

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/11/2016
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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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(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
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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.</p> <p>Survey dates: January 4-8, and 11, 2016</p> <p>Facility number: 012305 Provider number: 155779 AIM number: 200987990</p> <p>Census bed type: SNF: 36 SNF/NF: 19 Residential: 35 Total: 104</p> <p>Census payor type: Medicare: 15 Medicaid: 19 Other: 70 Total: 104</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on January 14, 2016 by 11474.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00184162) Survey on October 30, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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 serve meals to dependent residents in a manner to promote dignity regarding offering assistance to dine and meal service for 2 of 2 residents reviewed for dignified dining (Residents #78 and #61)</p> <p>Findings include:</p> <p>1. During a 1/4/16, lunch observation in the restorative dining room the following was observed:</p> <p>At 12:16 p.m., a staff member placed a meal in front of Resident #78, woke her and instructed her to eat. Resident #78 did not begin to eat.</p> <p>At 12:20 p.m., a staff member instructed Resident #78 to eat (4 minutes after her tray was served). The staff member was across the table from Resident #78. Resident #78 did not begin to eat. Resident #78 had not eaten any food</p>	F 0241	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Residents #78 and #61 were observed at 3 meals to ensure the following: The staff promotes care and services in a manner to protect dignity when serving meals to a dependent resident. Observation included: a) plates placed in front of residents b)trays set up for meals c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). Residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service</p> <p>Identification of other residents having the potential to be</p>	02/05/2016

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	<p>since her meal was served.</p> <p>At 12:22 p.m., a staff member instructed Resident #78 to eat (6 minutes after her tray was served). The staff member was across the table from Resident #78. Resident #78 did not begin to eat. Resident #78 had not eaten any food since her meal was served.</p> <p>At 12:23 p.m., a staff member instructed Resident #78 to eat (7 minutes after her tray was served). The staff member was across the table from Resident #78. Resident #78 did not begin to eat. Resident #78 had not eaten any food since her meal was served.</p> <p>At 12:24 p.m., a staff member had direct interaction with Resident #78 (8 minutes after her tray was served). The staff member cut a piece of food, put the food on the fork and gave Resident #78 a bite of food. Resident #78 ate the food. The staff member instructed Resident #78 to eat her meal and walked away. Resident #78 did not begin to feed herself. She sat looking at her meal.</p> <p>At 12:28 p.m., (4 minutes after she had a bite of food and a total of 12 minutes after her tray was served) a staff member sat down beside Resident #78 and fed her. Resident #78 ate the food that was</p>		<p>affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe 3 meals at to ensure the following: The staff promotes care and services in a manner to protect dignity when serving meals to a dependent resident. Observation included: a) plates placed in front of residents b)trays set up for meals within Resident reach c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). Residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following expectations in regards to the staff promote care and services in a manner to protect dignity when serving meals to a dependent resident. Observation included: : a) plates placed in front of</p>	

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	<p>offered to her. A staff member fed her the rest of her meal.</p> <p>Resident #78's meal consumption record for 1/4/16, lunch indicated the resident ate 100% of her meal.</p> <p>Resident #78's clinical record was reviewed on 1/8/16 at 11:41 a.m. Resident #78's current diagnoses included, but were not limited to, Alzheimer disease, depression, hypertension and dementia.</p> <p>Resident #78 had a current, 10/22/15, significant change, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely or never made decisions, required staff assistance for mobility and extensive staff assistance for eating.</p> <p>Resident #78 had a current, 10/22/15, care plan problem/need regarding difficulty in completing her activities of daily living, including eating, due to dementia and decreased mobility.</p> <p>Resident #78 had a current, 10/22/15, care plan problem/need regarding severe cognitive impairment. An approach to this problem included "My daily health care and well being needs will be staff-anticipated and addressed on a daily</p>		<p>residents b)trays set up for meals within Resident reach c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). Residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following observations of 1 meal service in the Restorative Dining Room will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance: a) plates placed in front of residents b)trays set up for meals within Resident reach c)prompting/cueing or assisted to eat d) engaged in meal before a staff member leaves the resident e) staff stays with resident when assisting them with eating f). Residents at the dining table are served their meals at close to the same time as possible g) no lengthy waits for meal service. Throughout the audit / observation period, all 3 meal</p>	

