

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 01/03/2013	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART				STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342			
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 2 & 3, 2013</p> <p>Facility number: 002627 Provider number: 002627 AIM number: NA</p> <p>Survey team: Lara Richards, RN, TC Kathleen "Kitty" Vargas, RN</p> <p>Census bed type: Residential: 122 Total: 122</p> <p>Census payor type: Other: 122 Total: 122</p> <p>Sample: 9</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 6, 2013, by Janelyn Kulik, RN.</p>			R0000	<p>Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</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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R0116	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure a criminal background check was completed at the time of hire for 1 of 5 employee files reviewed. (RA #1)</p> <p>Findings include:</p> <p>Review of the Employee File for RA (Resident Assistant) #1 on 1/3/13 at 11:30 a.m., indicated the RA had been hired on 9/2/12. The RA had signed a consent form for a criminal background check, however, a criminal background check was not available for review in the employee's file.</p> <p>Interview with the Business Office Manager on 1/3/13 at 2:30 p.m., indicated that she could not find where a criminal background check had been completed and she indicated that she put in a rush order for one.</p> <p>Review of the facility policy titled</p>	R0116	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> · No residents were affected by alleged deficient practice. · A criminal background check was completed on RA #1 on 1/4/13 and there were no findings. <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> · Current associate files have been audited to ensure completed criminal background checks have been obtained. <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> · Any newly hired associates will have their files audited by the BOD and a designee (2 people) to ensure compliance, prior to the new associates first day of employment. <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p>	01/04/2013			

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	"Criminal Background Checks" on 1/3/12 at 3:00 p.m., which was provided by the Resident Care Director and identified as current, indicated the following: "Each new employee will be considered conditionally employed pending the result of a criminal or additional background investigation."		<ul style="list-style-type: none"> · BOD or designee will audit new hire files monthly for compliance and will bring audits to present to the QA committee monthly for a minimum for 6 months to ensure compliance. · Regional directors will review during routine site visits and annual comprehensive process review. <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> · Implemented 1/4/13 	

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R0119	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3)-Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interview, the facility failed to ensure job specific orientation was completed for 2 of 2 dietary employees of the 5 employee files reviewed. (Dietary</p>	R0119	<p>R 119 Personnel-noncompliance</p> <p><i>What corrective action(s) will be accomplished for those residents</i></p>	01/11/2013			

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	<p>employee #1 and Dietary employee #2)</p> <p>Findings include:</p> <p>1. Review of the Employee File for Dietary employee #1 on 1/3/13 at 11:30 a.m., indicated the employee had been hired as "waitstaff" on 7/5/12. There was no documentation in the employee's file to indicate that she had received job specific orientation to the dietary department.</p> <p>Interview with the Business Office Manager on 1/3/13 at 12:30 p.m., indicated that she had talked to the Dietary Food Manager and he indicated the employee had received job specific orientation to the department but it was not documented.</p> <p>2. Review of the Employee File for Dietary employee #2 on 1/3/13 at 11:40 a.m., indicated the employee had been hired as "waitstaff" on 3/27/12. There was no documentation in the employee's file to indicate that she had received job specific orientation to the dietary department.</p> <p>Interview with the Business Office Manager on 1/3/13 at 12:30 p.m.,</p>		<p><i>found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> No residents were effected by the alleged deficient practice <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> Employee files have been audited for job specific orientation checklist on 1/4/13. Current associates have completed job specific orientation checklist as of 1/11/13 <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> Department managers are responsible for ensuring the job specific orientation checklist is completed and filed in the employee file within 2 weeks of the employees hire date. The BOD and or designee will complete file audits on all new hires within 30 days of employment to ensure compliance. 				

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	indicated that she had talked to the Dietary Food Manager and he indicated the employee had received job specific orientation to the department but it was not documented.		<p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> · The BOD will present the file audits to the QA committee monthly for 6 months to ensure compliance is met. · Regional directors will review during routine site visits and annual comprehensive process review. <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> · Implemented 1/11/13 				

