

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00189996.</p> <p>Complaint IN00189996- Substantiated. Federal/State deficiencies are cited at F279.</p> <p>Survey dates: January 11, 12, 13, 14, 19, 20, & 21, 2016</p> <p>Facility number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Census bed type: SNF: 41 SNF/NF: 56 Residential: 48 Total: 145</p> <p>Census payor type: Medicare: 22 Medicaid: 42 Other: 33 Total: 97</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
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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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F 0241 SS=E Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by #02748 on January 27, 2016.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity was provided for 2 of 2 residents observed who were exposed and within view from the hall and 5 residents who did not receive their lunch at the same time as the other residents at her table. One resident was observed lying in bed with a brief and a shirt on and one resident was observed with her feet on the floor mat beside of the bed with her face on the bed wearing a shirt and a brief. (Resident #149, Resident #233, Resident #76, Resident #87, Resident #38, Resident #252, Resident #28)</p>	F 0241	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i> Unable to correct alleged deficient practice, as event occurred in the past. Residents 233 and 76 were immediately</p>	02/20/2016	

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	<p>Findings include:</p> <p>1. During an observation on 1/11/16 at 11:58 a.m., Resident #149 was observed to be seated at the same table in the main dining room on the skilled unit with Resident #129 and Resident #147. QMA #1 was observed to serve Resident #129's and Resident #147's lunch to them. QMA #1 was observed to deliver lunch to 15 (fifteen) other residents at different tables in the skilled main dining room before serving Resident #149 the lunch meal. Resident #149 received her lunch at 12:28 p.m.</p> <p>During an observation on 1/11/16 at 12:17 p.m., the DON (Director of Nursing) indicated Resident #149 needed to have her lunch before the other residents in the dining room were served.</p> <p>During an interview on 1/20/16 at 3:05 p.m., the DON indicated all residents seated at the same table should be served their meals before serving residents at another table.</p> <p>2. During an observation on 1/11/16 at 3:13 p.m., Resident #233 was observed to be uncovered, lying in bed with her pants pulled halfway down, with a brief and a shirt on, sleeping. The residents room door and curtain were open. The resident</p>		<p>dressed and covered and suffered no apparent harm. 2) How the facility identified other residents: All residents that eat meals in the dining room have the potential to be affected by this alleged deficient practice. All residents with diminished capacity have the potential to be affected by this alleged deficient practice. 3) Measures put into place/ System changes: Immediate re-education provided for meal service staff regarding serving all residents at the same table before moving on. CDM/Designee shall observe meal service on varying shifts on various days of the week in alternating dining rooms 3 times weekly to ensure all residents are served at the table prior to serving the next table. Immediate re-education provided to the nursing department on maintaining residents' dignity by ensuring they are not left exposed to anyone. DON/designee shall conduct rounds on varying shifts on various days 3 times weekly to ensure residents dignity maintained. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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	<p>was able to be viewed from the hall.</p> <p>3. During an observation on 1/11/16 at 3:07 p.m., Resident #76 was observed to be lying partially out of bed with her face down on the bed. Resident #76 was wearing a brief and a shirt. LPN #1 assisted the resident into the bed and covered the resident. The resident's room door and curtains were open and the resident was able to be viewed from the hall.</p> <p>During an interview on 1/11/16 at 3:25 p.m., LPN #1 was indicated residents should not be uncovered in view of the hallway.</p> <p>4. On 1/11/16 at 12:00 p.m., QMA #1 served Resident #20 and Resident #124 the noon meal. Resident #20 and Resident #124's tablemate, Resident #87, was not served the noon meal until 12:19 p.m.</p> <p>5. On 1/11/16 at 12:14 p.m., QMA #1 served Resident #113's noon meal. Resident #113's tablemate, Resident #38, was not served the noon meal until 12:26 p.m.</p> <p>6. On 1/11/16 at 12:20 p.m., Resident #252 was observed to wait 15 minutes for</p>			