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	<p>basis."</p> <p>During an 1/8/16, 12:00 p.m., interview LPN #6, CNA #7 and CNA #8 all indicated Resident #78 could not feed herself and needed to be fed by a staff member.</p> <p>2. During a 1/7/16 observation of lunch in the restorative dining room the following was observed:</p> <p>At 12:10 p.m., Resident #61 sat at the table with a glass of milk placed out of reach.</p> <p>At 12:11 p.m., Resident #61's tablemate was served her meal.</p> <p>At 12:17 p.m., all the other residents in the room had been served and were eating. Resident #61 did not have a meal tray. Resident #61 looked around the room.</p> <p>At 12:19 p.m., Resident #61's tablemate was moved to a different table due to space concerns. Resident #61 had looked at her tablemate's food on and off since the tablemate was served 8 minutes prior. As the staff moved the tablemate's tray away, Resident #61 reached toward the tray.</p>		<p>services will be observed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>	

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	<p>At 12:21 p.m., Resident #61 reached for her milk but could not reach it.</p> <p>At 12:22 p.m., Resident #61 manipulated her napkin and silverware.</p> <p>At 12:23 p.m., Resident #61 was served her meal (A period of 12 minutes since she watched her tablemate be served and 6 minutes after everyone else in the room had been eating). Resident #61's meal was not a specialized order.</p> <p>Resident #61's clinical record was reviewed on 01/6/16 at 2:55 p.m. Resident #61's current diagnoses included, but were not limited to, a history of a right wrist fracture, depression, anxiety and Alzheimer's disease.</p> <p>Resident #61 had a current, 10/15/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired, rarely or never made decisions, required staff assistance for mobility and required extensive staff assistance to eat.</p> <p>Resident #61 had a, 10/15/15, care plan problem/need regarding having a problem completing activities of daily living due to secondary to dementia.</p>			

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F 0329 SS=D Bldg. 00	<p>Resident #61 had a, 10/15/15, care plan problem/need regarding severe cognitive impairment and the need of total assistance for all daily care needs. Approaches to this problem included, but were not limited to, "My daily health care and well being needs will be staff-anticipated and addressed on a daily basis."</p> <p>Review of a current, 2009, facility policy titled "The Dining Services Program", provided by RN Unit Manager #9 on 1/8/16 at 12:05 p.m., indicated the following: "..Provide a dining experience that enhances each individual's quality of life and maintains dignity."</p> <p>3.1-3(t)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a</p>			

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	<p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to administer insulin as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #9) and the nursing staff failed to ensure laboratory tests were obtained as ordered by the physician for medication monitoring for 1 of 5 residents reviewed for laboratory testing related to medication use. (Resident #9)</p> <p>Findings include:</p> <p>The clinical record for Resident #9 was reviewed on 1/7/16 at 8:06 a.m. Diagnoses for Resident #9 included, but were not limited to, diabetes mellitus, hypertension, depression, and dementia with behaviors.</p> <p>Current signed physician's orders for Resident #9 included, but were not limited to, the following orders: Levemir (insulin) inject 8 units</p>	F 0329	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1.) Resident #9 MAR (Medication Administration Record) was reviewed to ensure sliding scale insulin is being administered and documented as ordered by the physician. 2.) Resident #9 laboratory tests were completed with MD and Family notification.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1.) DHS or designee will review all residents with orders for sliding scale insulin coverage to ensure it is administered and documented as ordered by the physician. 2.) DHS or designee will review lab tracking for completion 5 times weekly to ensure it is administered and documented as ordered by the physician.</p>	02/05/2016

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	<p>subcutaneous every bedtime. This order originated on 1/15/15.</p> <p>Check blood sugar twice daily (6:00 a.m. and 4:00 p.m.). This order originated 10/8/14.</p> <p>Humalog (insulin) 4 units subcutaneous every evening if blood sugar is over 250. This order originated 11/22/15.</p> <p>A current health care plan, updated with the annual Minimum Data Assessment on 9/23/15, indicated Resident #9 had diabetes and the potential for hypo/hyperglycemia. Interventions for this care area included to check Resident #9's blood sugar and administer insulin as ordered by the physician, and observe the resident for signs and symptoms of hypo/hyperglycemia.</p> <p>Review of the November, 2015 and December, 2015, Medication Administration Records (MAR) indicated the following:</p> <p>November 1, at 4:00 p.m., the blood sugar result was 298, no insulin was documented as having been given, the resident should have received 4 units;</p> <p>November 11, at 5:00 p.m., the blood sugar result was 299, no insulin was documented as having been given, the resident should have received 4 units;</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following: 1). Guidelines for Accuchecks 2). Blood Sugar Monitoring 3). Lab Tracking 4). Accurate and Timely Lab draws</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 3 times per week times 8 weeks, then weekly times 2 months to ensure compliance: 1). sliding scale insulin administered as ordered and documented 2). Accurate documentation of sliding scale order on MAR 3.) Complete and timely lab tracking</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further</p>	

