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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>12/01/2011 |
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|--------------------|---|---------------|---|----------------------|
| R0000              | <p>This visit was for the Investigation of Complaint IN00100250.</p> <p>Complaint IN00100250 - Substantiated. State residential findings are cited at R273.</p> <p>Unrelated state residential findings are cited.</p> <p>Survey dates: November 30 and December 1, 2011</p> <p>Facility number: 004903<br/>Provider number: 004903<br/>AIM number: N/A</p> <p>Survey team:<br/>Anne Marie Crays RN</p> <p>Census bed type:<br/>Residential: 46<br/>Total: 46</p> <p>Census payor type:<br/>Other: 46<br/>Total: 46</p> <p>Sample: 5</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> | R0000         | <p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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| R0145              | <p>Quality review 12/04/11 by Suzanne Williams, RN</p> <p>(b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on observation, interview and record review, the facility failed to ensure siderail gaps were no more than 4 3/4 inches, for 1 of 1 resident reviewed with siderails, in a sample of 5. Resident C</p> <p>State findings include:</p> <p>1. On 11/30/11 at 7:10 P.M., CNA # 1 indicated she was going to check Resident C for incontinence. Resident C was observed lying in bed at that time. 1/2 siderails were observed to be up on either side.</p> <p>The clinical record of Resident C was reviewed on 11/30/11 at 6:30 P.M. Diagnoses included, but were not limited to, dementia.</p> <p>A Mini Mental Status Examination, dated 7/6/11, indicated the resident had a total score of 11. The examination indicated, "A score of 24 or above is considered normal...25 or less suggestive of impairment, 10 or less severe deficit."</p> | R0145         | <p><b>Citation #1</b><br/><b>R 145</b><br/><b>410 IAC 16.2-2-5-1.5 (b)</b><br/><b>Sanitation and Safety</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b><br/>Resident C had their side rails assessed by the Wellness Director utilizing our side rail assessment form to determine appropriateness for continued usage. The Wellness Director determined the side rails as not meeting the recommended gap specifications of less than 4 3/4 inches. The side rails were removed after receiving permission from the responsible party. The hospice provider was contacted and a bed was delivered with 1/2 side rails that were within the state mandated parameters.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</b></p> | 01/02/2012           |

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|   | <p>The most recent service plan, dated 8/25/11, indicated the resident "had trouble recalling the day, date, time, or where" she was located. A hospice care plan, dated "8/28/11 - 12/19/11," indicated, "At Risk for Injury R/T [related to] Falls...R/T Unaware of own safety...Use safety device...Use of Hospital Bed with 1/2 SR [siderails] up for pt [patient] safety and repositioning assistance."</p> <p>A Physician's order for the siderails was lacking in the clinical record. A siderail assessment was lacking in the clinical record.</p> <p>On 12/1/11 at 9:00 A.M., the siderail gaps were measured at 8 and 8 1/2 inches. The Director of Nursing [DON] and Administrator were notified at that time.</p> <p>On 12/1/11 at 9:15 A.M., the Administrator indicated she had the siderails removed, and was contacting hospice regarding obtaining a new bed for the resident. The DON indicated at that time that he would perform a facility-wide audit to determine if any other beds had siderails.</p> <p>On 12/1/11 at 10:30 A.M., the DON provided a "Bed Side Rail Assessment/Evaluation Form," dated</p> |   | <p><b>taken?</b><br/>The Wellness Director performed a re-assessment of clients residing at Bell Oaks Terrace utilizing the side rail assessment form and found current side rail utilization to be within the state mandated parameters. No other residents were found to be affected.</p> <p><b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b><br/>The Wellness Director, Residence Director, and licensed staff were re-educated to our policy and procedure regarding side rail utilization and state mandated gap specifications as referenced within the state residential regulation R 145 410 IAC 16.2-2-5-1.5 (b) Sanitation and Safety and FDA standard. Side rails will be assessed before installation on future resident beds to ensure compliance.</p> <p><b>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b><br/>For the next six months the Wellness Director and/or Designee will perform a random biweekly review of resident's who have side rails to ensure they</p> |   |  |   |  |

