or proceduresshould be considered to be subsequent remedial measures as that concept isemployed in Rule 407 and the federal Rules of Evidence and should beinadmissible in any proceedings on that basis.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	16.2-3.1			
F 0157 SS=G Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview	F 0157	Resident #2 was assessed and that assessment was	08/10/2015

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	,the facility failed to notify the physician when the resident's pressure ulcer advanced in stage and size. This deficiency affected 1 of 3 residents reviewed for pressure ulcers. (Resident#2) Resident # 2's pressure ulcer increased from a Stage 3 to a Stage 4 ulcer and increased in size by greater 2 centimeters (cm) in length and and 3 cm width over a six week time frame without physician notification or intervention. Findings include: During the record review for Resident #2 on 7/22/15 at 1:30 p.m., a Wound /Skin Healing Record indicated a blister on the left ischium was noted and staged at Stage 2. It measured 0.6 centimeters (cm) length, 0.8 cm width, 0.1 cm depth. Physician notified on 4/20/15. Treatment was silver alginate daily with mepilex dressing. 4/28/15: The wound measurement was 2.0 cm length, 2.0 cm width, 0.5 cm in depth. Dietary was notified on 4/28/15. Physician was notified on 4/28/15. Pressure Ulcer was staged at Stage 3. No change in treatment was noted. 5/5/15: The wound measurement was 2.0 cm length, 2.0 cm width, 0.5 cm depth. Stage 3, no change in treatment was		documented and communicated with her physician. A current treatment plan was implemented per physician order. All current residents were assessed for pressure sores. Any findings were communicated to the physician for updated treatment orders. All new admissions will have a full skin assessment and Braden scale completed and documented with any findings communicated to the attending physician for any treatment orders with communication documented. Skin assessments will be reviewed by the Director of Nursing or designee for proper documentation and accuracy and appropriate communication with the physician for current treatment orders. Any deficient practices will be corrected immediately. A Wound and Skin report will be submitted to the Director of Nursing weekly for review by the designated wound nurse. The Director of Nursing or designee will audit skin assessments, documentation and physician communication weekly to ensure accuracy and completeness. The Director of Nursing will report findings to the Quality Improvement Committee monthly for 6 months.	

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	noted. 5/12/15: The wound measurement was 2.0 cm length, 2.5 cm width, 0.3 cm depth, Stage 3, no change in treatment noted. 5/18/15: the wound measurement was 3.0 cm length, 3.2 cm width, 0.3 cm depth, Stage 3, no change in treatment noted. The Resident was seen in the wound care clinic. The treatment was changed to collagen powder with silver alginate with dressing. 5/25/15: The wound measurement was 3.5 cm length, 3.0 cm width, 0.2 cm depth, Stage 2 , no change in treatment noted. 6/2/15: The wound measurement was 3.4 cm length, 3.2 cm width, 0.3 cm depth, Stage 2, no change in treatment noted. 6/9/15: The wound measurement was 4.5 cm length, 5.0 cm width, 0.4 cm depth, Stage 3, no change in treatment noted. 6/16/15: The wound measurement was 5.0 cm length, 5.0 cm width, 0.4 cm depth, Stage 3, no change in treatment noted. 6/23/15: The wound measurement was			

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	5.6 cm length, 5.5 cm width, 0.5 cm depth, Stage 4, no change in treatment noted. 6/30/15: The wound measurement was 5.6 cm length, 5.8 cm width, 0.4 cm depth, Stage 4, no change in treatment noted. 7/7/15: The wound measurement was 5.8 cm length, 5.6 cm width, 0.4 cm depth, Stage 4, no change in treatment noted. 7/14/15:The wound measurement was 5.9 cm length, 6.0 cm width, 0.3 cm depth, Stage 4, no treatment change noted. During an interview with the Interim Director of Nursing (DON) and the MDS (Minimum Data Set) Coordinator on 7/23/15 at 3:30 p.m., the MDS Coordinator indicated the wound care clinic managed the care for the resident. Physician on staff did not make changes to the treatment of the wound. A review of the policy titled "Pressure Ulcer and Wound Management", not dated, indicated "... treatment guidelines...record in progress notes at least weekly when skin problems are identified and reported to the physician... Weekly Skin Assessment Protocol...9. The nurse who identified the new or			