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	<p>December 14, at 4:00 p.m., the blood sugar result was 288, no insulin was documented as having been given, the resident should have received 4 units;</p> <p>December 23, at 4:00 p.m., the blood sugar result was 299, no insulin was documented as having been given, the resident should have received 4 units;</p> <p>And December 26, at 4:00 p.m., the blood sugar result was 256, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>During an interview on 1/8/15 at 5:31 p.m., the Director of Nursing (DON) indicated she had not found any documentation of the administration of the 4 units of Humalog Resident #9 should have received when her blood sugar result was greater than 250 on the December, 2015 diabetic flow sheet or the December MAR for 12/14/15, 12/23/15, or 12/26/15. The DON indicated she had not found any documentation of the administration of the 4 units of Humalog Resident #9 should have received when her blood sugar result was greater than 250 on the November 2015 MAR for 11/1/15 and 11/11/15. She further indicated she was still looking for the November, 2015</p>		recommendation.	

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	<p>diabetic flow sheet.</p> <p>The facility failed to provide any additional information related to Resident #9's December and November 2015, 4 units of Humalog insulin documentation as of exit on 1/11/16.</p> <p>Review of the January, 2016, recapitulation of physician signed orders for Resident #9, indicated Resident #9 was to have a Complete Metabolic Profile (CMP- a panel of 14 blood laboratory tests which measure glucose level, electrolyte levels, kidney and liver functions), a Complete Blood Count (CBC- a blood laboratory test which measures kinds and numbers of cells in the blood, including red blood cells, white blood cells, and platelets), a Hemoglobin A1C (HbgA1C- a blood laboratory test which measures an average of blood sugar over the past 2 to 3 months) and a Thyroid Stimulating Hormone (TSH- a blood laboratory test to measure how well the thyroid is working) laboratory tests every 3 months. The laboratory tests were due in April, July, October, and January. The original date of this order was 1/15/15.</p> <p>Resident #9's clinical record lacked any results for the CMP, CBC, Hemoglobin A1c, and TSH laboratory tests ordered by</p>			

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	<p>the physician since July 2015.</p> <p>During an interview on 1/8/16 at 10:53 a.m., the Medical Records LPN indicated Resident #9 had no laboratory testing since July, 2015. She indicated she had called the laboratory to ensure they had no results for any laboratory tests since July, 2015.</p> <p>During an interview on 1/8/16 at 2:57 p.m., the Director of Nursing (DON) indicated a laboratory requisition had not been completed for Resident #9's physician ordered laboratory tests. The DON indicated the oversight had been missed in the audits and monthly rewrites of the resident's physician orders.</p> <p>Review of the current policy, dated 2012, titled "Blood Sugar Monitoring", provided by the Administrator on 1/11/16 at 9:02 a.m., included, but was not limited to, the following:</p> <p>"...DOCUMENTATION GUIDELINES Documentation may include: Date, time, blood glucose level... ...If insulin is ordered based on a sliding scale, document the type and amount of insulin administered and the site of injection...."</p> <p>Review of the current policy, dated</p>			

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F 0363 SS=B Bldg. 00	<p>11/22/2008, titled "LAB TRAKING GUIDELINES", provided by the Administrator on 1/11/16 at 9:02 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner to identify and treat infections and/or make medication adjustments.</p> <p>PROCEDURE:</p> <ol style="list-style-type: none"> When an order is received for a laboratory test it shall be added to the [Lab Tracking Log]. The nursing staff or person designated by the Executive Director or Director of Health Services shall monitor the [Tracking Log] to ensure tests have been completed per the physician order...." <p>3.1-48(a)(3)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p>			

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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060			
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	<p>Based on observation, interview and record review, the facility failed to follow menus for 1 of 2 meals observed (1/7/16, lunch). This deficient practice impacted 5 residents (Residents #66, #58, #8, #78 and #61).</p> <p>Findings include:</p> <p>During the 1/7/16, 12:06 p.m. to 12:45 p.m., lunch meal observation in the restorative dining room, eight residents were eating in the dining room. None of the residents were served peaches or a fruit replacement at the time their meals were served. Residents #66, #58, #8, #78 and #61 were not served peaches or an alternate to peaches at the time their meals were served. On 01/07/2016 12:42 p.m., at the end of their meals, Residents #66, #58, #8, #78 and #61 were offered the choice of either cherry pie or peaches as a dessert, not both as menued.</p> <p>Review of the, 1/7/16, lunch menu, provided by the Food Services Supervisor on 1/8/16 at 9:30 a.m. indicated the following:</p> <p>Regular diets were menued to receive: Chef Salad - 2 oz ham, 2 oz turkey, 1/2 of a chopped egg, 4 grape tomatoes, 1 oz cheese, 2 cups lettuce, 2 oz dressing. Yeast roll - 1 each Peaches - 4 oz</p>	F 0363	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1.) Residents #66, #58, #8, #78, and #61 observed for all 3 meals to ensure food is served as outlined through the menu.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1.) DFS or designee will review all residents within restorative dining to ensure meals are delivered as outlined through the menu.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DFS or designee will re-educate all staff on the following: 1). Complete Menu daily offerings 2). Appropriate alternative diet specific menu options 3). Importance of serving a well balanced nutritional meal.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5</p>	02/05/2016			