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|   | <p>8/23/11. The DON indicated it was in the clinical record under the "Wellness Tab." The assessment included: "...Can resident pull call light? Yes, Can resident reach and pull call light if entrapped in bed? Yes...Does resident prefer BSRs [bed side rails]? Yes per family request...Is resident cognitively capable of making risk assessment decisions? No...Number and position of BSR on resident's bed 1 @ HOB [head of bed] [right] side...Slat widths: can a body part get caught? [Left blank]...What is the gap space between bars in center of BSR? [Left blank]....Has safety of other devices been assessed/documented? No...Has a Negotiated Risk Agreement [NRA] been written and implemented? The use of an NRA is recommended. [Left blank]."</p> <p>The "Guidance for Industry and FDA Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," dated March 10, 2006, indicated, "...Potential zones of entrapment...Zone 1: within the rail, Zone 2: Under the rail, between the rail supports, or next to a single rail support...Zone 4: Under the rails, at the ends of the rails, Zone 5: Between the split rails...Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent a head from entering...the space</p> |   | <p>have been assessed utilizing the side rail assessment form, a Negotiated Risk Agreement per our policy, and that they are meeting the side rail gap specifications as indicated within Indiana Residential regulation and FDA standard R 145 410 IAC 16.2-2-5-1.5 (b) Sanitation and Safety. Audits will be reviewed to determine the need for the ongoing monitoring plan and corrected through the facility's QA process. Findings suggestive of compliance will result in cessation of monitoring plan.</p> <p><b>By what date will the systemic changes be completed?</b><br/>Compliance Date:<br/>January 2, 2012</p> |   |  |   |  |

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|   | <p>should be less than 120 mm (4 3/4 inches), representing the head breadth...."</p> <p>On 12/1/11 at 10:30 A.M., the DON provided the current facility policy on "Bedrail Use," dated 6/2008. The policy included: "The Residence Director, with assistance from the nurse and other management or consulting staff, should work with residents, their responsible parties, and health care providers as appropriate to promote safe use of bedrails for residents who desire to use them...the Resident Director should make residents/responsible parties aware of potential risks, which include: Strangling, suffocation, bodily injury or death when a resident or part of their body is caught between rails...To ensure safe bedrail use...the Residence Director is required to follow these steps: Ensure that it is the resident's desire to use bedrails (not the family or significant other's) by interviewing the resident and documenting the resident' preference in the Service Notes and Negotiated Service Plan. Determine that the resident is able to understand potential hazards of using bedrails. Complete a nursing assessment of the resident to verify his/her level of cognitive ability, if needed. Meet with resident and significant others to discuss the use of bedrails and the possible risks of use. Brainstorm possible</p> |   |   |   |  |   |  |

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| R0273   | <p>alternatives...."</p> <p>(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 resident dishes were sanitized correctly, having the potential to affect 46 of 46 residents residing at the facility.</p> <p>State findings include:</p> <p>1. On 11/30/11 at 4:30 P.M., during interview with Cook # 1, she indicated she was the only staff working in the kitchen. She indicated the dishwasher had been broken for approximately 1 week, and it was to be 3 weeks before they could get it fixed or get a replacement. She indicated staff had been hand washing the dishes in the 3 compartment sink. The 3rd sink was observed to be filled with cloudy water. Cook # 1 indicated she changed the water "every whipstitch." Cook # 1 indicated she did not know where the strips were to check the concentration of the sanitizer. Cook # 1 indicated there was no log to document the concentration, and she did not know how often it was checked.</p> <p>Testing strips were found on a counter at</p> | R0273   | <p><b>Citation #2</b><br/><b>R 273</b><br/><b>410 IAC 16.2-2-5-5.1 (f)</b><br/><b>Food and Nutritional Services</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b><br/>No residents were found to be affected. The Residence purchased a new dishwasher to replace the broken dishwasher upon notification to the Regional Director of Operations.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b><br/>No other residents were found to be affected.</p> <p><b>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b><br/>The Residence Director and kitchen staff were re-educated to appropriate sanitation and safety</p> | 01/02/2012  |  |   |  |