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	change in the skin condition is responsible for notifying the resident, physician and family/sponsor...." This Federal tag relates to complaint IN00177503. 3.1-5(2)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop a Plan of Care for Obstructive Chronic Bronchitis and Chronic Airway Obstruction for 1 of 16 residents reviewed for care plans. (Resident #1).	F 0279	Resident #1 discharged (Expired) All resident care plans were reviewed for accuracy and completeness by the MDS nurse and Social Services Director. All records were found to have current diagnosis and associated care plan.	08/10/2015

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	Findings include: The clinical record of Resident #1 was reviewed on 7/22/2015 at 10:30 a.m. Diagnoses included, but were not limited to, shortness of breath, Chronic Airway Obstruction, Congestive Heart Disease (CHF), Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation, and Obstructive Chronic Bronchitis with acute exacerbation. A Nursing note dated 5/9/2015, indicated the resident was admitted from the hospital with a diagnosis of COPD with exacerbation. A facility face sheet dated 5/12/2015, indicated the resident had an admitting diagnosis of Obstructive Chronic Bronchitis with acute bronchitis and Chronic Airway Obstruction. A Nursing note dated 6/3/2015, indicated the resident was readmitted from the hospital with a diagnosis of COPD. A Hospice Certification dated 6/3/2015 indicated the resident had a principle diagnosis of Obstructive Chronic Bronchitis with acute exacerbation. A Physicians order dated 5/9/2015,		Care Plans will be written within of the regulatory requirements time frame for admission and cycle including significant changes. The MDS nurse will ensure that the written care plan is current at each of the care conferences and includes hospice and any other outside agencies and is relevant to the diagnoses. The Director of Nursing or designee will audit 3 records per month for six months to monitor for accuracy and completeness. Any discrepancies or concerns will be corrected immediately and shared with the Interdisciplinary Team. The audit findings will be reported monthly to the Quality Improvement Committee.	

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	indicated "admit to skilled nursing facility", diagnosis Chronic Airway Obstruction. A review of the current facility and hospice Plans of Care, on 7/22/2015 at 11:00 a.m., did not include a Plan of Care for Obstructive Chronic Bronchitis and Chronic Airway Obstruction. During an interview with Minimum Data Set (MDS), Coordinator on 7/22/2015 at 1:30 p.m., she indicated there was no care plan for Resident #1 for Obstructive Chronic Bronchitis and Chronic Airway Obstruction. She indicated Resident #1 was admitted to the facility on 5/9/2015 and readmitted on 6/3/2015 with the diagnosis and should have had a care plan. A procedure for "Care Plans (Resident Care Planning)", received from the MDS Coordinator, on 7/24/2015 at 2:00 p.m., indicated "... after each discipline identifies problems and goals, the interdisciplinary team will develop the care plan...." 3.1-35(a)			
F 0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL			

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Bldg. 00	PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, record review and interview, the facility failed to provide provide pressure ulcer treatment, and failed to notify the physician when Resident # 2's pressure ulcer increased from a Stage 3 to a Stage 4 ulcer and increased in size by greater 2 centimeters (cm) in length and and 3 cm width over a six week time frame without physician notification or intervention for 1 of 3 residents reviewed for pressure ulcers. (Resident #2) Findings include: During the record review for Resident #2 on 7/22/15 at 1:30 p.m., a Wound /Skin Healing Record indicated a blister on the left ischium was noted and staged at Stage 2. It measured 0.6 centimeters (cm) length, 0.8 cm width, 0.1 cm depth. Physician notified on 4/20/15. Treatment was silver alginate daily with mepilex dressing.	F 0314	Resident #2 was assessed and that assessment was documented and communicated with the physician. A current treatment plan was implemented per physician order. All current residents were assessed for pressure sores. Any findings were communicated to the physician for updated treatment orders and have been added to the Skin Assessment and the Skin Monitoring form. Any and all treatments have be entered on the Treatment Administration Record. All new admissions will have a full skin assessment and Braden scale completed and documented with any findings communicated to the attending physician for any treatment orders with communication documented. Skin assessments will be reviewed by the Director of Nursing or designee for proper documentation and accuracy and appropriate communication with the physician for current treatment orders. Any deficient practices will be corrected	08/10/2015

