

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 02/05/2013
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NAME OF PROVIDER OR SUPPLIER SHADY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 10924 LINCOLNWAY E PLYMOUTH, IN 46563
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 04 & 05, 2013</p> <p>Facility number: 001147 Provider number: 001147 AIM number: N/A</p> <p>Survey team: Julie Wagoner, RN, TC Amber Bloss, Medical Surveyor III</p> <p>Census bed type: Residential: 44 Total: 44</p> <p>Census payor type: Medicaid: 44 Total: 44</p> <p>Sample: 07</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on February 15, 2013, by Brenda Meredith, R.N.</p>	R000000		

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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R000091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.</p> <p>Based on record review and interviews, the facility failed to ensure a thorough, complete written policy and procedure for preventing resident abuse was available and implemented in the facility. In addition, the facility failed to ensure 7 of 7 new employee files reviewed contained documentation that the new employees were oriented to the facility's policy and procedure to recognize and report abuse. (Employee #1, 2, 3, 4, 5, 6, and 7)</p> <p>Finding includes:</p> <p>1. Review of the Clinical Record for Resident #6, on 02/04/13 at 1:30 P.M., indicated on 11/28/12, the resident reported her purse and money was missing from her room.</p> <p>On 2/5/13 at 11:00 A.M., the "Shady Rest Home Client Complaint Form,</p>	R000091	<p>1. All available funds were returned to resident #6. Upon investigation resident #40 was not attacked by another resident with a knife and thus was not affected by the deficient practice. 2. No other residents have been affected by this alleged deficient practice. At the time of the survey, copies of the facilities "Resident Abuse Prevention" policy and related policies were reviewed. This includes "Violence in the Workplace", "Event Reporting", "Adult Protective Services", and "Abuse/Exploitation by Staff; Reporting and Investigation". 3. By March 22, 2013 the administrator shall modify the "Resident Abuse and Prevention" Policy to include staff orientation to abuse prevention, client protection during investigation and proper reporting. All staff shall be orientated to the modified "Abuse Prevention and Reporting" policy by March 22, 2013. The Director of Nursing</p>	03/22/2013			

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	<p>dated 11/28/12, was reviewed. The form indicated Resident #6 had reported her purse was missing. The complaint was received by the Administrator. The action taken, which was not dated, indicated the following: "Housekeepers found the purse in [Resident #8's name] clothes hamper hidden among her clothes. Purse with money in it was returned to [Resident #6's name]. [Resident #6's] claimed there was \$33 in it but only \$15 was found. When questioned [Resident #8's name] claimed there had been only \$15 in it when she took it. No remaining funds were found."</p> <p>Interview with the Administrator, on 02/05/13 at 2:00 P.M., confirmed he had not reported the missing funds to the Indiana State Department of Health.</p> <p>2. During an interview with the Administrator, on 02/05/13 at 9:00 A.M., he indicated he had had no allegations of abuse to report to the Indiana State Department of Health in the past year. When remarking how unusual having no allegations was for the type of facility, especially no resident allegations of physical or verbal abuse from other residents, the Administrator indicated he did a</p>		<p>shall inservice all staff and conduct testing to ensure understanding and compliance. All staff will be in-serviced annually on "Abuse Prevention" to ensure staff understand and implement the client "Abuse Prevention" policy and procedure as needed. The administrator will review all allegations and reports to ensure investigations and outcomes are conducted properly by staff report. 4. The administrator/designee shall orientate new staff to the "Abuse Prevention" policy and the policy shall be made available to residents upon request.</p>				

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	<p>reportable "incident" he had reported.</p> <p>On 2/5/13 at 11:00 A.M., the reportable incident, dated 05/17/12, was reviewed and indicated the following: "Another male client reported this client was walking down the road. QMA [Qualified Medication Aide] went after client and he willingly returned to the facility. Client report to [physician's name] that another client was going to cut his face with a knife, he took the knife away from the other client and threw it in the weeds." The form indicated under "Immediate Action" the psychologist spoke with the resident about leaving the facility and the resident was put on 15 minute checks. Preventative measures taken were to have staff remind the resident to talk to staff when he is feeling unsafe.</p> <p>During an interview, on 02/05/13 at 10:00 A.M., the Administrator indicated there was no investigation to determine if any other resident had threatened Resident #40 with a knife. There was no interview with any staff regarding the incident to determine if they had observed any altercations or near altercations between Resident #40 and any other resident. There were no interviews with other residents to determine if there had</p>						

