

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 02/05/2016
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NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST INDIANAPOLIS, IN 46227
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: February 3, 4, and 5, 2016.</p> <p>Facility number: 001121 Provider number: 001121 AIM number: N/A</p> <p>Census bed Type: Residential: 76 Total: 76</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on February 11, 2016.</p>	R 0000		
R 0121 Bldg. 00	<p>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</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>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 a pre-employment health screen was completed prior to patient contact for 1 of 5 employees reviewed for health screens (Licensed Practical Nurse [LPN] #1).</p>	R 0121	It is the policy of Bethany Village to ensure that all staff to have a health screen before coming into contact with residents. The corrective action that was taken for those residents that were affected by the one LPN without a physical was as follows: As soon as it was realized that a prior	03/04/2016

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	<p>Findings include:</p> <p>A review of LPN #1's employee file completed on 2/4/2016 at 2:05 p.m., indicated a employment start date of 10/8/2015. The health screen located in LPN #1's file was dated 10/15/2015. The file lacked a health screen dated prior to patient contact on 10/9/15.</p> <p>A review of LPN #1's time report record, indicated LPN #1 had patient contact on October 9, 12, 13, and 14, 2015.</p> <p>During an interview on 2/5/2016 at 10:30 a.m., the Business Office Manager (B.O.M.) indicated the only health screen on file at that time for LPN #1, was dated 10/15/2015. He indicated that upon hire LPN #1 was supposed to provide the facility with a health screen completed for previous employer, but was unable to do so. At that time, the health screen dated 10/15/2015, was obtained.</p> <p>On 2/5/2016 at 3:15 p.m., the General Manager (GM) provided a policy with a 10/2011 review date, titled Employee Health, and indicated it was the current policy used by the facility. The policy lacked information indicating employee health screens were to be completed prior to patient contact.</p>		<p>physical from the employee was not presented to Bethany Village Assisted Living that one was immediately scheduled with our immediate care center and completed on 10/15/16 To ensure that no residents will have the potential to be affected by the same deficient practice the following measures will be put in place: An in- service will be held with the Business Office Manager/Designee to ensure that he/she understands the rules/expectations of new hires prior to resident contact or being scheduled to provide care. After employee attends orientation day the file will be audited immediately by the Business Office Manager/Designee. The prospective employee will not be allowed to be placed on a working schedule if any incomplete paperwork is discovered by the audit. The Business Office Director/ Designee will complete paperwork that is discovered by the audit. Once the file is cleared by the Business Office Manager the General Manager will initial file for approval and give the perspective department manager permission to place the employee on the schedule. To monitor the corrective action to ensure this deficient practice does not occur again the Business Office Manager will review all new hires monthly to ensure that physicals and TB skin tests have been completed in the correct time</p>				

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R 0273 Bldg. 00	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure glove usage during meal preparation as indicated by facility policy for 76 of 76 residents who received food prepared in the kitchen.</p> <p>Findings Include:</p> <p>During the service of noon meal on 2/3/2016 at 11:00 a.m., the following was observed:</p> <p>1) Dietary Cook #1 was observed to handle the packaged buns with gloved hands. Cook #1 was observed</p>	R 0273	<p>frame and that new hires are not exposed to residents before such documentation occurs. The audits being conducted will be reviewed by the General Manager on a monthly basis. The quality assurance tool will be utilized for the new hire documentation in an effort to ensure compliance is in place. The Quality Assurance tool will be completed by the Business Office Manager/ General Manager on a monthly basis for the next 4 months.</p> <p>It is the practice of Bethany Village Assisted Living to ensure that all food preparation and serving areas are maintained in accordance with the state and local sanitation and food handling standards.</p> <p>The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All kitchen staff will be in-serviced on or before 03-03-2016 on proper hand washing/ lathering protocol and appropriate glove usage during food preparation/serving. Cook #1 has been re-educated on proper hand washing, glove usage, and cross contamination. Completed on</p>	03/04/2016