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F 0366 SS=D Bldg. 00	<p>Cherry pie - 1/10 pie</p> <p>During an 1/8/16, 9:47 a.m., interview, the Food Services Supervisor indicated peaches were menued to be served as part of the meal and were not a dessert to be offered as an alternative to pie. She indicated there must have been some confusion in the kitchen.</p> <p>3.1-20(i)(4)</p> <p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. Based on observation, interview and record review, the facility failed to serve substitutes of equal nutritional value for 1 of 2 meals observed (1/7/16 lunch). This deficient practice impacted 2 of 2 residents observed for menu substitution. (Residents #8, #61).</p>	F 0366	<p>residents will be conducted by the DFS or designee 3 times per week times 8 weeks, then weekly times 2 months to ensure compliance: 1).Complete Menu daily offerings 2). Appropriate alternative diet specific menu options 3). Importance of serving a well balanced nutritional meal.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1.) Residents #61 and #8 observed for all 3 meals to ensure food is served as outlined through the menu with substitutes</p>	02/05/2016

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	<p>Findings include:</p> <p>1. During an 1/7/16, 12:10 p.m., lunch observation, Resident #8 shook her head no when asked if she would like the chef salad that was on the menu for the day. The staff member asked the resident if she would like chicken tenders and fries. The resident nodded her head. The staff member did not state or offer the resident any fruit or vegetable. Only a meat and starch were stated. On 1/7/16 at 12:11 p.m., Resident #8 was served chicken tenders and fries. She was not offered or served a substitute for the vegetable and fruit which were on the regular menu. At the end of her meal, Resident #8 was offered cherry pie or peaches as a dessert, not both as menued.</p> <p>Resident #8's record was reviewed on 1/7/16 at 2:33 p.m. Resident #8's current diagnoses included, but were not limited to, dementia and hypertension.</p> <p>Resident #8 had a, 10/23/15, current, quarterly Minimum Data Set (MDS) assessment which indicated the resident was rarely or never understood, was severely cognitively impaired and rarely or never made decisions.</p> <p>2. During an 1/7/16, 12:17 p.m., lunch</p>		<p>of similar nutritive value.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1.) DFS or designee will review all residents within restorative dining to ensure substitute meals are delivered with similar nutritive value as outlined through the menu.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DFS or designee will re-educate all staff on the following: 1).Complete Menu daily offerings 2). Appropriate alternative diet specific menu options 3). Importance of serving a well balanced nutritional meal.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DFS or designee 3 times per week times 8 weeks, then weekly times 2 months to ensure compliance: 1).Complete Menu daily offerings 2). Appropriate alternative diet specific menu options 3). Importance of serving a well balanced nutritional meal.</p>	

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	<p>observation, a staff member spoke to Resident #61 asking her if she would like another meal because she didn't like salads. Resident #61 indicated yes. The staff member asked the resident if she would like chicken tenders and fries. The resident nodded her head. The staff member did not offer the resident any fruit or vegetable. Only a meat and starch were stated. On 1/7/16 at 12:23 p.m., Resident #61 was served chicken tenders and fries. She was not offered or served a substitute for the vegetable and fruit which were on the regular menu. At the end of her meal, Resident #61 was offered cherry pie or peaches as a dessert not both as menued.</p> <p>Resident #61's clinical record was reviewed on 01/6/16 at 2:55 p.m. Resident #61's current diagnoses included, but were not limited to, a history of a right wrist fracture, depression, anxiety and Alzheimer's disease.</p> <p>Resident #61 had a current, 10/15/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident was severely cognitively impaired and rarely or never made decisions.</p> <p>Review of the, 1/7/16, lunch menu,</p>		<p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>	

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	<p>provided by the Food Services Supervisor on 1/8/16 at 9:30 a.m. indicated the following:</p> <p>Regular diets were menued to receive: Chef Salad - 2 oz ham, 2 oz turkey, 1/2 of a chopped egg, 4 grape tomatoes, 1 oz cheese, 2 cups lettuce, 2 oz dressing. Yeast roll - 1 each Peaches - 4 oz Cherry pie - 1/10 pie</p> <p>The menu indicated when chicken tenders and fries were served as a "finger food diet" they were to be served with 4 ounces peaches, 1/2 cup mixed vegetables and 2 cookies in order to equal the same nutritive value of the primary menued item.</p> <p>During an 1/8/16, 9:47 a.m., interview, the Food Services Supervisor indicated she was unsure what nursing staff did to ensure residents had substitutes of the same nutritive value offered for all menued items. She indicated the dietary department all served what was requested off the Cafe' Menu as an alternate. She indicated there was no plan in place to ensure residents who did not make independent choices were offered nutritionally equivalent food for all menued items.</p> <p>During an 1/8/16, 12:00 p.m., interview</p>			

