

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 07/02/2014
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062
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R000000	<p>This visit was for a State Residential Licensure survey.</p> <p>Survey dates: July 1 and 2, 2014</p> <p>Facility number: 004417 Provider number: 004417 AIM number: N/A</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Gloria Bond, R.N. Sandra Nolder, R.N.</p> <p>Census bed type: Residential--91 Total--91</p> <p>Census payor type: Other--91 Total--91</p> <p>Residential Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by Tammy Alley RN on July 7, 2014.</p>	R000000	<p>This creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and request Desk Review in lieu of a Post Survey Review on or after July 23,2014.</p>	
R000116	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific</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>procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>Based on interview and record review, the facility failed to ensure reference checks were completed prior to hiring for 5 of 8 employee files reviewed for reference checks. (CNA #2, LPN #3, Server #4, Server #5, and Sales Coordinator)</p> <p>Findings include:</p> <p>The employee records were reviewed on 7/2/14 at 9:30 A.M.</p> <p>1. The "Employee Record" form indicated CNA #2's employment start date was 1/13/14. The form titled "Timecard" dated 1/01/2014-1/31/2014, indicated she started her general orientation on 1/13/14 and her floor orientation on 1/14/14. The form titled "Reference Check" was dated and signed 1/14/11.</p> <p>During an interview on 7/2/14 at 11:13 A.M., the BOM (Business Office Manager) indicated the "Reference Check" date and signature of 1/14/11, was the correct date. She indicated CNA</p>	R000116	<p>New form was developed for orientation of new hires to ensure that all reference checks are completed by the hiring manager prior to general orientation. The Business Office Manager will collect all of the required documentation prior to scheduling the new employee for orientation. The file will then be audited prior to the 90 day evaluation to ensure that all documents were completed within the probationary 90 day period. The Business Office Manager will notify the Executive Director if there are any missing items from the personnel file. Audit tool will be used to ensure all current employees have the reference checks. Ongoing no one will be allowed to take orientation until it is completed. Each employee file will be then check during their annual review for compliance. Initial audit will be completed by 8/22/2014.</p>	08/22/2014

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	<p>#2 had worked at the facility before from 1/14/11 until 8/18/13, and she was rehired on 1/13/14. She indicated because CNA #2 was only gone from the facility for four months, there was no new reference checks completed for her. She indicated, "We just asked people who had worked here with her before to see if she was okay to rehire."</p> <p>2. The "Employee Record" form indicated LPN #3's employment start date was 2/18/14. The form titled "Timecard" dated 2/02/2014-3/02/2014, indicated she started her general orientation on 2/18/14 and her floor orientation on 2/19/14. The form titled "Confidential Reference Check" lacked documentation that the reference checks were completed. A form titled "FAX" dated 2/13/14, indicated "Please complete reference check for [name of employee] &amp; [sign for and] return to me ASAP [as soon as possible]" signed by the DoN (Director of Nursing). A form titled "FAX" dated 2/13/14, indicated "Please complete reference check on [name of employee]" signed by the DoN.</p> <p>During an interview on 7/2/14 at 11:26 A.M., the BOM indicated the reference checks were not completed, but she was not sure what the back up plan was when the faxes were not answered. She</p>			

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	<p>indicated the individual supervisors were responsible for following up on the reference checks. She indicated LPN #3's supervisor was the DoN.</p> <p>During an interview on 7/2/14 at 12 P.M., the DoN indicated the back up plan when the faxes were not answered for the reference checks were to call or e-mail the people to try to get a response. She indicated LPN #3's reference checks had been missed when following up on reference checks.</p> <p>3. The "Employee Record" form indicated Server #4 employment start date was 2/4/14. The form titled "Timecard" dated 2/02/2014-3/01/2014, indicated she started her general orientation on 2/4/14 and her floor orientation on 2/21/14. A form titled "Confidential Reference Check" was partially completed and was not signed or dated by the person who partially completed the form.</p> <p>During an interview on 7/2/14 at 11:24 A.M., the BOM indicated Server #4's reference check was not completed, signed or dated.</p> <p>4. The "Employee Record" form indicated Server #5's employment start date was 2/4/14. The form titled</p>			