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R0145	<p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on observation and interview, the facility failed to ensure the call lights in the resident apartments were functioning accurately for 4 of 15 apartments observed. (Apartment #309, #321, #412, and #434)</p> <p>Findings include:</p> <p>On 1/3/13 at 10:45 a.m., the Environmental Tour was completed with the Maintenance Supervisor. The following was observed:</p> <p>a. In Apartment #412, the call light in the bedroom had no pull cord. The call light could not be activated. The call light in the bathroom was observed. It could not be activated. The pull cord to activate the call light in the bathroom could not be pulled. Interview with the Maintenance Supervisor at the time of the tour, indicated the call light cord in the bathroom was jammed and needed to be replaced. He also indicated the call light in the bedroom needed a pull cord. Two residents resided in the room.</p>	R0145	<p>R 145 Safety and Sanitation Standards- Deficiency <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i> · The call cord for apartment 412 has been replaced, call cord for apartments 434,321 and 309 were all repaired immediately and were registering on the pagers as of 1/3/12<i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i> · The maintenance director and or designee completed an audit of the call cords within the community on 1/7/13. No other call cords were identified to have concerns. <i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i> · The Maintenance Director and or designee will complete audits of the call cords monthly to ensure they are functioning properly <i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i> · The Maintenance</p>	01/07/2013			

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	<p>b. In Apartment #434, the call light in the bathroom did not function. Interview with the Maintenance Supervisor at that time, indicated when a call light was activated, it registered on the staff member's pager and would indicate the apartment number and the location of the call light that was activated. The staff pager was observed, it did not indicate the call light for Apartment #434 was activated. One resident resided in the room.</p> <p>c. In Apartment #321, the call light in the bathroom was activated. Observation of the staff pager indicated the call light for Apartment #321 did not register on the pager. One resident resided in the room.</p> <p>d. In Apartment #309, the call light in the bathroom was activated. Observation of the staff pager indicated the call light for Apartment #309 did not register on the pager. One resident resided in the room.</p> <p>Interview with the Maintenance Supervisor at the time of the tour, indicated the computer system for the call light system for Apartments #434, #321 and #309 needed to be updated. He indicated the call lights for those apartments were not</p>		<p>Director will present the call cord audits to the QA committee monthly for 6 months to ensure compliance · Regional directors will monitor on routine site visits and annual comprehensive process review. <i>By what date will these systemic changes be implemented?</i> · Implemented 1/07/13</p>				

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R0154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure all kitchen areas were clean and in a state of good repair related to stained floor tile and PVC piping for 1 of 2 kitchen areas. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation Tour on 1/2/13 at 10:07 a.m., with the Dietary Food Manager, the following was observed:</p> <p>a. The floor tile located underneath the dishwasher had an accumulation of lime build up.</p> <p>b. The white floor grate located underneath the dishwasher had an accumulation of dried food spillage. Further, there was an accumulation of a black substance along the base board underneath the dishwasher.</p> <p>c. Two of two tan transport carts located in the dishwashing area, had an accumulation of a black stained substance. Interview with the Dietary</p>	R0154	<p>R 154 Sanitation and safety standards- Deficiency</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> - No residents were effected by the alleged deficient practice - Items labeled a,b and d in the statement of deficiencies were correct immediately on 1/2/13 - Item c indicated that 2 transport carts were stained black- those carts have been discarded and replaced on 1/4/13 - The flooring identified to be "stained" in items e and f have been cleaned and the coffee and juice machines have been fixed to stop any drips from occurring as of 1/8/13 <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> - No residents have the potential to be effected - The Dining Services Director or designee will complete 10 minute sanitation rounds weekly to ensure compliance 	01/08/2013			

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	<p>Food Manager at the time, indicated dirty dishes were placed on top of the carts and that they needed to be thrown away.</p> <p>d. The white PVC piping located next to 2 of 2 garbage disposals, had an accumulation of dried food spillage.</p> <p>e. The tile floor located by the coffee machine was stained with a brown substance. Interview with the Dietary Food Manager at the time, indicated the coffee machine drips and it stains the floor.</p> <p>f. The tile floor located by the juice machine was stained with a red substance.</p> <p>Interview with the Dietary Food Manager at the time, indicated all of the above areas were in need of cleaning.</p>		<p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> The Dining Services Director or designee will complete 10 minute sanitation audits weekly to ensure compliance <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> Weekly sanitation audits will be presented to the QA committee monthly for 6 months to ensure compliance. Regional Directors will review audits during routine site visits and annual Comprehensive Process review <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> Implemented 1/8/13 				