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	4/28/15: The wound measurement was 2.0 cm length, 2.0 cm width, 0.5 cm in depth. Dietary was notified on 4/28/15. Physician was notified on 4/28/15. Pressure Ulcer was staged at Stage 3. No change in treatment was noted. 5/5/15: The wound measurement was 2.0 cm length, 2.0 cm width, 0.5 cm depth. Stage 3, no change in treatment was noted. 5/12/15: The wound measurement was 2.0 cm length, 2.5 cm width, 0.3 cm depth, Stage 3, no change in treatment noted. 5/18/15: the wound measurement was 3.0 cm length, 3.2 cm width, 0.3 cm depth, Stage 3, no change in treatment noted. The Resident was seen in wound care clinic. The treatment was changed to collagen powder with silver alginate with dressing. 5/25/15: The wound measurement was 3.5 cm length, 3.0 cm width, 0.2 cm depth, Stage 2 , no change in treatment noted. 6/2/15: The wound measurement was 3.4 cm length, 3.2 cm width, 0.3 cm depth, Stage 2, no change in treatment noted.		immediately. A Wound and Skin report will be submitted to the Director of Nursing weekly for review by the designated wound nurse. The Director of Nursing or designee will audit skin assessments, documentation and physician communication weekly to ensure accuracy and completeness. The Director of Nursing will report findings to the Quality Improvement Committee monthly for 6 months.	

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	6/9/15: The wound measurement was 4.5 cm length, 5.0 cm width, 0.4 cm depth, Stage 3, no change in treatment noted. 6/16/15: The wound measurement was 5.0 cm length, 5.0 cm width, 0.4 cm depth, Stage 3, no change in treatment noted. 6/23/15: The wound measurement was 5.6 cm length, 5.5 cm width, 0.5 cm depth, Stage 4, no change in treatment noted. 6/30/15: The wound measurement was 5.6 cm length, 5.8 cm width, 0.4 cm depth, Stage 4, no change in treatment noted. 7/7/15: The wound measurement was 5.8 cm length, 5.6 cm width, 0.4 cm depth, Stage 4, no change in treatment noted. 7/14/15:The wound measurement was 5.9 cm length, 6.0 cm width, 0.3 cm depth, Stage 4, no treatment change noted. 7/18/15: The wound measurement was 5.9 cm length, 6.0 cm width, 0.5 cm depth, Stage 4, Physician notified per telephone. A review of Wound Care Clinic progress			

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	note dated 7/1/15 , indicated Resident #2 had a left heel ulcer that continued to improve and decrease in size. During an interview with the Interim Director of Nursing (DON) and the MDS (Minimum Data Set) Coordinator on 7/23/15 at 3:30 p.m., the MDS Coordinator indicated the wound care clinic managed the care for the resident and the physician on staff did not make changes to the treatment of the wound. A review of the policy titled "Pressure Ulcer and Wound Management", not dated, indicated "... treatment guidelines...record in progress notes at least weekly when skin problems are identified and reported to the physician... Weekly Skin Assessment Protocol...9. The nurse who identified the new or change in the skin condition is responsible for notifying the resident, physician and family/sponsor...." This Federal tag relates to complaint IN00177503. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0371 SS=F	483.35(i) FOOD PROCURE,			

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Bldg. 00	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, record review and interview, the facility failed to ensure that food was covered, labeled and dated in the refrigerators, freezer and the dry storage area and that food was disposed after date of expiration in 1 of 1 kitchens, in the facility. This deficient practice had the potential to affect 24 of 24 residents. Findings include: During the tour of the kitchen on 7/20/2015 at 7:50 a.m., with the Resident Experience Manager and the Dietician, the following observations were made: 1.) The walk in refrigerator was observed to have open, uncovered, not dated and expired items: 6 chicken breasts uncovered opened and not dated. 10 ham slices opened and not dated. 16 cod fish fillets opened and not dated 12 fish fillets opened and not dated 1 container of blue cheese dressing outdated 1 medium metal container of pasta outdated	F 0371	All non-compliant items cited win the deficiency were immediately corrected. The dining services associates have been re-educated on all labeling and dating, storage,and removal of expired food item requirements. In addition, daily opening and closing checklists have been revised to specifically reflect the need to check for proper labeling and dating and removal of expired food items. The daily checklists will be monitored by the Dining Services Director or designee to ensure proper completion. Associates will be held accountable to the expectations as listed on the checklists and any deficient practices will be addressed immediately. The dining Services Director or designee will conduct an audit daily for 30 days to inspect and ensure procedures for labeling and dating, removal of expired food items, and proper covering of stored foods are being followed. Following the 30 day period, weekly sanitation audits will be completed by the Dining Services Director or designee to monitor for continued compliance in these areas. The Dining Services Director or	07/24/2015