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	<p>performing multiple tasks i.e.; touching plates, touching handles of serving utensils, leaving the service line twice to retrieve more buns, handling the order slips and the basket the slips were placed in, handled the steam table lids, touching serving pans, and then going back to handling buns and bun packaging with out changing gloves once.</p> <p>2) Dietary Cook #1 was observed to remove her gloves and wash her hands. She returned to service line with bare hands and prepared a grilled cheese. Touching the bread and the handle of brush used to spread the butter and the cheese. When the grilled cheese was done she placed her hand on the sandwich while cutting it. Then with bare hands placed the sandwich on the plate. Then Cook #1 continued to perform multiple tasks i.e.; touching plates, touching handles of serving utensils, leaving the service line to retrieve more buns, handling the order slips and the basket the slips were placed in, wiped hands on her pants, touched serving pans, and then going back to handling buns and bun packaging with out washing hands.</p> <p>3) Dietary Cook #1 was observed to place her hands in a sanitizer bucket bringing out a cloth, wiped a bowl of</p>		<p>02/25/2016. All residents have the potential to be affected by the deficient practice. The Food Service Manager /Designee will round the kitchen on an ongoing basis to ensure that proper hand washing, proper glove usage policies are being followed, protecting foods from potential contamination will be done by using serving utensils on ready to eat foods. The systemic changes that will be put in to place to ensure that the deficient practice does not reoccur are as follows: The Food Service Manager / Designee will round the kitchen on an on-going basis to ensure proper hand washing, glove usage, and appropriate utensils are being used. All kitchen staff will be in-serviced on proper handwashing, glove usage practices. Additional in-service on protecting food from potential contamination by using sanitized serving utensils will also occur on or before 03-03-2016. For additional oversight all department head managers, who serve as weekend managers, were in- serviced on 02-24-2016 on hand washing for food service roles, proper kitchen glove usage, and appropriate use of sanitized utensils. To monitor corrective actions to ensure the deficient practice will not recur, the following Quality Assurance tools will be followed:</p>				

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	<p>beets off with the cloth, and placed the cloth on to shelf under the steam table. Cook #1 then proceeded to prepare a grilled ham and cheese. While preparing the sandwich Cook #1 handled the bread, the butter brush handle, the cheese, and ham all with bare hands. When the sandwich was finished she held it down to cut it and placed it on the plate with bare hands. Was observed to, again, wipe her bare hands on her pants. She then took aforementioned cloth from the shelf, dipped it in the sanitizer bucket and then wiped down the steam table and the board in front of it. Cook #1 then picked up the knife she used to cut both sandwiches and wiped down the blade of the knife. Then, without putting on gloves, she dropped the cloth back into the bucket and proceeded to prepare another grilled ham and cheese sandwich and another grilled cheese sandwich. When the sandwiches were finished she picked up the previously used knife and cut the sandwiches.</p> <p>4) Dietary Cook #1 was observed to leave the service line and enter the dry food storage. She retrieved a package of gravy, returned to the service line and started preparing the gravy. She touched the package, the kettle, the spoon, and the stove with bare hands. She then wiped her hands on her pants and began to</p>		<p>Audit tool will be used to document proper usage of gloves, hand washing, and observance of any cross contamination. Audits will be done weekly for the next four weeks, then one time monthly the following three months, and then quarterly thereafter. Threshold will be set at 100% compliance and if not met additional action plans and in-service training will be developed. Any employee who fails to meet the compliance may result in disciplinary action up to and including termination.</p>	

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	<p>prepare a grilled cheese sandwich without washing her hands or utilizing gloves once.</p> <p>On 2/5/2016 at 09:00 a.m., the General Manager provided a policy on Proper Use of gloves, and indicated it was the current policy used by the facility. The policy indicated, "...It is the policy of this community to provide food in a safe manner while following the proper health codes outlined by the county/government agencies.</p> <p>Procedure</p> <ol style="list-style-type: none"> 1. Disposable, plastic gloves shall be used when handling ready to eat food items. 2. food employee shall minimize bare hand and contact with exposed food that is not in a ready to eat form. 3. Use tongs or other utensil wherever possible. This however, does not replace hand washing. Hands shall be washed in between each glove use. 4. Gloves should be removed when leaving the food preparation area within the kitchen, after touching your body, after coughing and/or sneezing. 5. Gloves are never to be worn in the dining room to serve or bust tables unless required under the universal precaution situations. 			