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to lack of documentation of Physician follow up after a resident exhibited signs of increased confusion following a medication change, incomplete transfer forms and clarification of an anti-anxiety medication order for 3 of 9 sampled residents. (Residents #1, #4, and #7)</p> <p>Findings include:</p> <p>1. The record for Resident #1 was reviewed on 1/2/13 at 2:10 p.m. The resident's diagnoses included, but were not limited to, dementing illness with associated behavioral symptoms.</p> <p>A Physician's order dated 11/1/12, indicated the resident's Seroquel (an antipsychotic medication) was</p>	R0349	<p>R 349 Clinical Records-noncompliance</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> · Resident #1's physician was contacted and notified on 1/3/13 of the condition changes noted on 11/17/12 and no further behaviors or condition changes had been observed since that date. · Resident # 7's transfer form was completed on 1/3/13 and added to her closed record, and a copy was mailed to her family. · A diagnosis has been obtained from the prescribing physician of resident # 4, and added her medical record related to the use of Ativan <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> · The Resident Care Director and or designee will complete audits on medical records for residents who have an order for antipsychotic medication to identify if they have exhibited any change of condition related to a med 	01/18/2013			

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	<p>increased to 25 milligrams (mg) two times a day. A "Healthcare Provider Communication Form" dated 11/17/12, indicated the resident's Physician had been faxed due to staff noticing an increase in confusion, hearing things, anxious/restless, and putting food in her hot chocolate. Staff indicated they noticed the condition change since the resident's Seroquel had been increased. There was no response from the Physician. Further, there was no documentation in the nursing progress notes to indicate if staff had attempted to contact the Physician again.</p> <p>Interview with the Resident Care Director on 1/3/13 at 9:30 a.m., indicated staff should have documented additional attempts at contacting the resident's doctor.</p>		<p>adjustment.</p> <ul style="list-style-type: none"> · The Resident Care Director and or designee will complete an audit of resident medical records who have transferred or discharged with the past 6 months to ensure the transforms were completed and in place. · The Resident Care Director and or designee will complete an audit of resident medical records who receive PRN medications to ensure they have a diagnosis related to the use of the PRN medication. <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> · All licensed nurses and qualified medication assistants were re-educated 1/9/13 on physician follow up communications, transfer/discharge forms and obtaining diagnosis for prn medications. · The Resident Care Director and or designee will complete audits weekly for any resident medical records who have received new orders for antipsychotic medication, had a transfer or discharge and/ or had an order obtained for a PRN medication to ensure compliance. <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> · The Resident Care Director and or designee will complete audits weekly for any resident medical records who have received new orders for antipsychotic medication, had a transfer or discharge and/ or had an order obtained for a PRN medication to ensure compliance. · Weekly audit findings will be 				

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	<p>2. The closed record for Resident #7 was reviewed on 1/2/13 at 3:00 p.m. Review of the Service Notes dated 9/22/12, indicated the resident moved out of the facility.</p> <p>The form titled, "Resident Transfer Form" was reviewed. The form had Resident #7's name on it, the physician's name and diagnoses of dementia and hypertension, the form was not complete.</p> <p>There was no information documented on the form for: -Name and address of facility transferring to -Advanced Directives -Reason for transfer -Diet</p> <p>There was no signature of the person arranging the transfer. There was no signature of the Responsible Party that indicated the transfer instructions were explained.</p>		<p>presented to the QA committee monthly for 6 months to ensure compliance</p> <ul style="list-style-type: none"> - Regional directors will monitor during routine site visits and annual comprehensive review process. <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> - Implemented by 1/18/13 				

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	<p>Interview with the Resident Care Director on 1/3/13 at 10:00 a.m., indicated the resident was transferred to another Assisted Living facility. She indicated the transfer form was not complete. She indicated a completed transfer form should be in the resident's record.</p> <p>3. The record for Resident #4 was reviewed on 1/2/13 at 1:50 p.m. The resident had diagnoses that included, but were not limited to, Dementia.</p> <p>Review of the December 2012 Physician Order Sheet, indicated the resident had a Physician's Order for Ativan (an antianxiety medication) 1 milligram orally every 6 hours as needed. The order did not include the reason or the specific symptom for the use of the medication.</p> <p>Interview with the Resident Care Director on 1/3/13 at 9:15 a.m., indicated the Physician's Order was incomplete. She indicated there should have been a reason or symptom documented for the use of the medication.</p> <p>Review of the September 2012 Medication Administration Record (MAR), indicated the resident received Ativan on 9/6/12 at 6:30 p.m. There was documentation on the MAR that indicated the resident was agitated. There was no</p>						