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	<p>"Timecard" dated 2/02/2014-3/01/2014, indicated she started her general orientation on 2/4/14 and her floor orientation on 2/25/14. Two forms titled "Confidential Reference Check" were partially completed and were not signed or dated by the person who partially completed the forms.</p> <p>During an interview on 7/2/14 at 11:18 A.M., the BOM indicated the reference checks were not dated. The Executive Director indicated at this time that the facility could not make up a date after the fact.</p> <p>5. The "Employee Record" form indicated the Sales Coordinator's employment start date was 2/2/14. The form titled "Timecard" dated 2/02/2014-3/16/2014, indicated she started her general orientation on 2/20/14 and her floor orientation on 2/25/14. A form titled "Confidential Reference Check" was partially completed and was not signed or dated by the person who partially completed the form.</p> <p>During an interview on 7/2/14 at 11:20 A.M., the BOM indicated the Sales Coordinator's reference check was not completed, signed or dated.</p> <p>During an interview on 7/2/14 at 11:30</p>			

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R000121	<p>A.M., the BOM indicated the reference checks need to be completed prior to an employee starting their employment. She indicated, "We need to focus more on completing the reference checks." She indicated, "Looks like I need to follow up better with the managers on the completion of the employee files."</p> <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 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.</p>			

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	<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 interview and record review, the facility failed to ensure employees received their second step tuberculin skin test for 2 of 8 employee files reviewed for Tuberculin testing. (LPN #3 and Server #5)</p> <p>Findings include:</p> <p>The employee records were reviewed on 7/2/14 at 9:30 A.M.</p> <p>1. The "Employee Record" form indicated LPN #3's employment start date was 2/18/14. The form titled "Timecard" dated 2/02/2014-3/02/2014, indicated she started her general orientation on 2/18/14 and her floor orientation on 2/19/14. A form titled "Tuberculin Testing for Employees" dated 2/18/14, indicated the first step TB skin test was completed on 2/18/14 and the second step TB skin test was completed on 3/19/14.</p>	R000121	All newly hired employees will have a tuberculin skin test prior to the scheduled date for general orientation. They will be scheduled by their hiring manager for a second step in 1-3 weeks. The Business Office Manager will audit to ensure completion of the second step PPD. The Department Head will be notified of any non-compliance to complete the 2nd step PPD and the department head will take action with the employee. The Annual tuberculin skin test will be given with the Annual Performance Appraisal and any discrepancies will be forwarded to the Executive Director. All employees will be in-serviced within 30 days. Auditing of all current employees and any missing test will be done as found. During annual review it will mandatory for them to have test. This will be ongoing. Will be completed on 8/22/2014.	08/22/2014			

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R000123	<p>2. The "Employee Record" form indicated Server #5's employment start date was 2/4/14. The form titled "Timecard" dated 2/02/2014-3/01/2014, indicated she started her general orientation on 2/4/14 and her floor orientation on 2/25/14. A form titled "Tuberculin Testing for Employees" dated 2/4/14, indicated the first step TB skin test was completed on 2/4/14 and the second step TB skin test was completed on 3/28/14.</p> <p>During an interview on 7/2/14 at 11:30 A.M., the BOM (Business Office Manager) indicated the second step TB skin tests for these employees had not been done timely. She indicated, "Looks like I need to follow up better with the managers on the completion of the employee files."</p> <p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration</p>			