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F 0257 SS=E Bldg. 00	<p>his meal after his tablemates had been served. Staff was observed to serve other tables first.</p> <p>7. On 1/11/16 at 12:15 p.m., Resident #28 was observed to wait 10 minutes for his meal, after his tablemate's were served their food. Staff was observed to serve other tables first.</p> <p>The facility lacked a policy for dignity of the residents and lacked a policy for serving for serving meals in the dining room.</p> <p>3.1-3(t)</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation, interview, and record review, the facility failed to provide comfortable and safe temperature levels for residents, staff and the public. The temperature of the restorative dining room was 67 degrees Fahrenheit for two</p>	F 0257	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the</i></p>	02/20/2016

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	<p>days. The dining room serves 17-21 residents per meal per day.</p> <p>Findings include:</p> <p>On 1/12/16 at 2:31 p.m., the temperature was 67 degrees Fahrenheit in the restorative dining room. There were approximately 18 residents in the dining room with two family members present.</p> <p>On 1/13/16 at 12:11 p.m., the temperature in the restorative dining room was 67 degrees Fahrenheit. No residents were in the dining room at that time.</p> <p>On 1/14/16 at 11:43 a.m., an interview with Resident #73's wife was queried about the temperature of the dining room and if her husband had any complaints of it being cold in the restorative dining room. She indicated he was unable to express these things. She indicated it's always cold in there especially in the morning.</p> <p>On 1/20/16 at 1:32 p.m., Restorative Aide #1 stated there were 17-21 residents in the dining room daily, depending on which meal it was and if someone did not feel well. Restorative Aide #1 queried as to whether she ever felt like it was cold in the dining room. She stated sometimes in</p>		<p><i>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified: Resident dining room temperature was reset to automatically remain at a minimum of 71°.</p> <p>2) How the facility identified other residents: All residents that eat in the restorative dining room have the potential to be affected by alleged deficient practice.</p> <p>3) Measures put into place/ System changes: Staff re-education provided regarding regulatory temperature range of 71°-81°. Thermostats shall be locked by maintenance. Maintenance/designee shall observe dining room temperatures on varying days at various times 3 times per week to ensure temperature is within proper range.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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	<p>the mornings, but she never thought it was cold, because she was being active, but the residents sometimes complain of it being cold.</p> <p>On 1/20/16 at 1:38 p.m., Maintenance #1 was notified of temperature of 67 degree's in the restorative dining room on 1/12/16 at 2:31 p.m. and 1/13/16 at 12:11 p.m. He indicated that maintenance regulated the temperature in the different areas of the building. He said he would check them, but the thermostats were automatic and should stay at the correct temperatures.</p> <p>On 1/21/16 at 10:01 a.m., an interview with Maintenance #2 indicated there was not a log maintained for temperature checks throughout the building.</p> <p>On 1/21/16 at 10:04 a.m., an interview with the Administrator indicated there was not a policy for maintaining the temperature of the facility.</p> <p>3.1-19(5)(h)</p>			

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review the facility failed to ensure a comprehensive care plan was implemented for 2 of 26 residents reviewed during Stage 2 of the survey. (Resident C, Resident F)</p>	F 0279	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the</i></p>	02/20/2016

