

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 10/16/2013
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NAME OF PROVIDER OR SUPPLIER GARDENS AT LAKE CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: October 15, 16, 2013</p> <p>Facility Number: 011389 Provider Number: 011389 AIM Number: N/A</p> <p>Survey team: Julie Wagoner, RN, TC Lora Swanson, RN</p> <p>Census bed type: Residential 19 Total: 19</p> <p>Census payor type: Other: 19 Total: 19</p> <p>Sample: 07</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on October 21, 2013, by Brenda Meredith, R.N.</p>	R000000	<p>Submission of this response and Plan of Correction in 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 or the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any</p>						

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	<p>subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interviews, the facility failed to ensure a physician's order was followed timely for 1 of 7 residents. (Resident #2)</p> <p>Finding includes:</p> <p>The clinical record for Resident #2 was reviewed on 10/15/13 at 3:00 P.M. Resident #2 was admitted to the facility, on 11/04/11, with diagnosis, including but not limited , dementia, hypertension, coronary artery disease, weakness in the lower extremities, urinary tract infections, diabetes mellitus, mood disorder and constipation.</p> <p>During the initial tour of the facility, conducted on 10/15/13 between 1:15 P.M. - 1:45 P.M., the Wellness Director, RN #1, indicated Resident #2 received Hospice services, required staff assistance for toileting, transferring, and dressing needs, was confused and was incontinent at</p>	R000090	R090 410 IAC 16.2-5-1.3(g) (1-6) Administration and Management – Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Nursing staff were inserviced and re-educated on the process of: (1) obtaining and implement- Ing a physician's order in a timely manner, (2) documenting in resident records, and using the communication book to be compliant with 410 IAC 16.2-5-1.3(g)(1-6). 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? No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Monitoring forms have been implemented to ensure physician's orders are	11/01/2013			

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	<p>times.</p> <p>A Resident service note, dated 09/01/13, indicated a fax was sent to the resident's physician requesting an order for a urinalysis test due to the resident's amber colored urine with an odor. A physician's order was received, on 09/03/13, for a urinalysis with a culture and sensitivity test if indicated. There was no further assessment of the resident or mention of the lab test for Resident #2 until 09/20/13, when the urinalysis and culture and sensitivity test results were received. On 09/23/13, a physician's order was received for an antibiotic to treat a urinary tract infection. On 09/25/13, an assessment of Resident #2 indicated her urine was yellow, had a slight odor, and she had an elevated temperature of 99.1 (degrees Fahrenheit).</p> <p>Interview with the Wellness Director, RN #1, on 10/16/13 at 2:20 P.M., indicated she had taken the original urine sample to the local lab on 09/06/13, but the laboratory would not accept the physician's order in the manner in which it was written. The urine sample was no longer viable when the clerical issue with the physician's order was clarified. RN</p>		<p>implemented in a timely manner. Nursing staff were inserviced and re-educated to the use of the monitoring tool. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director or designee will be responsible for oversight of physicians orders and will review the monitoring forms on a daily basis to ensure compliance. Regional nurse or designee will review monitoring system during quarterly visits. By what date will the systemic changes be completed? Nov. 1, 2013</p>				

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	#1 indicated she expected her nursing staff to document the issue in the clinical record and obtain another urine sample on the following Monday, 09/09/13, but no documentation or follow up, or additional sample was obtained until 09/20/13.				

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R000273	<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 maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interviews, the facility failed to ensure food was stored properly in 1 of 1 activity room refrigerators. This potentially affected 19 of 19 residents who might consume food stored in the activity room.</p> <p>Finding includes:</p> <p>During the environmental tour of the facility, conducted on 10/16/13 between 9:00 A.M. - 9:30 A.M., the following was noted in the refrigerator in the activity room:</p> <ol style="list-style-type: none"> Two uncovered bowls of ice cream were noted in the freezer unit. An uncovered, undated, partially used container of brown icing with a knife stuck in it was stored in the door of the refrigerator Two pies, unlabeled and undated, both covered with a loose piece of foil over them were stored on the second and bottom shelf of the refrigerator. A pie server was still in one of the pies. An unlabeled and undated, gallon of a brown liquid was noted stored in 	R000273	<p>R273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services – Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Staff were inserviced and re-educated regarding sanitary and safe food handling standards including proper storage. Staff were instructed on appropriate the use of the activity area refrigerator. How the facility will identify other residents having the potential to be affected by the same deficient practice? No residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Meaningful Pursuits Coordinator (MPC) will be responsible for monitoring activity area refrigerator assuring that food items are properly labeled, covered, dated, and stored or discarded after the activity is finished. How will the corrective action(s) be</p>	11/01/2013			

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	<p>a container labeled "Distilled Water." Interview with the Activity Director indicated the jug contained apple cider.</p> <p>5. A tray with 12 caramel apples was noted, uncovered and undated, on the shelf of the refrigerator. Interview with the Activity Director indicated the residents had made them on 10/15/13.</p>		<p>monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Residence Director (RD) will monitor activity area refrigerator in cooperation with the dining services checklist currently in place. Regional team will review at quarterly visits. By what date will the systemic changes be completed? Nov. 1, 2013</p>				

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R000410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interviews, the facility failed to ensure 1 of 7 residents reviewed had a Tuberculin skin test (TB test) completed timely upon admission. (Resident #8)</p> <p>Finding includes:</p> <p>The closed clinical record for Resident #8 was reviewed on 10/16/13 at 11:30 A.M. The resident's admission date, documented in the resident service notes, indicated she had been</p>	R000410	R410 410 IAC 16.2-5-12(e)(f)(g) Infection control – noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Residence Director (RD), Wellness Director (WD), and Residence Sales Manager (RSM) were inserviced and re-educated regarding TB testing and mantoux requirements upon admission. No other residents were found to be effected. How the facility will identify other residents	11/01/2013			

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	<p>admitted to the facility on 05/21/13.</p> <p>Review of the Tuberculosis Testing and Vaccine Consents and Records form for Resident #8 indicated she was not given a Mantoux Tuberculin skin test (TB test) until 07/25/13, over two months after she was admitted. Her record also contained documentation from the comprehensive long term care facility where she had lived prior to her admission to the residential facility of a two step Tuberculin Mantoux test. The documentation indicated the resident had been given a first step Mantoux test on 04/12/13, and a second step Mantoux test on 04/23/13. However, some of the documentation was incomplete on the form from the long term care facility.</p> <p>Interview with the Wellness Director, RN #1, on 10/16/13 at 2:45 P.M., indicated facility staff had thought they could utilize the Mantoux (TB) test documentation from the transferring facility and Resident #8 was not given any Mantoux testing on her admission to the Residential facility. Employee #1 indicated she had instructed her staff to administer a two step Mantoux test when she had realized Resident #8 had not been given any Mantoux test by her</p>		<p>having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Wellness Director will be responsible for obtaining and tracking the result of Mantoux tests upon admission. Residence Director or designee will maintain a separate binder with resident Mantoux records to assist with the monitoring. WD will utilize company forms in place to assure compliance with 410 IAC 16.2-5-12(e)(f)(g). 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? Wellness Director will utilize company tracking form currently in place. Residence Director will monitor Mantoux tracking binder and regional team will review with quarterly visits. By what date will the systemic changes be completed? Nov. 1, 2013</p>				

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	staff and she also realized the documentation was incomplete from the previous facility and two months after she was admitted to the facility.						