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	<p>number or dining assistant certificate or letter of completion, if applicable.</p> <p>(6) Position in the facility and job description.</p> <p>(7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills.</p> <p>(8) Signed acknowledgement of orientation to residents' rights.</p> <p>(9) Performance evaluations in accordance with facility policy.</p> <p>(10) Date and reason for separation.</p> <p>Based on interview and record review, the facility failed to ensure job specific orientation was completed for 2 of 8 employee files reviewed for job specific orientation completion. (CNA #2 and LPN #6)</p> <p>Findings include:</p> <p>The employee records were reviewed on 7/2/14 at 9:30 A.M.</p> <p>1. The "Employee Record" form indicated CNA #2's employment start date was 1/13/14. The form titled "Timecard" dated 1/01/2014-1/31/2014, indicated she started her general orientation on 1/13/14 and her floor orientation on 1/14/14. The "Certified Nursing Assistant/Home Health Aide Job Specific Orientation" for this employee was dated as being completed on 1/20/11. The "General Orientation Acknowledgement Form" was dated as being completed on 1/20/11.</p>	R000123	<p>New checklist form was developed for orientation of new hires (and re-hires) to ensure that all reference checks are completed by the hiring manager prior to general orientation. The Business Office Manager will collect all of the required documentation prior to scheduling the new employee for orientation. The file will then be audited prior to the 90 day evaluation to ensure that all documents were completed within the probationary 90 day period. The Business Office Manager will notify the Executive Director if there are any missing items from the personnel file. Initial audit will be completed by 8/22/2014. Ongoing audits on new employees will be completed during their 90 day probation period.</p>	08/22/2014

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	<p>During an interview on 7/2/14 at 11:13 A.M., the BOM (Business Office Manager) indicated CNA #2 had worked at the facility before from 1/14/11 until 8/18/13, and she was rehired on 1/13/14. She indicated because CNA #2 was only gone from the facility for four months, so the BOM did not think CNA #2 had to complete new general and job specific orientations.</p> <p>2. The "Employee Record" form indicated LPN #6's employment start date was 12/17/13. The form titled "Timecard" dated 12/08/2013-1/19/2014, indicated she started her general orientation on 12/23/13 and her floor orientation on 12/24/13. The "Licensed Nurse (LPN or RN) Job Specific Orientation" had the following sections that were not completed: "Public Relations," "Resident Care &amp; Safety," "Reports/Programs/Policies" and "Equipment." The following areas were not signed or dated: "Medication Validation."</p> <p>During an interview on 7/2/14 at 11:22 A.M., the BOM indicated LPN #6's job specific orientation was not completed.</p> <p>During an interview on 7/2/14 at 11:30 A.M., she indicated, "Looks like I need</p>			

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R000148	<p>to follow up better with the managers on the completion of the employee files."</p> <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: (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. Based on observation, interview and record review, the facility failed to have the heating and ventilating systems inspected annually. This deficiency had the potential to affect 91 of 91 residents</p>	R000148	Maintenance Director contracted with the HVAC certified inspector on 7/28/2014 for annual inspections. The Executive Director will oversee that the annual inspection is completed.	08/22/2014			

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	<p>residing in the facility.</p> <p>Findings include:</p> <p>The environmental tour of the facility began on 7/1/14 at 9:40 A.M., with the Maintenance Director in attendance.</p> <p>During an interview at this time, the Maintenance Director indicated the heating and ventilating system had not been inspected by a trained or certified individual for the last 10 years. He indicated he did not know he had to have a trained individual in HVAC (Heating, Ventilation, Air Conditioning systems) to inspect the heating and ventilating system annually. He indicated he had been the person "inspecting" the systems and he was not trained in HVAC systems. He indicated when he "inspected" the systems he changed the filters.</p> <p>A July schedule of the Maintenance weekly and monthly tasks were reviewed with the Maintenance Director on 7/1/14 at 11:20 A.M. The scheduled tasks included, but were not limited to: HVAC (Air Handlers) (moved air through the facility dependent on whether it was set on the heating or cooling mode): "Inspect air filter, verify operation, inspect belt and set proper tension."</p>		<p>Date of the initial inspection will be completed before 8/22/2014. See attached contract</p>				