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	1 medium container of cut apples outdated 1 large metal container of cut potatoes outdated 1 medium metal container of green beans outdated 1 package of sliced carrots opened and not dated 1 large metal container of cut cauliflower opened, not covered and not dated 24 eggplant patties opened and not dated 8 ham slices outdated 1 medium metal container of cut broccoli outdated 1 medium container of cut carrots outdated 2.) The walk in freezer was observed to have opened, not dated and expired items: 1 package of puree apples opened not dated 2 packages of tortilla patties outdated 3.) The reach in cooler/ refrigerator was observed to have outdated items: 1 container of barbeque sauce outdated 1 container of apple juice outdated 1 package of lemon slices outdated 4.) The dry storage for bread products contained 2 French bread loaves not opened but were observed to have mold		designee will report to the Quality Improvement Committee on the audit findings. Based on the findings, the Quality Improvement Committee will determine if increased auditing is required of if other measures need to be taken to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/24/2015

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	developed on slices of bread inside the closed package. During an interview on 7/20/2015 at 8:30 a.m., with the Resident Experience Manager, he indicated food items needed to be dated when opened, and all items should be covered when opened and dated. During an interview on 7/20/2015 at 9:00 a.m., with the Dietician, she indicated all opened items should be dated, all expired items should be disposed, and all items should be covered when opened and dated. The facility policy for " Food Storage and Handling", not dated, received from the Dietician on 7/23/2015 at 3:00 p.m., indicated "... Always securely cover food item...Check labels daily and discard out-dated food ! ...." 3.1-21(i)(2) 3.1-21(i)(3) .			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in			

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	sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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 and interview, the facility failed to ensure Tubersol stored in the medication room refrigerator was properly labeled when opened and the narcotics record was properly signed off by nurses conducting the count in 2 of 2 medication carts. This had the potential to affect 24 of 24 residents in the Health Center.	F 0431	The TB vial was properly discarded. No other residents were affected. The licensed nursing staff will be inserviced on the requirements for opening and utilization of multi-dose vials related to dating of the vial and the date for discarding. The Director of Nursing and/or designee will monitor compliance monthly for three months and quarterly for two quarters there	07/24/2015

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	Findings include: 1. During a medication storage review done on 7/24/15 at 8:30 a.m., a opened vial of Tubersol Tuberculin Testing solution was found opened and undated in the medication refrigerator. During an interview with the Interim Director of Nursing (DON) on 7/24/15 at 10:40 a.m., she indicated she was aware that vials were to be dated when opened and the solution was to be discarded 30 days after opening. A review of a policy titled "Storage of Vials and Ampules" dated 1/2006, indicated "Policy...Vials and ampules of injectable medications are stored in accordance with the manufacturer's recommendations or the pharmacy's directions for storage,use, and disposal...." 2. During a medication storage review done on 7/24/15 at 8:15 a.m., the narcotics sign off sheets were reviewed for Hall 1 and Hall 2. There were multiple instances where ongoing and offgoing nurses did not sign acknowledging the narcotic count was correct. During an interview with LPN#1 on		after. Any noncompliance will be immediately corrected and audit findings will be reported monthly to the Quality Improvement Committee.	

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	7/24/15 at 9:00 a.m., she indicated it is the expectation that the narcotics sheet is signed by the ongoing and offgoing nurse. A review of the policy titled " Controlled Drugs" dated 10/1/12 received from the DON on 7/24/15 at 10:45 a.m., indicated "...Narcotic Count and Inventory...2. The inventory of the controlled drugs and count sheets must be recorded on the narcotics records and signed for correctness of count. 3. The controlled drug record must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct...." 3.1-25(e)(3) 3.1-25(o)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents			