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	<p>Findings include:</p> <p>1. On 1/14/16 at 9:00 a.m., Resident C was admitted on 10/2/16 with the diagnosis, including but not limited to, joint replacement, fracture of neck of left femur, HTN, muscle weakness, dysphasia, pneumonitis due to inhalation of food and vomit, myelodysplastic syndrome, history of malignant neoplasm of large intestine.</p> <p>The Admission MDS (minimum data set), dated 10/9/15 and the 30 day MDS, dated, 10/28/15 indicated the resident had a colostomy.</p> <p>The review of nursing records indicated there was not a care plan initiated for care of colostomy.</p> <p>The doctors orders included, but were not limited to: 1/9/15: Change colostomy bag every 3 days, change colostomy wafer every Tuesday night 10/27/15: Check colostomy bag every day for proper placement and excess air every shift for proper placement and excess air.</p> <p>On 1/14/16 at 2:00 p.m. review of nursing notes dated 10/9/15 indicated the</p>		<p><i>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified: Care plan immediately initiated for ADL dependency for Resident F. Resident C discharged from the facility, unable to correct. 2) How the facility identified other residents: All residents have the potential to be affected by this alleged deficient practice. 3) Measures put into place/ System changes: Immediate re-education provided to the nursing department related to development of comprehensive plan of care protocols. DON/designee shall audit 5 charts for completion and accuracy of care plans. IDT shall audit 2 completed care plan reviews per week to ensure comprehensive plan of care developed. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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	<p>TAR (Treatment Administration Record) : change colostomy bag every 3 days, which was documented as being completed every 3 days. An order to change colostomy wafer, every Tuesday night, which was documented as being completed. On 10/27/15 an order on TAR to check colostomy bag everyday for proper placement and excess air every shift also documented as being completed.</p> <p>On 1/20/16 at 4:20 p.m., an interview with the Director Nursing indicated a care plan for a colostomy had not been initiated for Resident C.</p> <p>On 1/21/16 at 11:30 a.m., a policy was received from the Administrator titled Registered Nurse Job Description which indicated the RN was responsible for maintaining up to date nursing care plans. A document referring the RAI Manual Chapter 4 was received.</p> <p>2. On 1/12/16 at 10:39 a.m., Resident F was observed leaning to the right in bed. The resident indicated she was uncomfortable and would need assistance to reposition.</p> <p>On 1/13/16 at 1:45 p.m., Resident F's clinical record was reviewed. Resident F's diagnoses included, but were not</p>			

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	<p>limited to: hemiplegia and hemiparesis following a cerebrovascular accident affecting the non-dominant left side.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 12/24/15, indicated Resident F required the maximum assistance of two persons for bed mobility, transfers, locomotion on and off of the unit, dressing, toileting, and personal hygiene. The MDS further indicated Resident F was completely dependent for bathing.</p> <p>The clinical record lacked a plan of care regarding Resident F's inability to care for herself.</p> <p>On 1/14/16, at 9:36 a.m., CNA #1 and CNA #2 were observed to provide a bed bath for Resident F. Resident F was unable to turn or reposition herself and required the maximum assistance of one person to turn from side to side.</p> <p>On 1/19/16 at 9:47 a.m., RN #1 indicated Resident F did not have a care plan related to the residents difficulty in caring for the residents self.</p> <p>This Federal tag relates to Complaint IN00189996.</p> <p>3.1-35(a)</p>			