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F 0371 SS=F Bldg. 00	<p>LPN #6, CNA #7 and CNA #8 all indicated when a resident did not want the regular menued meal the staff offered them an entree item from the "Cafe' Menu." All three indicated they did not offer fruits and vegetables just the entree. All three indicated they would get a fruit or vegetable only if the resident requested it. They believed the entree alone was the alternate.</p> <p>During an 1/8/16, 12:05 p.m., interview, Dietary Assistant #15 indicated the dietary department served whatever item from the "Cafe' Menu" that was requested by the nursing staff. He additionally indicated there were fruit and vegetable items available for a substitute if requested.</p> <p>3.1-21(a)(4)</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 Based on observation, interview and record review, the facility failed to prepare and distribute food under sanitary conditions regarding glove use and using</p>	F 0371	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient</p>	02/05/2016

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	<p>hands instead of utensils. The deficient practice impacted Resident #61. This deficient practice has the potential to impact 55 of 55 residents who ate meals prepared and served from the facility's main kitchen.</p> <p>Findings include:</p> <p>1. On 1/7/16 from 8:44 a.m. to 9:06 a.m., breakfast meal service and lunch chef salad preparation were observed. The following concerns were observed:</p> <p>On 1/7/16 at 8:47 a.m., Cook #4 used his gloved hands to place salad in the food processor. With the same gloves he touched the outside of the salad bag and the recipe book, drawer handles and a scoop. With the same gloves Cook #4 scooped the chopped lettuce and ran his finger around the outside edge of the scoop resulting in these touched lettuce pieces being placed on the salad plate.</p> <p>On 01/7/16 at 8:52 a.m., Cook #4 washed his hands and put on clean gloves. He carried the ham container to the counter with the food processor. Cook #4 placed ham in the food processor with his gloved hands. He then used his gloves to open a drawer and remove a scoop. He scooped the chopped ham and touched the ham with his gloved hands as he</p>		<p>practice: Food that was improperly prepared was discarded prior to serving and remade using proper hand and glove techniques. Proper utensils were utilized on hot line to ensure proper food preparation. Properly handling ready to eat food. Resident #61 will be properly assisted for all meals in a sanitary manner. Staff Member #6 will receive proper food handling education. Cooks #4 and #5 will receive proper food handling education and sanitary practices.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DFS or designee will re-educate the dietary and nursing staff on the following guideline: 1). Guidelines for proper utensil usage on food line 2). Guidelines for hand washing 3). Guidelines for glove usage 4). Guidelines for proper assistance with meals for Residents</p>		

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	<p>placed it on the plate.</p> <p>On 1/07/16 at 8:57 a.m., Cook #4 placed turkey in the food processor with his gloved hand. He scooped the turkey out of the food processor into the serving bowl with the same gloved hands. He opened drawers with the same gloves. He scooped the ham from the serving bowl and placed it on the plate. He touched the chopped turkey with the same gloves while placing it on the plate.</p> <p>On 1/07/16 at 9:01 a.m., Cook #4 placed chopped hard boiled eggs and cheese on the salad plate with the other salad items. He touched both the eggs and cheese with the same gloves he had used for the chopped turkey.</p> <p>On 1/7/16 at 9:03 a.m., Cook #4 indicated the salad was complete and ready to be refrigerated to await service. With contaminated gloves, Cook #4 had made contact with every food item placed on the salad plate.</p> <p>On 1/07/16 from 8:56 a.m. to 9:05 a.m., Cook #5 was serving breakfast. Cook #5 touched bacon and toast with his gloved hand while serving a resident meal tray. He then touched paper meal tickets, utensils, counter tops, food, and jelly packets. Using the same gloves he sliced</p>		<p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of dining room meal service will be conducted by the DFS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance:</p> <p>1). Observe meal service to ensure food is served in a safe sanitary manner, including hand washing, glove usage, and proper utensil usage. 2). Observe dining room meal service to ensure Residents are properly cued and assisted in a proper sanitary procedure.</p> <p>Throughout the audit / observation period, all 3 meal services for the dining room will be observed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>				