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R 0306 Bldg. 00	<p>6. Gloves shall be changed and hands washed when moving from one duty to another throughout the food preparation and daily routines to prevent cross contamination...."</p> <p>During an interview on 2/5/2016 at 10:30 a.m., the General Manager and Dietary Manager indicated the staff received training and facility policies are gone over during orientation. They indicated that employees are expected to use a spatula or tongs, or wear disposable gloves when handling food. They also indicated the staff is expected to wash hands and change gloves each time they change jobs or leave the line to prevent contamination of food, equipment, and utensils.</p> <p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (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.</p>			

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	<p>(8) The signature of the person conducting the disposal of the drug.</p> <p>(9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on record review and interview, the facility failed to ensure disposition of medications administered by the facility were documented in the clinical record for 1 of 2 residents reviewed for medication disposition (Resident #87).</p> <p>Findings include:</p> <p>A closed record review for Resident #87 was completed on 2/4/2016 at 2:45 p.m. Diagnoses included, but were not limited to, anxiety and depression.</p> <p>A review of the closed record, indicated Resident #87 discharged from the facility on 12/16/2015.</p> <p>A review of current physician orders at discharge on 12/16/2015 included, but were not limited to, Remeron, Miralax, meclizine, acetaminophen, and Tums.</p> <p>The medication disposition documentation dated 12/16/2015, lacked documentation for Remeron, Miralax, meclizine, acetaminophen, and Tums.</p> <p>During at interview on 2/5/2016 at 11:30 a.m., the Clinical Director (CD) indicated there was no documentation found for</p>	R 0306	<p>It is the policy of Bethany Village Assisted Living nursing department to document the disposition or destruction of all medications in the clinical record at the time of discharge. To ensure that this practice is followed on all discharged residents the following corrective actions will be accomplished:</p> <p>All Licensed Nurses will be in-serviced on proper documentation of medications and their disposition at the time of discharge. All licensed nurses will be in-serviced by 03/04/2016. All discharged records will be audited within 5 days of discharge to ensure that medications were properly disposed of and documentation of the disposal is present in the clinical record and adheres to all regulations. A Quality Assurance tool will be completed for review of and compliance by the Clinical Directory/Designee weekly for 1 month, then 1 time per month over the next 3 months. If 100% compliance is not achieved, then the Quality Assurance audits will continue an additional 3 months.</p>	03/04/2016

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R 0349 Bldg. 00	<p>medication disposition of those 5 medications.</p> <p>On 2/5/2016 at 1:55 p.m., the CD provided a policy revised on 7/2011 on Disposition of Medications and indicated it was the current policy used by the facility. The policy indicated, "...The nurse will document [medications dispensed/disposed of at discharge] in the clinical record and/or the 'Medication Release Form'...."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure medication orders were accurate and complete for a resident admitted to the facility. (Resident #64)</p> <p>Findings include: The clinical record of Resident #64 was reviewed on 2/4/16 at 9:20 a.m.</p>	R 0349	<p>Corrective action was taken immediately for resident #64 bytranscribing the missed medication to their medication administration record. The facility will identify other residents having thepotential to be affected by the same deficient practice by auditing all newadmission clinical records within 24 hours of admission. All audit tools willbe kept within the</p>	03/04/2016