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a care plan was followed for 1 of 2 residents in a total sample of 35 residents reviewed for turning and positioning (Resident #68) and the facility failed to follow the physicians written plan of care for 1 of 1 residents reviewed for dialysis. Blood pressures were not assessed at bedtime on dialysis days. (Resident #73)</p> <p>Findings include:</p> <p>1. During an observation on 1/13/16 at 9:15 a.m., Resident #68 was observed to be sitting in the lobby during an activity. Resident #68 was asleep and bent over in her wheelchair.</p> <p>During observations on 1/14/16 at 9:30 a.m., 10:41 a.m., and 2:18 p.m., Resident #68 was observed to be lying on her left</p>	F 0282	<p>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident 68 assessed, no negative outcome related to alleged deficient practice. Order clarification for blood pressure to be taken at bedtime on dialysis days for Resident 73. 2) How the facility identified other residents: All residents have the potential to be affected by this alleged deficient practice. 3) Measures put into place/</p>	02/20/2016
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	<p>side in bed, sleeping.</p> <p>The clinical record for Resident #68 was reviewed on 1/14/16 at 8:55 am. Resident #68 had diagnoses including, but not limited to, Alzheimer's disease, anxiety disorder, depressive disorder, and subdural hemorrhage. A quarterly MDS (Minimum Data Set) assessment, dated 12/29/15, indicated Resident #68 had a BIMS (Brief Interview for Mental Status) assessment score of 3, which indicated severe cognition impairment. The MDS indicated Resident #68 was at risk for pressure ulcers and was a 1 person extensive assist for bed mobility and a 2 person extensive assist for transfers. The MDS further indicated Resident #68 was not on a turning/repositioning program.</p> <p>A care plan for ADL (Activity of Daily Living) self-care deficit, dated 12/29/15, indicated Resident #68 required staff participation to reposition and turn in bed.</p> <p>During an interview on 1/14/16 at 2:08 p.m., LPN #1 indicated if a resident had to be turned and/or repositioned, the times should be documented in the chart. LPN #1 indicated when a resident is turned and/or repositioned, the CNA would document the times in the residents computerized charting. LPN #1</p>		<p>System changes: Immediate re-education provided to nursing staff to ensure care plan interventions are followed. DON/designee shall conduct observations of residents on varying shifts 3 times per week to ensure resident's specific plan of care is being followed. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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	<p>indicated the turning/repositioning task would trigger in the computer for a resident who required turning/repositioning. LPN #1 indicated Resident #68 had not triggered for such a task.</p> <p>The Registered Nurse (RN) and the Licensed Practical Nurse (LPN) job descriptions, revised on 5/1/09 and obtained from the Administrator on 1/21/16 at 11:30 a.m., indicated one of the primary responsibilities of the RN is to document progress of the nursing care plan of the resident.</p> <p>2. On 1/13/16 at 10:40 a.m., Resident #73's clinical record was reviewed. Resident #73's diagnoses included, but were not limited to, end stage renal disease.</p> <p>The physicians orders included, but were not limited to: Monitor blood pressure upon return from dialysis on Monday, Wednesday, and Fridays and at bedtime on dialysis days, started on 11/13/15.</p> <p>The clinical record lacked a bedtime blood pressure assessment on 12/7/15, 12/14/15, 12/21/15, 12/26/15, 12/28/15, 1/4/16, and 1/11/16.</p> <p>On 1/20/16 at 4:19 p.m., the DON</p>			

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F 0371 SS=D Bldg. 00	<p>indicated they were unable to locate Resident #73's bedtime blood pressure assessments.</p> <p>3.1-35(g)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to serve food under sanitary conditions for 3 of 27 residents observed in the skilled dining room. Bowls and glasses were handled by the rims and thumbs were observed on the edges of plates for 1 of 2 dining observations. (Resident #129, Resident #147, Resident #148) The facility failed to ensure the kitchen was clean.</p> <p>Findings include:</p> <p>1. During an observation on 1/11/16 at 11:58 a.m., QMA #1 was observed to</p>	F 0371	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i> Immediate actions taken for those residents identified: Unable to correct alleged deficient practice for residents identified, as event occurred in</p>	02/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2016	
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	<p>deliver salad bowls to Resident #129 and Resident #147. QMA #1 was observed to handle the bowls by the rims. QMA #1 was observed to sanitize her hands and leaned against a resident's table, placing both hands on the table. QMA #1 then served Resident #148's plate, handling the plate by the edge.</p> <p>During an interview on 1/21/16 at 0836, QMA #1 indicated plates, bowls, and cups should not be handled by the rims. QMA #1 further indicated hands should not be touching the food when it is served.</p> <p>The facility lacked documentation of a policy for handling of the serviceware during serving of food to the residents.</p> <p>2. On 1/14/16 at 11:30 p.m., dietary staff # 2 and # 3, were observed to be serving food on the tray line without a cover over their beards.</p> <p>3. On 1/11/16 at 9:31 a.m., the kitchen floor was observed to be soiled in multiple areas. The floor was soiled behind and beside the stove area, under countertops, sink, and around the wall edges. The floor under the large mixer was also soiled. The middle wall with the knife rack was soiled on the bottom of the wall. The same was observed on</p>		<p>the past. Employees providing meal service with facial hair immediately placed protectors on. Kitchen floor and walls were mopped. 2) How the facility identified other residents: All residents have the potential to be affected by this alleged deficient practice. 3) Measures put into place/ System changes: Immediate re-education provided to dietary staff regarding proper hygiene, sanitary practices specific to handling items during meal service and cleaning practices. CDM/designee shall monitor delivery of items during meal service for alternating meals at various shifts on varying days 3 times per week. CDM/designee shall monitor staff wearing proper facial guards while in food prep/service areas at various shifts on varying days 3 times per week. New power washing machine purchased and has been scheduled for deep clean to be completed. CDM/designee shall monitor proper floor/wall cleaning on varying shifts and varying days 3 times per week. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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F 0441 SS=D Bldg. 00	<p>1/14/16 at 10:30 a.m.</p> <p>On 1/21/16 at 11:00 a.m., the Administrator indicated that kitchen staff who have beards, should have them covered.</p> <p>On 1/14/16 at 1:00 p.m., dietary staff #1 provided a kitchen cleaning policy, which indicated that the kitchen floor should be mopped daily.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and</p>			