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	<p>documentation on the MAR or in the Service Notes that indicated the effectiveness of the medication.</p> <p>Review of the October 2012 MAR, indicated the resident received Ativan on 10/17/12. There was no documentation on the MAR or in the Service Notes that indicated the reason the medication was given. There was no documentation in the record that indicated the effectiveness of the medication.</p> <p>Interview on 1/3/13 at 9:05 a.m., with the Memory Care Unit Manger, indicated there was incomplete documentation for the use and effectiveness of the Ativan.</p> <p>The policy titled, "Medication-Professional Practice Guidelines" revised on 9/20/12, was provided by the Memory Care Unit Manager on 1/2/13. She indicated the policy was current.</p> <p>The policy indicated: PRN (as needed) Medications -PRN Medications require a physician order to correspond with the reason/specific symptom that indicates the need for use of the medication. -Medications given as PRN or as needed basis are recorded, at the time of administration or assistance, on the back</p>						

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	of the MAR. -Effectiveness results of the PRN medication should be documented on the MAR within a reasonable time following administration/assistance.						

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R0407	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, record review and interview, the facility failed to ensure all employees adequately sanitized the resident glucometers after each use for 1 of 1 observation of a resident receiving blood glucose monitoring. (LPN #1, Resident #9)</p> <p>Findings include:</p> <p>On 1/3/13 at 11:55 a.m., LPN #1 was observed obtaining a blood glucose reading for Resident #9. The LPN obtained the resident's own glucometer from the Medication Room. She then took the glucometer to Resident #9's apartment. She obtained a blood sample from the resident and obtained the blood glucose reading.</p> <p>The LPN left the resident's apartment,</p>	R0407	<p>R 407 Infection Control-noncompliance</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> · No residents were affected by the alleged deficient practice. All diabetic residents have potential to be affected. <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> · The Resident Care Director has identified all residents that the nursing staff obtains blood glucose readings on. · The Resident Care Director has obtained sanitizing wipes for the use with glucometers · licensed nurses and qualified medication assistants have been re-educated on the proper sanitization of glucometers 	01/18/2013			

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	<p>went back to the Medication Room and placed the resident's glucometer into a storage bag. She did not clean the glucometer with any sanitizing product.</p> <p>The policy titled "Glucometer Cleaning" and dated 9/7/12, was provided by the Resident Care Director on 1/3/13. She indicated the policy was current.</p> <p>The policy indicated; The following recommendations should be followed regarding the cleaning and disinfection of glucometers after each resident use. Procedure 1. If visible blood or bloody fluids are present, first wipe with a cloth dampened with soap and water to remove any visible organic material. 2. The exterior surface should then be cleaned by using a cloth/wipe that contains a dilute bleach solution of 1:10.</p> <p>Interview with LPN #1 on 1/3/13 at 12:05 p.m., indicated she did not clean the glucometer with any sanitizing solution. She indicated at times she would wipe the glucometer with alcohol swabs. She indicated she had never used a bleach solution for sanitizing the glucometers. She</p>		<p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> · The Resident Care Director or designee will hold quarterly in-services on how to properly sanitize glucometers · Resident Care Director or designee will complete 3 random skills test monthly related to blood glucose monitoring <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i></p> <ul style="list-style-type: none"> · The QA committee will review the random skills test monthly for 6 months to ensure compliance is met. · Regional Director of Quality Service will review during routine site and during annual comprehensive process review. <p><i>By what date will these systemic changes be implemented?</i></p> <ul style="list-style-type: none"> · Implemented 1/18/13 				

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	<p>indicated each resident had their own glucometer.</p> <p>Interview with the Resident Care Director on 1/3/13 at 1:50 p.m., indicated the facility had not used a bleach solution to sanitize the glucometers.</p>						

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R0412	<p>410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray.</p> <p>Based on record review and interview the facility failed to ensure an annual risk assessment for tuberculosis was completed for 1 of 8 residents reviewed for tuberculosis screening in a sample of 9. (Resident #6)</p> <p>Findings include:</p> <p>The record for Resident #6 was reviewed on 1/2/13 at 12:20 p.m. The resident was admitted to the facility on 9/3/11. Prior to admission, the resident had a chest x-ray completed on 9/28/11. The results of the chest x-ray indicated, "No evidence of TB (tuberculosis)."</p> <p>The form titled, "Resident Tuberculosis Testing Record" was reviewed. The form indicated the resident was allergic to tuberculin testing. There was no additional</p>	R0412	<p>R 412 Infection Control - Noncompliance <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #6 had an annual tuberculosis risk assessment completed, the form was completed and added to her medical file on 1/4/13. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The Resident Care Director or designee has completed an audit of resident medical records who have been identified as "positive reactors" or are allergic to tuberculin testing, no other residents have been noted to be missing the annual tuberculosis risk assessment. licensed nurses will be re-educated on the policy and procedure for annual risk assessment related to positive TB reactors and or</i></p>	01/18/2013			

