

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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
R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00204481.</p> <p>Survey dates: July 8, 11 and 12, 2016</p> <p>Facility number: 013330 Provider number: 013330 AIM number: N/A</p> <p>Residential census: 32</p> <p>Sample: 13</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 14454 on July 15, 2016.</p>	R 0000		
R 0119  Bldg. 00	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</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.

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>(A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on interview and record reviews, the facility failed to provide orientation regarding the specialized needs for a dementia population, resident rights including abuse for 2 of their 6 recently hired staff members. (Employee #3 and Employee #5)</p> <p>Finding includes:</p> <p>During an interview on 7/11/16 at 9:30 A.M., Employee #3 indicated the facility was a specialized facility for resident's</p>	R 0119	<p>Employee #3 resigned from her position as of 7/14/16. Employee #5 received orientation for resident rights, abuse and dementia training on 5/16/16. Checklist was not in employee file but located and filed accordingly. Dementia training scheduled monthly moving forward to ensure continued compliance. 8/17/16 is next training scheduled. Employee files will be audited by 7/31/16 to ensure all other employees have the required training on Resident rights, abuse and dementia training. During</p>	08/17/2016

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>with dementia.</p> <p>During an interview on 7/11/16 at 11:15 A.M., Resident D's daughter indicated she did not think staff were given information or in-services on how to deal with residents who have dementia.</p> <p>On 7/11/16 at 1:30 P.M., a sample of six recently hired employee records were reviewed. Employee #3 was hired on 6/24/16. At the time of the survey, she was acting Director of Nursing on 7/8/16 and 7/11/16. There was no documentation in the employee's file indicating Employee #3 had orientation regarding resident rights, abuse and dementia training.</p> <p>On 7/12/16 at 9:45 A.M., Employee #5 was hired on 5/16/16. There was no documentation in the employee's file indicating Employee #5 had orientation regarding resident rights, abuse and dementia training.</p> <p>During an interview on 7/12/16 at 2:20 P.M., the Business Office Manager (BOM) indicated she could not find any evidence of orientation of abuse, resident rights or dementia for Employee's #3 and #5. The BOM indicated the facility's practice was for each new employee to complete 5 dementia videos during the</p>		<p>the initial orientation employees will receive and be checked off on training for resident rights, abuse and dementia training per new hire orientation checklist. The Administrator and Business Office Manager will be responsible to check and confirm that new employees receive the resident rights, abuse, and dementia training. Chart audits will be completed for 7 months, the audits will be conducted every two weeks for 3 months and monthly for the last 4 months.</p>	

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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
R 0120  Bldg. 00	<p>orientation phase. A New Employee Orientation Checklist, dated 2/8/12, was received from the BOM. The checklist included resident rights and abuse reporting but no dementia videos were listed. The BOM indicated there was no policy regarding the orientation procedures for the facility.</p> <p>On 7/12/16 at 11:25 P.M., the Director of Nursing provided information regarding "Training and Education," dated 2/2011, and indicated the policy was the one currently used by the facility and was part of the Resident Abuse and Neglect policy. The policy indicated "...1. During orientation and prior to resident contact, in-services will be provided to all employees about resident rights, management of angry, aggressive and/or catastrophic behaviors of residents in a manner that preserves dignity and is non-abusive; and the process for reporting witnessed or suspected abuse...."</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments</p>			

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on interviews and record reviews, the facility failed to provide an annual in-service regarding Resident Rights for 3 of 4 staff members reviewed. (Employee #6, #2 and #9)</p> <p>Finding includes:</p>	R 0120	<p><b><u>Personnel -Resident Rights/Abuse and Neglect</u></b> Staff members # 6, #2, and #9 all received Resident Rights in-servicing on 7-19-16.</p> <p>Employees to receive Resident Rights; Abuse and</p>	07/26/2016

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>On 7/11/16 at 1:50 P.M., a sample of 4 employee records, hired over 9 months ago, were reviewed. Employee #6 was hired on 4/23/15. There was no documentation in the employee's file indicating Employee #6 had an annual in-service regarding resident rights. The employee's job title was RN (Registered Nurse).</p> <p>Employee #2 was hired on 5/7/15 and there was no documentation in employee's file indicating Employee #2 had an annual resident rights in-service. The employee's job title was CNA (Certified Nurse Assistant).</p> <p>Employee #9 was hired on 7/28/15 and there was no documentation in the employee's file indicating Employee #9 had an annual resident rights in-service. The employee's job title was Activity Director.</p> <p>On 7/12/16 at 11:25 P.M., the Director of Nursing provided information regarding "Training and Education," dated 2/2011, and indicated the policy was the one currently used by the facility and was part of the Resident Abuse and Neglect policy. The policy indicated "...3. Annually, or more frequently if mandated by State regulation, a mandatory</p>		<p>Neglect-in-services by 7/26/16 and annually thereafter.</p> <p>Employee files have been audited (7/26/16) and remaining Staff members trained.</p> <p>Upon hire and annually staff will receive resident rightstraining and abuse/Neglect training.</p> <p>Administrator and BOM will be responsible to ensure compliance.</p> <p>Audits will be conducted for 7 months, the First 3 months audits will be conducted every 2 weeks, and monthly for the remaining 4 months.</p> <p>In-service training record document is attached to show the tool that will be used to track in-servicing.</p>	