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R000154	<p>HVAC (Heat Pumps) (heated and cooled areas of the facility): "Verify operation, inspect/change air filter, inspect/change belt and set proper tension."</p> <p>HVAC (PTAC) (Packaged Terminal Air Conditioner Unit) (Individual heating and cooling systems for individual apartments): "Clean air filters."</p> <p>During an interview at this time, the Maintenance Director indicated he followed this schedule each week and month to prompt him when his tasks were due. He indicated he could not provide documentation to show the heating and ventilation systems had been "inspected" by him each month because the computer did not keep track of that task after it was completed to allow him to print that task off.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain cooking and serving pans in sanitary condition. This deficiency had</p>	R000154	All Food service employees will be in-serviced by the Director of Food and Beverage on proper cleaning of the pans. Ongoing the Director of Food and	08/22/2014

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	<p>the potential to affect all 91 of 91 residents residing in the facility who were served food from the kitchen.</p> <p>Findings include:</p> <p>During an initial sanitation tour of the kitchen on 7/1/14 at 9:45 A.M., a stack of 4 to 5 kitchen pans were observed upside down on a metal rack. The metal rack was near the prep area of the kitchen. The pan on the bottom of the stack was observed with a string of a yellowish debris hanging from the metal lip of this rectangular pan.</p> <p>In an interview at this time, Cook #1 indicated this was most likely a piece of plastic wrap that did not come off during the cleaning process, and she removed it.</p> <p>Other pans were observed with an edge of what had been identified as plastic wrap mixed with some food debris. The kitchen manager came by and indicated the wrap that is used to cover the food before serving can be hard to remove and these pans needed to be rinsed again.</p> <p>A facility, "Manual cleaning and sanitizing with three compartment sink," was provided on 7/2/14 at 9:40 A.M. The procedure indicated the following: "Equipment and utensils are thoroughly</p>		<p>Beverage and Assistant Director of Food and Beverage will perform weekly checks of the pans the ensure compliance and report any findings to the Executive Director. Will be completed by 8/22/2014</p>	

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 07/02/2014
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062
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R000214	<p>washed in the first sink in a detergent solution...Equipment and utensils are rinsed free of detergent and abrasive with clean, hot, clear water...Equipment and utensils are sanitized in the third compartment according to one of the following methods:...Immersion for at least 30 seconds in clean hot water..."</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to evaluate the individual needs related to substantial weight loss and gain and failed to complete a semi-annual evaluation, for 1 of 8 residents reviewed for evaluations. In addition, the facility failed to ensure pre-admission evaluations were completed for 2 of 6 residents reviewed for pre-admission evaluations. (Residents #7, #8 and #46)</p> <p>Findings include:</p>	R000214	<p>A new assessment form was made to include the date and time that the Pre-Admission assessment was completed (See attachment). The licensed nurses will be in-serviced on the new form. All potential new residents will be assessed before move in and the date and time documented on the pre-admission assessment form. . The Director of Nursing and Executive Director will routinely monitor the new admissions for compliance. Resident weights will be obtained upon move in and</p>	08/22/2014

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	<p>1. Resident #46's record was reviewed on 7/1/14 at 2:25 P.M. Diagnoses included, but were not limited to, pneumonia, hypertension, coronary artery disease, Stage 3 kidney disease, congestive heart failure and history of respiratory failure.</p> <p>The "Vital Sign/Weight Flow Sheet" record had documentation of monthly weights as follows: 12/02/13--191 12/29/13--180 01/29/14--176 02/03/14--176 03/29/14--179 04/29/14--177 05/28/14--176 06/28/14--175 07/01/14--185 07/02/14--179</p> <p>An evaluation of the resident's decreasing weights over the past six months, to determine individual needs related to the weight loss, was not found.</p> <p>During an interview on 7/2/14 at 11 A.M., the DoN (Director of Nursing) indicated the semi evaluation was the service plan and she had completed a new one to address the weight issues with the resident on 7/1/14 after the weight</p>		<p>every month thereafter. Weights will be documented on the Vital Sign and Weight Record. If the weight shows an undesirable loss/ gain of 7.5% or more from the prior weight recorded another staff member will reweight the resident within 24 hours. The resident's physician will be notified of the weight loss or gain by the nurse after the 2nd weight is obtained. The resident and their designated responsible party will be notified of any significant weight loss or gain of 5% or more. All nursing personnel will be in-serviced within 30 days. New assessment was created with highlighted required areas. These areas need to be filled in and will be audit by DON or designee. This will be ongoing. An audit tool is being used and will be completed by 8/22-2014 for all current residents.</p>				