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|   | <p>that time, and the sanitation sink water was tested. The strip recorded "0" ppm [parts per million]. Cook # 1 indicated she did not know what the correct concentration should be.</p> <p>On 11/30/11 at 5:25 P.M., Cook # 1 was observed to be filling up the 3rd sink from the regular spigot. The sanitizer hose was not in the 3rd sink. During interview, Cook # 1 placed the sanitizer hose in the sink, and indicated she was unsure how much solution to use. Cook # 1 began washing dishes, and placed them in the sanitizer water. Cook # 1 indicated she was unsure how long she was to leave them in the solution. Cook # 1 indicated she did not usually have to wash all of the dishes after supper, but would help the CNAs that night. The water in the sanitizing sink was checked at that time with a testing strip, and tested "0 ppm."</p> <p>On 11/30/11 at 5:25 P.M., during interview with CNA # 1, she indicated the CNAs would help clear the dishes, but did not usually wash them. CNA # 1 indicated a dietary aide would usually wash the supper dishes.</p> <p>On 12/1/11 at 8:45 A.M., during interview with the Director of Nursing [DON], he indicated he attempted to get the sanitizer water to test at 200 ppm, but</p> |   | <p>standards pertaining to food prep and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation standards, including 410 IAC 7-24. The cooking staff were re-educated to utilization of the 3 compartment sinks in the absence of the dishwasher along with proper sanitizing solution, testing, and recording appropriate documentation as indicated within our policy "Washing and Sanitizing Dishes/Utensils."</p> <p><b>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b><br/>For the next six months the Residence Director and/or Designee will perform a random weekly review of kitchen sanitation and safety standards to ensure continued compliance with Indiana state residential regulation R 273 410 IAC 16.2-2-5-5.1 (f) Food and Nutritional Services. Audits will be reviewed to determine the need for the ongoing monitoring plan and corrected through the facility's QA process. Findings suggestive of compliance will result in cessation of monitoring plan.</p> <p><b>By what date will the systemic</b></p> |   |  |   |  |

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|   | <p>was unable to do so. The DON indicated he had a call out to the service representative responsible for the sanitizer.</p> <p>On 12/1/11 at 9:30 A.M., the service representative demonstrated the correct procedure to fill up the sanitizer sink. The service representative indicated the sanitizer hose was to be used to fill the sink. The service representative indicated the testing strip should read between 150 and 400 ppm. The water was tested after cooling, and registered 200 ppm. The DON indicated he would inservice staff on the correct sanitation procedure.</p> <p>2. On 11/30/11 at 6:00 P.M., the DON provided the current facility policy on "Washing and Sanitizing Dishes/Utensils," sated 6/2008. The policy included: "...If a commercial dishwasher is not working properly and thus cannot be used, dishes may be washed by hand in the three-compartment sink. The following procedures must be followed to ensure appropriate cleaning and sanitation:...Wash the dishes/utensils with detergent and hot water (120 degrees F.) Rinse with clear, hot water to remove soap and food particles. Sanitize for one minute in the third compartment to kill any remaining bacteria. An appropriate sanitizing solution can be purchased from</p> |   | <p><b>changes be completed?</b><br/>Compliance Date:<br/>January 2, 2012</p>                                    |   |  |   |  |

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|   | <p>the food supply vendor....Utensils, equipment, preparation surfaces and the kitchen area must be kept clean at all times...."</p> <p>This state residential finding relates to Complaint IN00100250.</p> |   |   |                      |   |