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	<p>corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control techniques were used during the provision of care to residents for 1 of 7 residents observed for care. Handwashing was only done for 3 -10 seconds while providing care to a resident. (Resident #76)</p> <p>Findings include:</p> <p>During an observation on 1/13/16 at 9:55 a.m., CNA #3 was observed to give a shower to Resident #76. CNA #3 washed her hands for 3 (three) seconds, applied gloves, lowered the head and foot</p>	F 0441	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p>Immediate actions taken for those residents identified: Unable to correct alleged deficient practice, as event occurred in the past. Residents identified with no negative</p>	02/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/21/2016	
NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630			
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	<p>of the bed, and removed the floor mat. CNA #3 removed the gloves and washed her hands for 7 (seven) seconds. CNA #3 applied gloves, removed a pillow from between the mattress and the bed rails and placed the Hoyer lift pad under the resident's right side. CNA #3 assisted the resident to turn onto the right side and pulled the lift pad under the resident's left side. CNA #3 turned on the shower water and changed her gloves. CNA #4 entered the room and applied gloves with no hand hygiene performed. CNA #3 and CNA #4 assisted Resident #76 onto the shower chair and removed the resident's dirty gown. CNA #4 removed the left glove and exited the room with the right glove on. CNA #3 washed her hands for 5 seconds. CNA #3 applied clean gloves and proceeded to shower the resident and wash the resident's hair. CNA #3 was observed to remove her gloves and wash her hands for 3-5 seconds throughout the shower. CNA #5 entered the room and placed clean linens on Resident #76's bed and assisted CNA #3 with placing the resident into bed.</p> <p>During an interview on 1/13/16 at 12:58 p.m., CNA #3 and CNA #5 indicated hands should be washed for 40 - 60 seconds and sanitized for 20 - 40</p>		<p>outcomes. 2) How the facility identified other residents: All residents have the potential to be affected by this alleged deficient practice. 3) Measures put into place/ System changes: Immediate re-education provided to nursing staff regarding hand washing procedures and washing between glove changes. DON/designee shall observe for proper hand hygiene on various shifts on varying days 3 times per week. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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F 9999 Bldg. 00	<p>seconds.</p> <p>A policy titled, "Hand Washing", updated 11/2015 and obtained from the Administrator on 1/20/16 at 1:35 p.m., indicated hand should be washed for a total of 40 - 60 seconds.</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of the cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p>			F 9999	<p>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: No residents identified as affected. RN #2 has completed the required annual Dementia training. 2) How the facility</p>		02/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2016
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	<p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure inservices were provided for 1 of 10 employees reviewed, in that, annual Dementia training was not completed. (RN #2)</p> <p>Findings include:</p> <p>During record review on 1/19/16 at 8:45 a.m., RN #2 was observed to have not completed any Dementia training for the past year.</p> <p>During an interview on 1/19/16 at 9:10 a.m., the Human Resources Coordinator indicated the dementia training for RN #2 had not been completed. The HR Coordinator indicated the computer system had not alerted RN #2 that the dementia inservices needed to be completed.</p> <p>During an interview with the DON (Director of Nursing) on 1/20/16 at 3:55 p.m., she indicated the inservices form dementia training for RN #2 had not been completed. She further indicated RN #2 would be completing the inservices by tomorrow.</p> <p>A policy titled, "Required Inservicing", dated 1/2014, and obtained from the</p>		<p>identified other residents: No residents identified as affected. 3) Measures put into place/ System changes: An audit of current employee files will be completed to ensure that annual in-service related to Residents Rights and dementia training is in compliance. Facility staff will be in serviced regarding requirement to complete annual in-service training as scheduled per Human Resources. Human Resources will notify staff of upcoming months scheduled in-service. Staff will have thru the last day of the month to complete required in-services scheduled for that month. Human Resources will maintain a tracking log of completed in-services and due dates. Administrator/designee will audit 2 employee files per week to ensure that required in-services have been completed. The Director of Nursing/designee is responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>	