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	<p>strawberries. He touched the strawberries with his gloved hands. Cook #5 repeated this process throughout meal service. He served all bacon, all toast and sliced all strawberries with his hands. All the food service was done while wearing the same pair of gloves he was observed wearing at 8:56 a.m.</p> <p>During a 1/7/16, 9:06 a.m., interview, The Food Services Supervisor indicated food should be touched by utensils not gloved hands. She also indicated all health care residents receive meals prepared in the main kitchen.</p> <p>Review of the "Facility Census Form" completed by the facility on 1/4/15 indicated 55 residents resided in the health care area of the facility.</p> <p>2. On 1/07/16 at 12:24 p.m., LPN #6 sat up Resident #61's meal tray and with her bare hands handed Resident #61 a piece of chicken strips. The resident consumed the food which was handed to her.</p> <p>On 1/07/16 at 12:26 p.m., LPN #6 with her bare hands handed Resident #61 a french fry. The resident consumed the food that was handed to her.</p> <p>On 1/07/16 at 12:27 p.m., LPN #6 offered Resident #61 a piece of chicken</p>			

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F 0514 SS=D Bldg. 00	<p>strips using a fork. Resident #61 removed the strip from the fork with her hands and ate it.</p> <p>On 1/07/16 at 12:30 p.m., LPN #6 with her bare hands handed Resident #61 a french fry. The resident consumed the food that was handed to her.</p> <p>A current, 1/2012, facility policy titled "Glove Use Guidelines", provided by the Food Services Supervisor on 1/7/15 at 9:48 a.m., indicated the following: " (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or raw animal food, used for one purpose and discarded when damaged or soiled, or when interruptions occur in operation."</p> <p>3.1-21(i)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient</p>			

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	<p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure resident clinical records were complete and accurate regarding vital signs and physician's progress notes for 2 of 20 residents reviewed for complete clinical records (Resident #34 and #9).</p> <p>Findings include:</p> <p>1. Resident #34's clinical record was reviewed on 1/07/16 at 10:01 a.m. Resident #34's diagnoses included, but were not limited to, macular degeneration, hypertension, dementia and anxiety.</p> <p>When reviewed on 1/7/16, Resident #34's chart lacked any physician's progress note since 9/29/15.</p> <p>The Director of Nursing was questioned regarding Resident #34's progress notes on 1/7/16. The DON indicated she would look into the situation and follow up.</p> <p>Physician's progress note's for Resident #34, dated 10/5/15, 11/5/15, 12/6/15, and 1/4/16 were left on the conference room</p>	F 0514	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #34 was reviewed to ensure current progress notes are on chart. Resident #9 MAR (Medication Administration Record) was reviewed to ensure blood pressures were obtained and documented as ordered by the physician.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents to ensure updated progress notes are present in the chart. DHS or designee will review all Residents with orders for blood pressure monitoring to ensure the blood pressure tested as ordered and documented on MAR.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the</p>	02/05/2016

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	<p>table on 1/8/16 at an unknown time. Each Physician's progress note had a fax transmittal date of 1/7/16 stamped at the bottom.</p> <p>During an 1/8/16, 3:22 p.m., interview the Medical Records LPN indicated Resident #34's last 4 physician's progress note could not be found in the facility and had been faxed to the facility by the doctor's office. She additionally indicated the doctor's office had informed her each note had been left at the nursing station within a few days of each visit. The Medical Records LPN indicated she was unable to determine how the breakdown occurred.</p> <p>2. The clinical record for Resident #9 was reviewed on 1/7/16 at 8:06 a.m. Diagnoses for Resident #9 included, but were not limited to, diabetes mellitus, hypertension, depression, and dementia with behaviors.</p> <p>Current signed physician orders for Resident #9 included, but were not limited to, the following: Lorsartan (a blood pressure medication) 50 milligrams (mg) by mouth once a day. This order originated 5/18/15. Monitor blood pressure two times a day (a.m. and p.m.) with a manual cuff and record readings. This order originated on 11/25/15.</p>		<p>Licensed Nurses on the following guidelines: 1). Blood Pressure Monitoring 2). Clinical Documentation 3). Progress notes present in chart</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: 1). The following audits and /or observations for 5 residents will be conducted by the DHS or designee 3 times per week times 8 weeks, then weekly times 2 months to ensure compliance with orders for blood pressure monitoring to ensure the blood pressure tested as ordered and documented on MAR. 2). The following audits and /or observations for 5 residents will be conducted by the DHS or designee 3 times per week times 8 weeks, then weekly times 2 months to ensure compliance with progress notes present in chart.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>	