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	<p>been any resident threatening others with a knife. The Administrator indicated Resident #40 and many other facility residents were often delusional due to their psychiatric issues. He indicated the resident later "recanted" the story.</p> <p>During an interview, on 02/05/13 at 2:30 P.M., the Administrator indicated he had not followed the facility policy and procedure regarding the reported incident for Resident #40.</p> <p>On 2/5/13 at 2:15 P.M., the facility policy and procedure, titled, "Abuse//Exploitation by Staff: Reporting and Investigation", dated October 1, 2009, was reviewed and included the following: "...4.5 The Corporate Compliance Committee shall investigation the circumstances of the alleged abuse, neglect or exploitation incident(s) and determine liability to the Center and the course of action to the investigate the incident(s)...4.8 During the course of the investigation, the client(s) shall be given opportunity to provide a verbal or written account of the alleged abuse incident(s) to the Center's Performance Improvement Specialist..." The policy was not specific to the investigative process for allegations of abuse against one</p>			

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	resident by another resident.				

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R000148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interviews, the facility failed to maintain resident equipment, grounds, and the building in clean and good repair and free from hazards. This potentially affected 44 of 44 residents.</p> <p>Finding includes:</p> <p>The environmental tour of the facility, accompanied by the Housekeeping Supervisor, was conducted on 02/05/13 between 11:15 A.M. - 12:30 P.M., indicated the following:</p> <p>1. The right side of 8 exit steps outside the men's exit door were covered with a layer of ice. The</p>	R000148	<p>1. No residents were affected by these alleged deficiencies. 2. No other residents have been affected by these alleged deficiencies. 3. By March 30, 2013 the following procedures and repairs shall be implemented by the corporate maintenance staff or contractors. (1) and (2) The snow removal service shall ensure all steps and walkways are free of snow and ice as needed. The facility housekeeping staff/designees shall check walks and steps to ensure they are properly maintained. Maintenance shall inspect, clean, and repair the dripping gutters. (3) The footstool shall be removed and replaced.</p>	03/29/2013			

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	<p>guttering noted above the steps was noted to be dripping during the observation. Interview with the Housekeeping Supervisor, Employee #10, during the tour, indicated the doors were unlocked and the residents frequently went in and out the doors and down the steps so they could walk around the grounds. Employee #10 also indicated the facility paid a service to provide grounds keeping services including snow removal and salt for the steps.</p> <p>2. The 5 steps and the landing outside the emergency exit door, in the activity room, was noted to have between 1 -2 inches of snow and ice buildup on them.</p> <p>3. A footstool, located in the men's lounge was noted to have peeling and cracked edges.</p> <p>4. A coffee maker, located in the activity room, was noted to be grimy and dirty. Interview with Employee #10, during the tour, indicated the coffee pot belonged to one of the residents and was placed there and maintained by the resident. In addition, there were 5 dining room chair with cracked and torn vinyl on the seats and back.</p> <p>5. The kitchen cupboards, located in an upstairs room and utilized for Resident cooking classes and small group therapy, were noted to have</p>		<p>The coffee pot shall be removed. All torn vinyl chairs shall be repaired. (5) The kitchen cabinets will be replaced. (6) the carpet tare will be repaired. (7) The woodwork will be painted. (8) The vinyl floor will be repaired. The bathtub will be repaired or removed. (9) The vinyl chairs shall be repaired. (10) The handrail will be refinished. (11) The sprinkler system trim rings will be repaired. (12) The heater cover will be replaced. (13) The electrical outlet was inspected and was found to be safe. (14) The exit door will be repaired. 4. Corporate maintenance will conduct monthly safety inspections. During inclement weather environmental staff and/or charge personnel/designee on duty shall monitor and maintain steps and walkways inbetween times of removal by the snow removal service.</p>				