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R 0000 Bldg. 00	<p>Administrator on 1/21/16 at 10:04 a.m., indicated staff employed at the facility would be required to have 3 (three) hours of dementia training annually.</p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00190464.</p> <p>Complaint IN00190464 Substantiated No deficiencies cited related to the allegations are cited.</p> <p>Residential Census: 48</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on interview and record review, the facility failed to ensure a First Aid certified staff member was on site for 10 of 11 days reviewed.</p> <p>Findings include:</p> <p>On 1/20/16 at 1:00 p.m., the schedules were reviewed. The schedules indicated a First Aid certified staff was not present</p>	R 0117	<p>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of</p>	02/20/2016			

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	<p>for:</p> <p>1/10/16: evening and night shift 1/12/16: evening shift 1/13/16: evening shift 1/14/16: evening shift 1/15/16: day, evening, and night shift 1/16/16: day and night shift 1/17/16: day and night shift 1/18/16: day and evening shift 1/19/16: day, evening, and night shift 1/20/16: evening and night shift</p> <p>On 1/20/16 at 1:35 p.m., the ALD (Assisted Living Director) and the ALUM (Assisted Living Unit Manager) indicated they would look for additional First Aid certifications.</p> <p>On 1/21/16 at 8:35 a.m., the ALUM indicated they were unable to locate any additional employees with First Aid certifications.</p> <p>On 1/21/16 at 2:07 p.m., the Administrator provided the "Personnel Policy", dated June 2014. The policy included, but was not limited to, the facility will provide at a minimum one awake staff member with first aid training...</p>		<p>federal and state law.</p> <p>1) Immediate actions taken for those residents identified: No residents identified as affected.</p> <p>2) How the facility identified other residents: No residents identified as affected.</p> <p>3) Measures put into place/ System changes: Re-education provided to nursing staff regarding regulation requiring First Aid present on each shift. Course completed by staff for first aid certification on January 29, 2015. AL Director/Designee shall audit the schedule that First Aid certified staff are present daily on all shifts. AL Director/designee shall audit AL staff have current First Aid recertification monthly thereafter.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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R 0185 Bldg. 00	<p>410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E) Physical Plant Standards - Noncompliance</p> <p>(i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall:</p> <p>(1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level.</p> <p>(2) Provide each resident the following items upon request at the time of admission:</p> <p>(A) A bed:</p> <p>(i) of appropriate size and height for the resident;</p> <p>(ii) with a clean and comfortable mattress; and</p> <p>(iii) with comfortable bedding appropriate to the temperature of the facility.</p> <p>(B) A bedside cabinet or table with a hard surface and washable top.</p> <p>(C) A cushioned comfortable chair.</p> <p>(D) A bedside lamp.</p> <p>(E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device.</p> <p>(3) Provide cubicle curtains or screens if requested by a resident in a shared room.</p> <p>(4) Provide a method by which each resident may summon a staff person at any time.</p> <p>(5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area.</p> <p>(6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare.</p> <p>(7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have</p>			