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	<p>loss issue was brought to her attention. She indicated she had asked the night nurse to assess the resident due to she had gained 10 pounds in the past three days. She indicated she only asked the nurse to assess the resident's ankles and feet for edema, so no other assessments were completed. She indicated the resident had weight loss and gains at (name of the facility) when she was there for rehabilitation before she was admitted to this facility on 12/2/13. She indicated she had faxed the doctor on 7/1/14 and notified him of the weight changes from her admission until 7/1/14.2. On 7/1/14 at 2:10 P.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, CVA (Cerebral Vascular Accident / stroke), and a history of skin cancer.</p> <p>The resident's record lacked a pre-admission assessment evaluation. In an interview at this time, the DNS (Director of Nursing Services) indicated she would look for it.</p> <p>As of exit on 7/2/14 at 11:30 A.M., the DNS was unable to locate any other evaluations at this time on this resident. She indicated the way it is suppose to work is that a deposit is made and then an assessment is done. The assessment usually stays with the deposit until the</p>			

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R000217	<p>resident is ready to be admitted, but she had been unable to locate the original assessment / pre-admission evaluation.</p> <p>3. On 7/1/14 at 1:30 P.M., Resident #8's record was reviewed. Diagnoses included, but were not limited to, general weakness, and COPD (Chronic Obstructive Pulmonary Disease / chronic obstruction of airflow out of the lungs).</p> <p>The resident's record lacked a pre-admission evaluation. In an interview at this time, the DNS indicated she would look for it.</p> <p>On 7/2/14 at 10:00 A.M., the DNS indicated she had been unable to locate anymore information or evaluations on this resident.</p> <p>As of exit on 7/2/14 at 11:30 A.M., no other information was provided.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and</p>						

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	<p>(D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure a service plan was updated as a resident's individual needs changed, for 1 of 8 residents reviewed for service plans. (Resident #46)</p> <p>Findings include:</p> <p>Resident #46's record was reviewed on 7/1/14 at 2:25 P.M. Diagnoses included, but were not limited to, pneumonia, hypertension, coronary artery disease, Stage 3 kidney disease, congestive heart failure and history of respiratory failure.</p> <p>The "Residential Individual Service Plan" indicated the resident's re-admission date</p>	R000217	Resident weights will be obtained upon move in and every month thereafter. Weights will be documented on the Vital Sign and Weight Record. If the weight shows an undesirable loss/ gain of 7.5% or more from the prior weight recorded another staff member will reweight the resident within 24 hours. The resident's physician will be notified of the weight loss or gain by the nurse after the 2nd weight is obtained. The resident and their designated responsible party will be notified of any significant weight loss or gain of 5% or more. All nursing personnel will be in-serviced within 30 days. This will be ongoing. An audit tool is being used and will be completed by 8/22-2014 for all current residents	08/22/2014			

