

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER WHITLOCK PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 S ELM ST CRAWFORDSVILLE, IN 47933
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R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey Date: 4/11/14</p> <p>Facility Number: 004419</p> <p>Survey Team: Mary Weyls RN TC Lori Brettnacher RN Megan Burgess RN Kewanna Gordon RN</p> <p>Census Bed Type: Residential: 39 Total: 39</p> <p>Census Payor Type: Other: 39 Total: 39</p> <p>Sample: 8</p> <p>These state findings are in accordance with 410 IAC 16.2</p>	R000000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
R000026	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on observation and interview the facility failed to post a copy of the resident's rights in a publicly accessible area.</p> <p>Findings include:</p> <p>During General Observations of the facility on 4/11/14 at 10 a.m., a copy of the "Resident Rights" was observed not to be posted.</p> <p>During interview of the ED (executive director) on 4/11/14 at 10 a.m., the ED indicated the Resident Rights were not posted.</p> <p>5-1.2(a)</p>	R000026	<p>Residents' Rights - Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected by this alleged noncompliance.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A resident council meeting was conducted on 4/16/2014 and resident rights were reviewed. Residents were asked if they had any questions about resident rights.</p> <p>What measures will be put into place or what systemic</p>	04/30/2014

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			<p>changes will the facility make to ensure that the deficient practice does not recur? The Executive Director (ED) reviewed Indiana State R 055 410 IAC 16.2-5-1.2(a). and Resident Rights on 4/22/2014. The ED will be responsible for ensuring Resident Rights are available in a publicly accessible area, in at least a 12 point type, and in a language the resident understands.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The ED will be responsible for monitoring Resident Rights are posted in a publicly accessible area through weekly rounds of the community to ensure continued compliance for a period of 6 months. Posting noncompliance will be reviewed and corrected through the Whitlock House QA process. A Quality Assurance meeting will be held after six months to determine the need for the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance.</p>	

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R000118	<p>410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review the facility failed to ensure an employee providing ADL (activities of daily living) was currently certified for 1 of 11 CNA (certified nursing assistant) certificates reviewed. (CNA #6)</p> <p>Findings include:</p> <p>During review of CNA certificates, provided on 4/11/14 at 11 a.m., from the office manager, CNA #6's certificate was noted with an expiration date of 2/28/14.</p> <p>During an interview on 4/11/14 at 2:00 p.m., RN #4 indicated the license/certification verification website listed an expiration date of 2/28/14 for CNA #6's certification.</p>	R000118	<p>By what date will the systemic changes be completed? 4/30/14</p> <p>Personnel - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected by this alleged deficiency.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ED has reviewed C N A certificates to ensure they are current. There are no residents affected by this alleged deficiency.</p> <p>What measures will be put into place or what systemic changes will the facility make</p>	04/30/2014			

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	<p>During interview of the ED (executive director) on 4/11/14 at 2:15 p.m., the director indicated he wasn't sure who was responsible for ensuring CNA certificates were current.</p> <p>5-1.4(c)</p>				<p>to ensure that the deficient practice does not recur? The certification for C N A #6 has been renewed and verified. The Executive Director (ED) reviewed Indiana State R 055 410 IAC 16.2-5-1.4(c) – Personnel on 4/22/2014. The ED will be responsible for ensuring C N A certificates are current before hire and during employment. A copy of each C N A certification will be maintained in a binder that can be reviewed easily for expiration dates.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The ED will be responsible for ensuring C N A certificates are current before hire and during employment. A copy of each C N A certification will be maintained in a binder that can be reviewed easily for expiration dates. ED will review this book monthly and take appropriate action for expired certifications. This process will be reviewed through the Whitlock House QA program. A Quality Assurance meeting will be held after six months to determine the need for the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and</p>		

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R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p>		<p>Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance.</p> <p>By what date will the systemic changes be completed? 4/30/2014</p>	

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	<p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review the facility failed to ensure an employee received a tuberculin skin test at time of employment and/or within one month prior to employment for 1 of 5 employee records reviewed. (Employee # 5)</p> <p>Findings include:</p> <p>During review of CNA (certified nursing assistant) #5's employee file on 4/11/14 at 1 p.m., documentation indicating the employee had received a tuberculin skin test was lacking.</p> <p>During interview of the office manager on 4/11/14 at 1:15 p.m., the office manager indicated she could not find where CNA #5 had received a tuberculin skin test prior to or since employment. The office manager indicated CNA #5's start date at the facility was 2/11/14.</p> <p>A policy and procedure titled "TB [tuberculin] Testing" dated 1/1/14, was received on 4/11/14 at 1:45 p.m. from</p>	R000121	<p>Personnel – Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected by this alleged deficiency.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ED has reviewed all employee TB records to ensure compliance. There are no residents affected by this alleged deficiency.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The tuberculin skin test has been completed for certification for CNA #5. The Executive Director (ED) reviewed Indiana State R 410 IAC 16.2-5-1.4(f)(1-4) Personnel on 4/24/2014. The ED</p>	04/30/2014

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R000273	<p>RN #4. The policy indicated "TB testing will be completed per state regulations for residents, staff and volunteers.."</p> <p>5-1.4(f)(1)</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are</p>				<p>will be responsible for ensuring employees are screened for tuberculosis prior to employment, and annually thereafter.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The ED will be responsible for ensuring employees are screened for tuberculosis prior to employment, and annually thereafter. Employee PPDs will be maintained in a separate binder, the ED will review this binder monthly to ensure compliance. This process will be reviewed through the Whitlock House QA program. A Quality Assurance meeting will be held after six months to determine the need for the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance.</p> <p>By what date will the systemic changes be completed? 4/30/2014</p>		

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	<p>maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and record review the facility failed to ensure the kitchen area was maintained in accordance with state and local sanitation standards for 1 of 1 kitchen observation.</p> <p>Findings include:</p> <p>During general kitchen observation on 4/11/14 at 9:30 a.m., with Assistant Chef #2 , the following was observed:</p> <p>A cover was absent for a large trash container.</p> <p>Kitchen staff (#3) was not wearing a hair covering.</p> <p>Review of a facility policy and procedure titled " Kitchen Sanitation and Safety" received from RN #4 on 4/11/14 at 1:15 p.m., indicated "Garbage containers must be kept covered when not in use and reasonably clean at all times."</p> <p>Review of a facility policy and procedure, dated July 2013, titled "Dining Room Etiquette and Dress Code" received from RN #4 on 4/11/14 at 1:45 p.m., indicated, "...Hair nets, chef hats, or skull caps that cover all hair must be</p>	R000273	<p>Food and Nutritional Services - Deficiency</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>No residents were found to be affected by this alleged deficiency.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>There are no residents affected by this alleged deficiency.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>Immediately upon report of concern a cover was placed on the large trash container, and a hair net was used by kitchen staff #3. All staff will be in serviced regarding the facility policy on Kitchen Sanitation & Safety to keep trash containers covered when not in use. All staff will be in serviced regarding the facility policy on Dining Room Etiquette regarding donning of hairnets when entering food prep areas.</p>	04/30/2014			

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	worn in the food preparation area (Kitchen)...." 5-5.1(f)		The ED will be responsible for ensuring compliance with these policies. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The ED will perform random weekly audits of kitchen sanitation using the Kitchen Sanitation Checklist. This process will be reviewed through the Whitlock House QA program. A Quality Assurance meeting will be held after six months to determine the need for the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 4/30/14				