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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
R 0121 Bldg. 00	<p>in-service will be presented for all staff on resident rights...."</p> <p>During an interview, on 7/12/16 at 2:20 P.M., the Business Office Manager (BOM) indicated she could not find any evidence of any annual in-service regarding resident rights.</p> <p>During an interview, on 7/12/16 at 2:30 P.M., the Director of Nursing indicated the annual in-services had not included information about the resident's rights.</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</p>			

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>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 reviews and interview, the facility failed to ensure 4 of 6 staff members had received the Tuberculin (TB) test at time of hire and/or completed the two-step method of TB testing. ( Employee #3, #5, #7 and #8) In addition, facility failed to ensure licensed nursing personnel was administering the Tuberculin (TB) test for 3 of 6 employee files reviewed. (Employee #8, #11 and #10)</p> <p>Finding includes:</p> <p>1. On 7/11/16 at 1:30 P.M., a sample of</p>	R 0121	<p><b>TB Compliance</b> 1. Employee #3 is no longer working at the facility. 2. Employee #5 had a chest x-ray on 5/20/16 –received from location and now in her chart. 3. Employee #7 had first step done on 7/13/16 and second step to be given on 7/26/16. Both steps completed by LPN. 4. Employee #8 had their second step TB test redone and completed by LPN on 7/12/16. 5. Employee #11 and #10 will be completed by 7/28/16 by LPN. All facility residents have the potential to be affected. All residents within facility to have a chart audit to ensure compliance.</p>	07/26/2016

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 07/12/2016	
NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545			
(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>six recently hired employee records were reviewed. Employee #3 was hired on 6/24/16. There was no documentation Employee #3 had a TB test, or a chest x-ray prior to or on her start date. The employee's job title was RN (Registered Nurse).</p> <p>The employee record for Employee #5 indicated she was hired on 5/16/16. There was no documentation indicating Employee #5 had a TB test, or a chest x-ray prior to or on her start date. The employees' job title was CNA (Certified Nursing Assistant).</p> <p>The employee record for Employee #7 indicated she was hired on 7/7/16 and her job title was a Cook Aide. There was no documentation indicating Employee #7 had a TB test, or a chest x-ray, prior to or on her start date.</p> <p>The employee record for Employee #8 indicated she was hired on 6/21/16. There was no documentation indicating Employee #8 had completed the Second Step process. A form titled "TB Test Documentation Form" dated 7/5/16, indicated the test had not been read. The employee's job title was Marketing.</p> <p>During an interview, on 7/12/16 at 11:00 A.M., the Business Manager indicated</p>		<p>Audit tool created. All employee personnel records will be audited to ensure compliance with the TB testing. The Business Office Manager will monitor all new employee paperwork. Audit tool created. All new employee personnel files will be checked by Business Office Manager and Administrator to ensure the TB tests and results of these tests have been verified. This check will occur prior to new hires being scheduled for orientation and prior to new move-ins physically coming into the community. Chart audits for staff members and residents will be completed for 7 months, every 2 weeks for the first 3 months and monthly audits for the remaining 4 months. TB tests will only be administered by licensed nursing personnel effective immediately and on-going per This will all be in accordance with the rule: (1) At the time of employment, or within one month prior to employment, and at least annually thereafter, employees and non paid 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 twelvemonths, the baseline tuberculin skin testing should employ the two-step method. If the first step is</p>				