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	<p>peeling laminate with the underlying particle board exposed. There was a 3 foot by 6 inch panel just below the sink area noted to be missing. In addition, the countertops were noted to be dirty with crumbs and had chipped laminate around the edges.</p> <p>6. The carpet, located in the upstairs Activity room/office, was noted to have a 3 inch by 4 inch I-shaped tear in it. Interview with the Activity Director, during the tour, indicated residents utilized the room for 1:1 activities and some small group sessions.</p> <p>7. The woodwork along the upstairs hallway and door frames leading to small room utilized for group and individual therapy sessions, was noted to have large areas of chipped and peeling paint with dark wood exposed underneath the white and/or light pink paint.</p> <p>8. A bathroom, located near the upstairs therapy rooms was noted to have a cracked laminate floor beside the toilet with the floor heaved up. In addition, there was a moldy rag located in the tub drain of the bathtub and a window air conditioner located in the bathtub. Interview with Employee #10, during the tour, indicated the bathtub was not utilized anymore and needed torn out. She indicated the water was shut off to the</p>						

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	<p>bathtub.</p> <p>9. Eight straight chairs, located in the Chapel resident lounge, were noted to be ripped around the edges and/or on the seat portion. In addition, the television stand was noted to have missing finished on the edges with exposed particle board.</p> <p>10. An approximately 6 inch portion of the handrail located on women side of the facility was noted to be heavily marred with uneven gnarled bare wood exposed.</p> <p>11. The sprinkler head, located in the housekeeping closet and in the walkway to the dining room, was noted to be hanging down from the ceiling. Interview with Employee #10, during the tour, indicated the sprinklers were recently replaced and the new sprinklers did not fit right and were falling down.</p> <p>12. The baseboard heater, running the length of one side of the Resident "Pop" room was noted to be missing the face. A treadmill, utilized was residents, was noted in the "Pop" room and the cord was noted to spark when Employee #10 plugged the treadmill into the outlet. Interview with an anonymous resident, on 02/05/13 at 9:30 A.M., indicated the treadmill would often "spark" when it was plugged in and utilized.</p> <p>13. The end of the service ramp, by</p>						

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	<p>the exit door was noted to be very dark and dim even with the lighting available. Interview with Employee #10, during the tour, indicated residents utilized the ramp often to access the outside. The concrete wall, located to the left side of the exit door was noted to be crumbling. Employee #10 indicated the wall inside the adjacent laundry room had been repaired and she did not know if the wall by the exit door was to going to be repaired.</p> <p>14. The emergency exit door, located in the main dining room was noted to have at least 1-2 inches of rust across the bottom of the entire door.</p>			

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R000273	<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 and interviews, the facility failed to ensure the walls in 1 of 1 kitchens was maintained in a sanitized manner. In addition, the facility failed to ensure 1 of 1 ice machines in the facility was maintained in a sanitized manner. This potentially affected 44 of 44 residents in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen, conducted, on 02/04/13 between 9:45 A.M. - 10:00 A.M., the walls behind the dishwashing area, hand washing sink, and stove appeared to have peeling paint.</p> <p>Observation of the kitchen, conducted, on 02/05/13 between 2:45 P.M. - 3:00 P.M., and interview with the Food Service Supervisor, on 02/05/13 at 3:00 P.M., indicated the finish was worn off from frequent cleaning on the wall and the underlying particle board was exposed. The Food Service Supervisor indicated the walls had</p>	R000273	<p>1. No residents were affected by these alleged deficiencies. 2. No other residents were affected by these alleged deficiencies. 3. The following procedures and repairs shall or have been implemented: the ice machine was properly cleaned by kitchen personnel on 2/6/13. The unit is scheduled for replacement. The kitchen's existing wall boards will be replaced with new washable plastic or vinyl boards by corporate maintenance or a contractor. 4. The Food Service Supervisor will monitor the monthly kitchen cleaning schedule and procedures for both the ice machine and the kitchen walls to ensure they are properly cleaned and maintained.</p>	03/29/2013			

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	<p>been in the observed condition "for a long time." She indicated only "major" issues were fixed by the corporation.</p> <p>Observation of the ice machine, on 02/05/13 between 11:15 A.M. - 12:30 P.M., during the Environmental tour of the facility, indicated there was a thick, fuzzy gray buildup inside the ice bin along the metal strip just below the hinges to attach the lid to the ice machine. In addition, there was an accumulation of a black moldy appearing substance along the plastic molding on both sides of the ice machine. Interview with the Food Service Supervisor, during the environmental tour, indicated the ice machine was cleaned every month and had last been cleaned three weeks ago. She indicated evidently the staff member cleaning had not been getting down far enough to see the buildup.</p>						