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	<p>to the facility was 12/2/13. The date of the "Residential Individual Service Plan" was 12/7/13. The Dining Assistance and Diet area indicated the resident required escorts to and from meals, reminders and verbal cues. She was on a regular diet and she was not on any supplements. Vital Signs and Weights area indicated the resident's weights was scheduled every month and "Nursing to monitor for changes *report loss/gain of 5% or greater to MD/family/resident*."</p> <p>The "Vital Sign/Weight Flow Sheet" record had documentation of monthly weights as follows: 12/02/13--191 12/29/13--180 01/29/14--176 02/03/14--176 03/29/14--179 04/29/14--177 05/28/14--176 06/28/14--175 07/01/14--185 07/02/14--179</p> <p>The lab results dated 1/21/14 for the resident's Protein level was 5.2 and normal was 6.0 to 8.3. She had an Albumin level of 3.4 and normal was 3.5 to 5.5.</p> <p>The resident's record lacked</p>		and will be completed semi annually with service plan reviews or a change of condition.	

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	<p>documentation that the doctor or her family was notified of the 5% weight loss from 12/2/13 to 12/29/13. The resident's record lacked documentation that the doctor or her family was notified of the 7.5% weight loss from 12/2/13 to 1/29/14.</p> <p>The resident's record lacked documentation that the service plan was updated when the resident had the significant change with the 5% weight loss.</p> <p>During an interview on 7/2/14 at 11 A.M., the DoN (Director of Nursing) indicated the semi evaluation was the service plan and she had completed a new one to address the weight issues with the resident on 7/1/14 after the weight loss issue was brought to her attention. She indicated she had asked the night nurse to assess the resident due to she had gained 10 pounds in the past three days. She indicated she only asked the nurse to assess the resident's ankles and feet for edema, so no other assessments were completed. She indicated the resident had weight loss and gains at (name of the facility) when she was there for rehabilitation before she was admitted to this facility on 12/2/13. She indicated she had faxed the doctor on 7/1/14 and notified him of the weight changes from</p>			

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R000408	<p>her admission until 7/1/14.</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on observation, interview and record review the facility failed to do chest x rays prior to admission on 2 out of 6 residents reviewed for diagnostic chest x-rays prior to admission. (Resident #7 and #8)</p> <p>Findings include:</p> <p>1. On 7/1/14 at 2:10 P.M., Resident #7's record was reviewed. Diagnoses included, but were not limited to, CVA (Cerebral Vascular Accident), and a history of skin cancer.</p> <p>The resident's record indicated she was admitted to the facility on 10/31/13. A radiology report indicated a diagnostic chest x-ray was done on 11/4/13.</p> <p>As of exit on 7/2/14 at 11:30 A.M., the Director of Nursing Services indicated there were no other chest x-rays able to be located for this resident.</p> <p>2. On 7/1/14 at 1:30 P.M., Resident #8's</p>	R000408	<p>A diagnostic Chest Xray will be obtained for each resident prior to admission. The resident will also have the two step tuberculin skin test before or upon admission. The Director of Nursing will collect the CXR and ensure that the admitting nurse completes the first step of the tuberculin skin test and schedules the second step on the Medication Administration Record. Once the two step tuberculin skin test is completed, the resident will be scheduled for a PPD annually. All resident records will be audit within 72 hours post move to ensure compliance by Director of Nursing or designee. Audits will be done semi-annually by the Director of Nursing and the ADON to ensure the completion. All personnel will be in-serviced within 30 days. Will be completed by 8/22/2014</p>	08/22/2014

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R000410	<p>record was reviewed. Diagnoses included, but were not limited to, general weakness, and COPD (Chronic Obstructive Pulmonary Disease / chronic obstruction of airflow out of the lungs).</p> <p>The record indicated this resident was admitted to the facility on 10/31/13. A radiology report indicated a diagnostic chest x-ray was done on 11/2/13.</p> <p>As of exit on 7/2/14 at 11:30 A.M., the Director of Nursing Services indicated there was another chest that was found on this resident, but it was dated 1/4/11.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of</p>			