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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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	<p>clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs.</p> <p>Based on observation and interview, the facility failed to provide an alarm system to notify the staff for assistance in for 1 of 14 residents reviewed on the dementia care unit. (Resident #299)</p> <p>Findings include:</p> <p>During an observation on 1/20/16 at 9:45 a.m., Resident #299 was observed to not have a means to summon assistance or personnel in the bedroom or bathroom.</p> <p>During an interview on 1/20/16 at 9:59 a.m., LPN #5 indicated the resident's on the Assisted Living dementia care unit did not have an alarm on the person or in the resident rooms or bathrooms.</p> <p>During an interview on 1/20/16 at 1:37 p.m., LPN #5 indicated the dementia care unit might have 1 (one) resident who may be capable of using an alarm system. Upon further query, LPN #5 indicated she was surprised the unit did not have an emergency call system.</p> <p>During an interview on 1/21/16 at 9:09</p>	R 0185	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p>Immediate actions taken for those residents identified: 15 minute checks completed on Memory Care Unit until emergency call pendants could be issued to each resident. Pendants were in place and functioning on January 20, 2015.</p> <p>2) How the facility identified other residents: All residents residing on Memory Care Unit have the potential to be affected.</p> <p>3) Measures put into place/ System changes: Immediate education provided to nursing staff regarding regulation requiring an alarm system to notify the staff for assistance. Care task assigned for nursing staff to check pendant is in place and functioning daily. AL</p>	02/20/2016

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R 0217 Bldg. 00	<p>a.m., the DON indicated the resident on the Assisted Living dementia care unit were supplied with alarm pendants or wristbands last evening and residents as well as staff were inserviced on the use of them.</p> <p>The facility lacked documentation of a policy regarding summoning assistance for a resident on the dementia care unit.</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 (D) preference; of the resident. (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. (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. (4) No identification and documentation of</p>		<p>Director/designee shall audit care task completed and that pendants are in place 3 times per week. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>		

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	<p>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 record review and interview, the facility failed to ensure the service plan was signed for 3 of 7 residents reviewed for service plans. (Resident #299 , Resident #311, Resident #301)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #299 was reviewed on 1/20/16 at 9:57 a.m. Resident #299 was observed to not have a signed service plan.</p> <p>During an interview on 1/20/16 at 3:45 p.m., the Regional Consultant indicated the facility had been aware there was a problem with the service plans.2. On 1/20/16 at 9:00 a.m., Resident #311's clinical record was reviewed. The clinical record lacked a signed service plan</p> <p>On 1/20/16 at 11:46 a.m., the ALD (Assisted Living Director) indicated they were unable to provide a signed service plan for Resident #311.</p>	R 0217	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i> Resident 299 and 301 service plans were reviewed and signed. Resident 311 no longer resides in the facility. 2) How the facility identified other residents: All residents have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: Immediate re-education provided to staff regarding Evaluation of Resident Needs policy. AL Director/designee shall complete audit to ensure that all resident service plans have been reviewed and agreed upon with signature. AL Director/designee shall audit 2</p>	02/20/2016	

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	<p>3. On 1/20/16 at 1:30 p.m., the chart was reviewed for Resident # 301. The service plan agreement was not signed by the resident.</p> <p>On 1/20/16 at 11:16 a.m., the Assisted Living Director indicated he was unable to provide a signed service plan for Resident # 301.</p> <p>During an interview on 1/21/16 at 9:47 a.m., the ALD indicated he was not aware at the time that the resident needed to have the service plan signed by the resident, family member, or responsible party. He indicated the facility had changed the policy now and the facility is having the service plan signed.</p> <p>A policy titled, "Evaluation of Resident's Needs", dated 3/2014 and obtained from the Administrator on 1/21/16 at 10:04 a.m., indicated the agreed upon service plan, "would be signed and dated by the resident/responsible party ..."</p>		<p>completed service plan reviews per week to ensure signature obtained per protocol. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>		