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NAME OF PROVIDER OR SUPPLIER PRAIRIE LAKES HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9730 PRAIRIE LAKES BLVD E NOBLESVILLE, IN 46060
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	<p>Review of the November, 2015 and December, 2015 Medication Administration Records indicated missing blood pressure readings on the following dates and times:</p> <p>November 26, p.m., November 29, a.m., November 29, p.m., November 30, a.m., November 30, p.m., December 3, a.m., December 4, p.m., December 6, a.m., December 8, p.m., December 9, a.m., December 9, p.m., December 11, a.m., December 14, a.m., December 15, a.m., December 16, a.m., December 18, p.m., December 23, a.m., December 23, p.m., December 24, p.m., December 29, a.m., and December 31, p.m.</p> <p>During an interview on 1/8/15 at 2:57 p.m., the Director of Nursing (DON) indicated blood pressure readings were to be documented on the Medication Administration Records. She indicated she had looked on the vital signs flow sheet but there were no documented blood pressure for the above dates and times.</p> <p>During an interview on 1/8/16 at 3:16 p.m., LPN #3 indicated blood pressure readings were to be documented on the Medication Administration Records.</p>			

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	<p>During an interview on 1/11/16 at 10:35 a.m., the Social Services Director indicated Resident #9 was seen by the Nurse Practitioner on 11/25/15. The Nurse Practitioner gave the order for the blood pressure monitoring twice a day with a manual cuff related to a behavioral episode on 11/25/15.</p> <p>Review of the current facility policy, dated 9/25/14, titled "GUIDELINES FOR MEDICAL RECORDS CLINICAL DOCUMENTATION", provided by the DON on 1/11/16 at 12:48 p.m., included, but was not limited to, the following:</p> <p>"I. POLICY GUIDELINES The campus shall maintain a complete, ongoing, and organized resident record on each resident from the time of admission until termination of the resident's stay at the campus... ...A. General Guidelines 1. A complete, timely, and accurate resident record is created and maintained for each resident. 2. The resident's record provides complete documentation of the services provided to an individual...."</p> <p>3.1-50(a)(1)</p>			

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F 0520 SS=F Bldg. 00	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview, and record review, the facility failed to successfully implement a plan of action to address sanitary food distribution.</p> <p>This deficient practice had the potential to impact 55 of 55 residents that resided in facility.</p> <p>Findings include:</p> <p>1. On 1/7/16 at 9:03 a.m., Cook #4</p>	F 0520	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Food that was improperly prepared was discarded prior to serving and remade using proper hand and glove techniques. Proper utensils were utilized on hot line to ensure proper food preparation. Properly handling ready to eat food.</p>	02/05/2016

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	<p>indicated the salad was complete and ready to be refrigerated to await service. With contaminated gloves, Cook #4 had made contact with every food item placed on the salad plate.</p> <p>On 1/07/16 from 8:56 a.m. to 9:05 a.m., Cook #5 was serving breakfast. Cook #5 touched bacon and toast with his gloved had while serving a resident meal tray. He then touched paper meal tickets, utensils, counter tops, food, and jelly packets. Using the same gloves he sliced strawberries. He touched the strawberries with his gloved hands. Cook #5 repeated this process throughout meal service. He served all bacon,all toast and sliced all strawberries with his hands. All the food service was done while wearing the same pair of gloves he was observed wearing at 8:56 a.m.</p> <p>During a 1/7/16, 9:06 a.m., interview, The Food Services Supervisor indicated food should be touched by utensils not gloved hands. She also indicated all health care residents receive meals prepared in the main kitchen.</p> <p>Review of the "Facility Census Form" completed by the facility on 1/4/15 indicated 55 residents resided in the health care area of the facility.</p>		<p>Resident #61 will be properly assisted for all meals in a sanitary manner. Staff Member #6 will receive proper food handling education. Cooks #4 and #5 will receive proper food handling education and sanitary practices.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: ED or designee will re-educate the Quality Assurance Committee on the following guideline: Quality Assessment and Assurance Process</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be</p>	

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	<p>2. On 1/07/16 at 12:24 p.m., LPN #6 sat up Resident #61's meal tray and with her bare hands handed Resident #61 a piece of chicken strips. The resident consumed the food which was handed to her.</p> <p>On 1/07/16 at 12:26 p.m., LPN #6 with her bare hands handed Resident #61 a french fry. The resident consumed the food that was handed to her.</p> <p>On 1/07/16 at 12:27 p.m., LPN #6 offered Resident #61 a piece of chicken strips using a fork. Resident #61 removed the strip from the fork with her hands and ate it.</p> <p>On 1/07/16 at 12:30 p.m., LPN #6 with her bare hands handed Resident #61 a french fry. The resident consumed the food that was handed to her.</p> <p>A current, 1/2012, facility policy titled "Glove Use Guidelines", provided by the Food Services Supervisor on 1/7/15 at 9:48 a.m., indicated the following: " (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or raw animal food, used for one purpose and discarded when damaged or soiled, or when interruptions occur in operation."</p> <p>3. During a 1/11/16, 1:20 p.m., interview</p>		<p>conducted by the ED or designee monthly times 6 months to ensure compliance: 1). Review of Quality Assessment and Assurance minutes to ensure the results of the audit and / or observations for food safety are reported, reviewed and trended for compliance thru the campus Quality Assurance Committee.</p> <p>The results of the audit and / or observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>the Administrator indicated the QAA committee met monthly, and on a quarterly basis. The Administrator indicated dietary sanitation had not been reviewed since she had become the Administrator in February 2015.</p> <p>During a 1/11/16, 1:32 p.m. interview, the Administrator indicated the facility had a change in Dietary Managers and the previous sanitation audits that were conducted from last year's survey were not being used by the new Dietary Manager. The Administrator indicated the facility will have to put new audit tools in place for this year.</p> <p>Review of the current facility policy, undated, titled "GUIDELINES FOR THE QUALITY ASSESSMENT AND ASSURANCE PROCESS", provided by the Administrator on 1/11/16 at 1:36 p.m., included, but was not limited to, the following:</p> <p>"I. PURPOSE: To provide continuous evaluation of campus systems to distinguish between isolated, pattern or systemic concerns, ensure systems are functioning appropriately, to prevent problems from arising to the extent possible, recognize incremental change that may be early signs of potential/future problems, and</p>			