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	<p>information on the form.</p> <p>Review of the resident record indicated there was no evidence an annual risk assessment for tuberculosis was completed in September 2012.</p> <p>The policy titled "Physician's Evaluations" dated 12/6/12, was provided by the Resident Care Director on 1/3/13. She indicated the policy was current.</p> <p>The policy indicated: The procedure for Tuberculosis screening: Residents must provide documentation of a negative tuberculosis (TB) screening prior to moving into the community. Unless a more-stringent state-specific requirement exists, negative PPD (purified protein derivative, a TB test), Mantoux or chest x-ray are acceptable screening tools. Some states require an annual tuberculosis re-screening. The Resident Tuberculosis Testing Record form can be used to record results of annual tests. Indiana-Requires Tuberculosis Signs and Symptoms form.</p> <p>Interview with the Resident Care</p>		<p>residents with allergies to the tuberculin testing by 1/18/13</p> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i> · The Resident Care Director or designee will complete monthly audits of residents due for annual TB tests to ensure compliance <i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i> · The QA committee will review the audits monthly for a minimum of 6 months to ensure compliance. · Regional Director of Quality Service will review audits during routine site and during annual comprehensive process review.</p> <p><i>By what date will these systemic changes be implemented?</i> · Implemented 1/18/13</p>				

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	Director on 1/2/12 at 1:55 p.m., indicated the annual tuberculosis risk assessment was not completed for Resident #6. She indicated it should have been completed in September 2012.						

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R0414	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review and interview, the facility failed to ensure all employees washed their hands after direct resident contact and glove removal for 1 of 1 observation of a resident receiving blood glucose monitoring. (LPN #1, Resident #9)</p> <p>Findings include:</p> <p>On 1/3/13 at 11:55 a.m., LPN #1 was observed obtaining a blood glucose reading for Resident #9. The LPN obtained the supplies from the Medication Room. She then took the supplies to Resident #9's apartment. She washed her hands with soap and water, she applied gloves and she obtained the blood sample and the blood glucose reading. She then removed her gloves. She did not wash her hands or use an alcohol gel.</p> <p>The LPN left the resident's apartment, went back to the Medication Room and disposed of the contaminated lancet. She signed the Medication Administration record.</p>	R0414	<p>R 414 Infection Control <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> · The staff member who was observed by the surveyor to not wash her hands after removing her gloves received documented education on infection control and handwashing and a handwashing skills test was completed on 1/5/13 <i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i> · The Resident Care Director or designee has re-educate Associates on the community hand washing policy on 1/11/13 <i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i> · The Resident Care Director or designee will complete 9 random medication pass audits monthly, 3 on each shift, to assure proper hand washing/ sanitizing during medication pass. · The Resident Care Director or designee will hold quarterly hand washing in-services and complete hand 	01/11/2013			

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	<p>The LPN then obtained a thermometer and stethoscope to obtain vitals on another resident. She did not wash her hands with soap and water or use alcohol gel prior to obtaining the equipment.</p> <p>The policy titled "Standard/Universal Precautions and Infection Control" and dated 9/7/12, was provided by the Resident Care Director on 1/3/13. She indicated the policy was current.</p> <p>The policy indicated the recommended Standard/Universal Precautions are: Disposable gloves -hands should be washed after gloves are removed. Hand washing -hands should be washed before and after providing care to any resident. It is recommended that staff wash hands before leaving a resident's apartment.</p> <p>Interview with LPN #1 on 1/3/13 at 12:05 p.m., indicated she did not wash her hands with soap and water or use an alcohol gel after obtaining a blood glucose sample and removing her gloves.</p> <p>Interview with the Resident Care Director on 1/3/13 at 1:50 p.m.,</p>		<p>washing skills test with nursing associates upon hire and quarterly. <i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</i> · The QA committee will review the random medication pass audits monthly for a minimum of 6 months to ensure compliance. · Regional Director of Quality Service will review audits during routine site and during annual comprehensive process review. <i>By what date will these systemic changes be implemented?</i> · Implemented 1/11/13</p>				

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	indicated the LPN should have washed her hands after removing her gloves.				