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>Employee #3, #5, #7 and #8 were currently working in the facility.</p> <p>On 7/12/16 at 11:30 A.M., the Director of Nursing (DON) provided a policy titled, "Tuberculosis Screening," dated 12/22/14, and indicated the policy was the one currently used by the facility. The policy indicated "...a. At the time of employment or one (1) before the date the employee or volunteer begins providing services one of the following will occur...ii. The first tuberculin skin test must be read prior to the employee starting work. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step..."</p> <p>2. Employee record reviews were completed on 7/11/16 and 7/12/16 with the following results:</p> <p>a. A form titled "TB Test Documentation Form" for Employee #8 indicated she had been administered her first TB test on 6/15/16. The form indicated the "Signature of Licensed Person Administering Test" was CNA (Certified Nursing Assistant) #2. The form indicated "Signature of Licensed Person Reporting Test Data" was the Director of Nursing. Employee #8 was also administered the Second Step TB test on 7/5/16 by CNA #2</p>		<p>negative, a second test should be performed one to three weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) the facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4)An employee with symptoms or signs of active disease shall not be permitted to work until tuberculosis is ruled out.</p>	

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>b. A form titled "TB Test Documentation Form" for Employee #11 indicated she had been administered a TB test on 6/23/16. The form indicated the "Signature of Licensed Person Administering Test" was CNA #2. The form indicated "Signature of Licensed Person Reporting Test Data" was CNA #2.</p> <p>c. A form titled "TB Test Documentation Form" for Employee #10 indicated she had been administered a TB test on 5/3/16. The form indicated the "Signature of Licensed Person Administering Test" was CNA #2. The form indicated "Signature of Licensed Person Reporting Test Data" was an LPN (name not legible).</p> <p>A "TB Education Program," undated, and retrieved from the American Lung Association website on 7/12/16, indicated a nursing assistant may not give or read a TB test as "they are not qualified to give injections." This information was located in the section titled "Who Can Take the Basic TB Course."</p> <p>During an interview, on 7/12/16 at 9:58 A.M., the Director of Nursing (DON) indicated the TB tests for Employee #8, #10 and #11 were administered by CNA</p>			

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>#2. The DON indicated CNA #2 had received certification from their pharmacy to administer the TB test. The DON indicated CNA #2 had been administrating the intradermal TB injection test to employees since March of 2016. The DON did not have a policy regarding the administration of TB tests indicating who was to administer and read the test.</p> <p>During an interview, on 7/12/16 at 1:10 P.M., the Administrator indicated he had no idea CNA #2 was administering intradermal TB injection tests to his employees. The Administrator indicated a CNA should not be giving injections of any kind.</p>			

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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
R 0410  Bldg. 00	<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 infection with tuberculosis. (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 record review and interview, the facility failed to ensure a 2nd step tuberculin skin test was read timely for 1 of 7 residents reviewed for tuberculin skin tests. (Resident #5)</p> <p>Finding includes:</p> <p>On 7/12/16 at 1:30 P.M., the clinical record for Resident #5 was reviewed. Resident #5 was admitted to the facility on 5/10/16. The diagnoses included, but were not limited to: "...advanced dementia, hypertension, hypothyroid and lupus...."</p>	R 0410	<b>Infection Control</b> Resident #5 had her TB test redone by Health Service Director – first step done on 7/12/16 and second step completed on 7/26/16. Resident records were audited (7/26/16) and all of the Other facility residents had current TB tests. Upon admission, residents will have proof Of TB testing prior to admission or be read within 48 to 72 hours upon admission. Health Service Director will be responsible for monitoring New resident admission TB tests to Ensure compliance. Audits will be completed for 7 months, the first 3 Months will conducted	07/26/2016

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 07/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
--	--

(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>A form titled, "TB (Tuberculin) Test Documentation Form," dated 5/10/16, indicated, the first TB skin test was administered on 5/10/16, and the date the test was read was on 5/12/16. The 2nd step TB skin test was administered on 6/2/16, there was no date or test result documented for the 2nd step TB test.</p> <p>During an interview, on 7/12/16 at 2:00 P.M., the Director of Nursing indicated the TB skin test should be read and results documented 48-72 hours after the test was administered.</p> <p>On 7/12/16 at 2:15 P.M., the Director of Nursing provided a policy titled, "Tuberculosis Screening," dated 12/2014, and indicated the policy was the one currently used by the facility. The policy indicated "...2. The facility shall establish, document and implement a tuberculosis infection control program that complies with the guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care settings, which includes: ...b. Maintaining documentation of any:...ii. Tuberculosis screening test of an individual who is employed by the facility, provides volunteer services for the facility or is admitted to the facility...."</p>		<p>every 2 weeks And the final 4 months conducted monthly. TB tracking audit tool created and attached. This will all be in accordance with the rule: (e) a tuberculin skin test shall be completed within three months prior to admission or upon admission and read at 48 to 72 hours. The result shall be recorded in millimeters of in duration 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 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 to three weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (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>	

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

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 07/12/2016
NAME OF PROVIDER OR SUPPLIER  HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545		
(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	