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	<p>correct identified issues...</p> <p>...A. PROCEDURE:</p> <p>1. The primary purpose of the Quality Assessment and Assurance Plan are:</p> <p>...e. To develop plans of correction and evaluate corrective actions taken to obtain the desired results...</p> <p>10. The Quality Assessment and Assurance Committee shall determine the types of quality assessment and assurance activities to be used and shall approve all data-collection tools, monitoring tools, and activities that encompass all categories of care rendered to determine:</p> <p>a. Their appropriateness;</p> <p>b. The standards against which they are measured; and</p> <p>c. Their effectiveness to meet resident care needs.</p> <p>11. Any and all activities of correction will be approved by the committee so duplicate activities do not occur. All corrective activities will be monitored to determine appropriateness and/or the need for alternative measures.</p> <p>a. The QAA Committee shall make every effort to determine the root cause of the deficiency to determine appropriate action interventions.</p> <p>12. The corrective action interventions shall be monitored to ensure the effect of the implemented changes are accomplishing the desired results...."</p>			

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F 9999 Bldg. 00	<p>3.1-52(b)(2)</p> <p>STATE RULE:</p> <p>3.1-14 (u) In addition to the required inservice hours in subsection (1), 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 (30) days of 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 cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 5 of 5 "as needed" employees had 3 hours of dementia-specific training. (Employee #'s 10, 11, 12, 13, 14) This deficient practice had a potential to affect 31 residents with dementia of 55 residents living in the facility.</p>	F 9999	<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Staff who have regular contact with residents shall have a minimum of 6 hours of dementia specific training within 6 months of initial employment and 3 hours annually thereafter to meet the needs or preferences of cognitively impaired residents.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents with dementia diagnosis have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate all staff of the requirement of</p>	02/05/2016

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	<p>Findings include:</p> <p>The employee records review was completed on 1/8/16 at 9:50 a.m. The records indicated the following 5 employee's did not have annual dementia training: Employee #10 hired 5/10/2010, Employee #11 hired 3/11/2014, Employee #12 hired 7/25/2012, Employee #13 hired 11/12/2013, Employee #14 hired 7/22/2009.</p> <p>During an interview on 1/8/16 at 12:00 p.m., the Administrator indicated she did not have any record of dementia training for Employees #10, #11, #12, #13, and #14.</p> <p>The "RESIDENT CENSUS AND CONDITIONS OF RESIDENTS" form provided on 1//5/16 at 9:56 a.m., by the Administrator indicated 31 of 55 residents had dementia.</p> <p>Review of the current facility policy, undated, titled "In-Service Training Program", provided by the Unit Manager #9 on 1/8/16 at 12:05 p.m., included but was not limited to, the following:</p> <p>"I. Policy Statement All personnel must participate in</p>		<p>dementia specific training and regulations.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 10 staff members will be conducted by the DHS or designee monthly for 6 months to ensure proper dementia training requirements are met.</p> <p>The results of the audit and / or observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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R 0000 Bldg. 00	<p>regularly scheduled in-service training classes.... ...A. Policy Interpretation and Implementation 1. All personnel are required to attend regularly scheduled in-service training classes... 4. Attendance at in-service training classes is mandatory and is considered working time for pay purposes... 6. All training classes attended by each employee will be entered on the respective employee's Employee Training attendance Record by the Department Supervisor or other person(s) designated by that supervisor...."</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 49 Sample:9</p> <p>Praire Lakes Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00184162) Survey on October 30, 2015. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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

PRINTED: 01/28/2016

FORM APPROVED

OMB NO. 0938-0391

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