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	<p>infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin 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>Based on interview and record review, the facility failed to ensure that a second step tuberculin (PPD--Purified Protein Derivative) skin test was completed within 1 to 3 weeks after the first test was completed upon or within 3 months prior to admission; or provided documentation that a tuberculin skin test or other tuberculosis screen was completed during the preceding 12 months. This deficiency affected 2 of 5 residents admitted since November, 2013, in a survey sample of 8 residents reviewed. (Residents #46 and #500)</p> <p>Findings include:</p> <p>1. The closed clinical record for Resident #500 was reviewed on 7/1/14 at 2:40 P.M. The resident was admitted to the facility on 2/8/14 and was discharged on 4/11/14.</p> <p>A first step PPD test was given on 2/5/14, and read on 2/7/14, in the attending physician's office.</p> <p>A second step PPD, or other documentation indicating a tuberculosis</p>	R000410	<p>The resident will also have the two step tuberculin skin test before or upon admission. The admitting nurse will give the first step if it is not done prior to admission and schedules the second step on the Medication Administration Record. Once the two step tuberculin skin test is completed, the resident will be scheduled for a PPD annually. Audits will be done semi-annually by the Director of Nursing and the ADON to ensure the completion. All personnel will be in-serviced within 30 days. New tool created see attached. Audit tool was used and once completed will be reviewed on semi-annual review. Will be complied by 8/22/2014</p>	08/22/2014

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 07/02/2014
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	<p>skin test or other screen had been done in the preceding 12 months, was not found.</p> <p>On 7/2/14 at 9:00 A.M., the Director of Nursing was given the opportunity to provided documentation of the second step PPD or skin testing done in the prior 12 months.</p> <p>In an interview on 7/2/14 at 10:50 A.M., the Director of Nursing indicated she was unable to find any documentation that a second step PPD test had been done by the facility following admission, or that the resident had received skin testing or screening in the previous 12 months.2. Resident #46's record was reviewed on 7/1/14 at 2:25 P.M. Diagnoses included, but were not limited to, pneumonia, history of respiratory failure, Stage 3 kidney disease, congestive heart failure and hypertension.</p> <p>A "Resident Immunization and Health History Form" indicated the resident had a Mantoux (tuberculosis) skin test completed on 10/9/13 at (name of facility) and the Mantoux skin test was read on 10/11/13 at (name of facility).</p> <p>A "Resident Immunization and Health History Form" indicated the resident had a Mantoux skin test completed on 12/2/13 at the present facility. The form</p>			

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	<p>lacked documentation when the 12/2/13 Mantoux skin test was read.</p> <p>During an interview on 7/2/14 at 11 A.M., the DoN (Director of Nursing) indicated the resident's Mantoux skin test from 12/2/13 was read and was signed off on the December 2013 MAR (Medication Administration Record), but the nurse did not document the mm (millimeters) of induration (amount or redness or raised welt) and signature on the "Immunization Form." She indicated without appropriate documentation the facility was unable to show the resident's Mantoux skin test was read as a negative result and in the appropriate time frame.</p> <p>3. In an interview on 7/2/14 at 11:10 A.M., the Director of Nursing indicated she had a facility procedure for tuberculosis skin testing. She indicated there was no specific staff to oversee the program, and that giving, reading, tracking, and monitoring of PPD skin tests or other screening methods "fell under Nursing" (department), and that "everyone (nurses) does."</p> <p>On 7/2/14 at 11:30 A.M., the Director of Nursing provided a seven-page document titled "Recommendations for Implementation of the Indiana State Department of Health's Tuberculin</p>			

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	<p>Shortage Guidelines for Acute and Long Term Care Facilities in the State of Indiana--September 20, 2013." The document mirrored the regulatory language for pre-employment testing of staff and pre-admission testing of new residents, with alternative methods of screening for tuberculosis due to the shortage of tuberculin skin testing solutions at that time.</p> <p>The document did not describe the facility's in-house procedures or specific staff responsibilities for administering, reading, tracking or monitoring of tuberculosis screening, to ensure the State rule was implemented.</p>						