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	infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record review and interview, the facility failed to ensure tuberculosis (TB) screening was completed for new employees. This deficient practice affected 2 of 5 new employees screened for TB. (CNA#6 and CNA#7) Findings include: 1. During a record review on 7/21/15 at 3:09 p.m., CNA#6"s pre-employment record indicated a hire date of 5/6/15, a	F 0441	Any employee without a documented second step Mantoux were taken off the work schedule. All employee files were audited for compliance with Mantoux testing as a part of infection control policies. Any employee needing a second step Mantoux received one. Results were read and documented. A copy of the documentation was placed in the Mantoux Record file. The policy on TB testing has been revised to include annual screenings for employees who have previously tested positive to	08/04/2015

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	Mantoux skin was completed on 5/1/15 and read on 5/3/15. No second step was completed. 2. During a record review on 7/21/15 at 3:09 p.m., CNA#7's pre-employment record indicated a hire date of 4/1/15, no record of any tuberculin skin test noted in the record. During an interview with Human Resources Director on 7/21/15 at 3:09 p.m., she indicated the two employees did not complete pre-employment TB testing. A review of policy titled "Procedure for Mantoux (TB) Testing", dated 11/1/2013, indicated "...Mantoux testing is completed as a 2-step procedure as required by regulation. All associates must complete the initial test, including the reading of the results before they may be scheduled to work in their department...Prior to day 21 of their employment, and after their initial TB test, the second test must be administered and then read...." 3.1-18(k) 3.1-14(t)(1)		skin testing.The Director of Human Resources or designee will be responsible for maintaining the Mantoux testing records. All new employees file will be reviewed for status of Mantoux testing prior to initial resident assignment. Each new employee hired within a quarter will have their Mantoux record reviewed by the Director of Human Resources or designee within two weeks of the previous quarter's end for completion of the testing. Any incomplete record will be reviewed by the Director of Human Resources and/or Director of Nursing for immediate correction. The quarterly audits will be reported quarterly to the Quality Improvement Committee.	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 42 Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5	R 0000	UniversityPlace ("the Provider") submits this Plan of Correction ("POC") in accordancewith specific regulatory requirements. This POC should not be construed as an admission of any all allegeddeficiency cited. The Provider submitsthe POC with the intention that it be inadmissible by any third party in anycivil or criminal against the Provider or any employee, agent, officer,director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of thissurvey if at any time the provider determines that the disputed findings, (1)are relied upon to adversely influence or serve as a basis, in any way, for theselection and/or imposition of future remedies, whether such remedies areimposed by the Centers for Medicare and Medicaid Services ("CMS") the State ofIndiana or any other entity; or (2) to serve, in any way, to facilitate orpromote action by any third party against the Provider. Any changes to Provider policy or proceduresshould be considered to be subsequent remedial measures as that concept isemployed in Rule 407 and the federal Rules of Evidence and should beinadmissible in any	

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			proceedings on that basis.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each 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: (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. (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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited			

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	to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview the facility failed to ensure new personnel were screened for Tuberculosis (TB) using the two-step procedure skin test. This deficient practice affected 2 of 5 employees reviewed for TB screening. (Employee #1 and Employee #2) Findings include: 1. During a review of Employee #1 health records on 7/23/15 at 2:15 p.m., the records indicated a hire date of 5/6/15, a first step skin test was completed. No second step skin test was completed. 2. During a review of Employee #2 health records on 7/23/15 at 2:45 p.m., the records indicated a hire date of 6/3/15, a first step skin test was completed. No second step skin test was completed. During an interview with the Business Office Manager on 07/23/15 at 3:04 p.m., she indicated both employees were missing step two of the two-step process. Policy Review completed on 7/22/15 at 9:30 a.m., titled "Procedures for Mantoux	R 0121	The TB vial was properly discarded. No other residents were affected. The licensed nursing staff will beinserviced on the requirements for opening and utilization of multi-dose vialsrelated to dating of the vial and the date for discarding. The Director of Nursing and/or designeewill monitor compliance monthly for three months and quarterly for two quarterthereafter. Any noncompliance will beimmediately corrected and audit findings will be reported monthly to theQuality Improvement Committee.	07/24/2015