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R 0383 Bldg. 00	<p>Diagnoses for the resident included, but were not limited to, dementia.</p> <p>The resident was admitted to the facility on 2/2/16. A Physician Order Report from another facility, dated 1/29/16, indicated the resident was to receive donepezil 20 milligrams (mg) at bedtime. Donepezil is a medication used for treating dementia in patients with Alzheimer's disease.</p> <p>On 2/4/16 at 10:00 a.m., the Clinical Director indicated the medications on the 1/29/16 Physician Order Report were the medications the resident was supposed to receive after being admitted to the facility on 2/2/16.</p> <p>Donepezil 20 mg. was not found on Resident #64's admitting orders, nor on his Medication Administration Record for February, 2016.</p> <p>On 2/5/16 the Clinical Director indicated, the medication had been overlooked when they were transcribing his orders at the time of his admission.</p> <p>410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive</p>		<p>plan of correction binder for the next 4 months.</p> <p>To ensure practice does not occur again all licensed nurses will be in-serviced on proper transcribing of admission orders by 03/04/2016.</p> <p>The corrective action will be monitored to ensure the deficient practice does not recur by Clinical Director/Designee weekly for 1 month, then 1 time for the next 3 months. If 100% compliance is not achieved, then the Quality Assurance audits will continue for an additional 3 months.</p>	

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	<p>careplan for the resident that includes the following:</p> <p>(1) Psychosocial rehabilitation services that are to be provided within the community.</p> <p>(2) A comprehensive range of activities to meet multiple levels of need, including the following:</p> <p>(A) Recreational and socialization activities.</p> <p>(B) Social skills.</p> <p>(C) Training, occupational, and work programs.</p> <p>(D) Opportunities for progression into less restrictive and more independent living arrangements.</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive careplan was developed, in cooperation with a mental health service provider, for a resident with a diagnosis of a major mental illness. (Resident #68)</p> <p>Findings include:</p> <p>The clinical record of Resident #68 was reviewed on 2/3/16 at 1:11 p.m. Diagnoses for the resident included, but were not limited to, major depressive disorder and bipolar disorder.</p> <p>A [name of mental health service provider] mental health progress note, dated 11/10/15, indicated the facility referred resident to the provider due to, "increased social isolation, lack of motivation, poor personal care skills [including refusal to bathe and urinating</p>	R 0383	<p>Corrective action was taken immediately for resident #68 by assisting resident in making an appointment for psycho social follow up, maintaining a copy of visit notes, and updating the service plan as appropriate. The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing all resident charts that would require a comprehensive care plan due to diagnosis of a major mental illness. The Clinical Director/Designee will complete the review and update any service plans as appropriate. To ensure practice does not occur again, the Clinical Director, Assistant Clinical Director, and General Manager, will be in-serviced on when a comprehensive care plan is to be developed on 03/04/2016. The corrective action will be monitored to ensure the deficient practice does not recur by the</p>	03/04/2016

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NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3530 S SHELBY ST INDIANAPOLIS, IN 46227
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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
	<p>in bed], excessive sleep during the day and lack of sleep at night." Client Statement - "I ...want to start drawing and painting again."</p> <p>A Service Plan for the resident, dated 12/12/15, indicated the following:</p> <p>Hygiene: Assistance to be given daily for A.M. and P.M. care, provided by a home health agency and nursing. The kind of assistance to be provided was not specified.</p> <p>Bathing: The services to be provided were not specified.</p> <p>Behaviors: Interventions needed for episodic behaviors. The only intervention indicated was, "reassurance," to be provided by nursing.</p> <p>Activities: Inform and encourage resident participation in scheduled activities.</p> <p>The service plan did not indicate any facility interventions for sleeping during the day, lack of sleep at night, the resident's interest in drawing and painting, or specific hygiene, bathing interventions.</p> <p>On 2/5/16 at 11:30 a.m., the Clinical</p>		<p>Clinical Director/ Designee completing random weekly audits the first month, then 1 time monthly for the next 3 months. If 100% compliance is not achieved, then the Quality Assurance audits will continue for an additional 3 months.</p>	

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

PRINTED: 03/01/2016
FORM APPROVED
OMB NO. 0938-0391

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	Director indicated, "I think we are going to try to incorporate mental health goals into our service plans."				