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	(TB) Testing" dated 11/01/2013 indicated "Mantoux testing is completed as a 2-step procedure as required by regulation...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure that food was covered, labeled and dated in the refrigerators, freezer and the dry storage area and that food was disposed after date of expiration in 1 of 1 kitchens, in the facility. This deficient practice had the potential to affect 42 out of 42 residents. Findings include: During the tour of the kitchen on 7/20/2015 at 7:50 a.m., with the Resident Experience Manager and the Dietician, the following observations were made: 1.) The walk in refrigerator was observed to have open, uncovered, not dated and expired items: 6 chicken breasts uncovered opened and not dated.	R 0273	All non-compliant items cited win the deficiency were immediately corrected. The dining services associates have been re-educated on all labeling and dating, storage,and removal of expired food item requirements. In addition, daily opening and closing checklists have been revised to specifically reflect the need to check for proper labeling and dating and removal of expired food items. The daily checklists will be monitored by the Dining Services Director or designee to ensure proper completion. Associates will be held accountable to the expectations as listed on the checklists and any deficient practices will be addressed immediately. The dining Services Director or designee will conduct an audit daily for 30 days to inspect and ensure procedures for labeling and dating, removal of expired food items, and proper	07/24/2015

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	10 ham slices opened and not dated. 16 cod fish fillets opened and not dated 12 fish fillets opened and not dated 1 container of blue cheese dressing outdated 1 medium metal container of pasta outdated 1 medium container of cut apples outdated 1 large metal container of cut potatoes outdated 1 medium metal container of green beans outdated 1 package of sliced carrots opened and not dated 1 large metal container of cut cauliflower opened, not covered and not dated 24 eggplant patties opened and not dated 8 ham slices outdated 1 medium metal container of cut broccoli outdated 1 medium container of cut carrots outdated 2.) The walk in freezer was observed to have opened, not dated and expired items: 1 package of puree apples opened not dated 2 packages of tortilla patties outdated 3.) The reach in cooler/ refrigerator was observed to have outdated items: 1 container of barbeque sauce outdated		covering of stored foods are being followed. Following the 30 day period, weekly sanitation audits will be completed by the Dining Services Director or designee to monitor for continued compliance in these areas. The Dining Services Director or designee will report to the Quality Improvement Committee on the audit findings. Based on the findings, the Quality Improvement Committee will determine if increased auditing is required of if other measures need to be taken to ensure compliance.	

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	1 container of apple juice outdated 1 package of lemon slices outdated 4.) The dry storage for bread products contained 2 French bread loaves not opened but were observed to have mold developed on slices of bread inside the closed package. During an interview on 7/20/2015 at 8:30 a.m., with the Resident Experience Manager, he indicated food items needed to be dated when opened, and all items should be covered when opened and dated. During an interview on 7/20/2015 at 9:00 a.m., with the Dietician, she indicated all opened items should be dated, all expired items should be disposed, and all items should be covered when opened and dated. The facility policy for " Food Storage and Handling", not dated, received from the Dietician on 7/23/2015 at 3:00 p.m., indicated "... Always securely cover food item...Check labels daily and discard out-dated food ! ...." .			
R 0306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance			

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Bldg. 00	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.			
	Based on observation and interview, the facility failed to dispose of expired medication within the recommended pharmaceutical guidelines in 1 of 2 medication carts reviewed, this affected 1 of 42 residents. (Resident #9) Finding include: During observation of medication storage on 7/24/15 at 10:30 a.m., the first floor medication cart contained a vial of Humalog insulin belonging to Resident #9 with an opened date of 6/22/15. During an interview with LPN #6 on 7/24/15 at 10:40 a.m., she indicated she was unsure how long the insulin was good for after opened, she was unable to	R 0306	The TB vial was properly discarded. No other residents were affected. The licensed nursing staff will be inserviced on the requirements for opening and utilization of multi-dose vials related to dating of the vial and the date for discarding. The Director of Nursing and/or designee will monitor compliance monthly for three months and quarterly for two quarters thereafter. Any noncompliance will be immediately corrected and audit findings will be reported monthly to the Quality Improvement Committee.	07/24/2015

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	locate a chart used as a guideline for insulin storage. During an interview with the Interim Manager of Resident Services on 7/24/15 at 10:47 a.m., she indicated she was looking for a chart the facility used as a guideline for insulin storage and indicated the facility follows the pharmaceutical recommendations for insulin storage and disposal. Review of "Insulin Storage Recommendations" dated 5/7/13 received from the Interim Manager of Resident Services on 7/24/15 at 11:39 a.m., indicated Humalog after opened expires in 28 days whether it is refrigerated or at room temperature.			