

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/31/2012
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 27, 28, 29, 30 and 31, 2012</p> <p>Facility number: 003673 Provider number: 155725 AIM number: 200450890</p> <p>Survey team: Rita Mullen, RN, TC Michelle Hosteter, RN (August 27, 28 and 29, 2012) Michelle Carter, RN</p> <p>Census bed type: SNF/NF: 2 SNF: 27 Residential: 36 Total: 65</p> <p>Census payor type: Medicare: 11 Other: 54 Total: 65</p> <p>Sample: 10 Residential sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>University Place ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</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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	Quality review completed on September 10, 2012 by Bev Faulkner, RN			

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F0325 SS=E	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed ensure a system was in place to ensure the residents weights were obtained in a consistent manner and that the recorded weights were monitored and residents were assessed for weight loss or gain in a timely fashion. This effected 4 of 5 residents reviewed for weight changes in a sample of 10. (Residents #3, 6, 12 and 18)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #6 was reviewed on 8/29/12 at 1:00 P.M. Resident was admitted to the facility on 8/9/12.</p> <p>Diagnoses included, but were not limited to, aphasia, stroke, diabetes, dementia and depression. The resident was being fed by a gastric tube and received nothing my</p>	F0325	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 8/31 12 UP obtained weights for resident #6, #18, #12, and #3 in the Healthcare Center. The weights were documented by DON and designee and a re-weight was obtained for any weight gain or loss of 3 pounds. All re-weights were obtained on 8/31 and any weight gain or loss of 3 pounds, the MD and families and facility Dietician were notified and proper interventions were put into place. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility have the potential to be affected by this alleged deficient practice. On 8/31 12 UP obtained 100% of resident weights in the Healthcare Center. The weights were documented by DON and designee and a re-weight	10/06/2012	

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	<p>mouth.</p> <p>A review of weights entered in the computer for the month of August 2012, indicated the following three weights:</p> <p>184.1 lbs on 8/13/12</p> <p>194.4 lbs on 8/16/12 (a 10.3 lb weight gain in three days)</p> <p>187.5 lbs on 8/29/12</p> <p>A Lab report, dated 8/14/12, indicated a sodium level of 122 (normal levels are 136 - 145). The physician had been notified and feeding tube flushes were reduced from 120 cc (cubic centimeters) four times a day to 60 cc four times a day.</p> <p>A Nutrition Assessment, dated 8/16/12, indicated the resident did not have a weight loss, weighed 184 lbs, was on a tube feeding, and was having difficulty with sodium levels being low. Tube feeding flushes were reduced due to the low sodium levels. The 10.3 lb weight gain was not addressed.</p> <p>A Nursing note, dated 8/20/12 at 6:38 P.M., indicated "...At approx (approximate) 11:30 p staff went to turn res (resident) et (and) noted copious amounts of fluid coming from mouth et</p>		<p>was obtained for any weight gain or loss of 3 pounds. All re-weights were obtained on 8/31 and any weight gain or loss of 3 pounds, the MD and families and facility Dietician were notified and proper interventions were put into place. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Directed in-service training for all nursing staff from the Healthcare Center on the policy and procedure for weighing the resident was completed on 9/18/12. Directed in-service training for licensed nurses on weight assessment and intervention was completed on 9/18/12. Directed in-service training of Registered Dietician on expectations, policies and procedures of the facility regarding timely follow-up of weight interventions. Evaluate the availability of Dietician coverage to provide needed services to our residents. Make changes as needed. - 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; and DON or designee will audit charts for daily weights, weekly weights, and monthly weights. DON or designee will report monitored findings to the Quality Assurance committee on a monthly basis x3 months, then quarterly there-after for 2 quarters. The</p>				

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	<p>nose. Writer immediately ran to room, noted res blue color et secretions. Verbal order to call 911...."</p> <p>A Hospital Discharge Instruction, dated 8/22/12, indicated Resident #6 had a diagnosis of SIADH (syndrome of inappropriate antidiuretic hormone hypersecretion) and hyponatrenia (low sodium).</p> <p>During an interview with the Registered Dietitian, on 8/29/12 at 2:30 P.M., she indicated she had used the weight, 184, from 8/13/12 in her notes and not the 194 weight. She was waiting on the reweight, but the resident went to the hospital before the reweight was done.</p> <p>2. The clinical record of Resident #12 was reviewed on 8/28/12 at 9:30 A.M. Resident#12 was admitted to the facility on 7/29/12.</p> <p>Diagnoses included, but were not limited to, history of stroke, dysphagia and congestive heart failure.</p> <p>A review of weights entered in the computer for the months of July and August 2012, indicated the following weights:</p> <p>103.9 lbs on 7/31/12</p>		<p>committee will review the findings to determine if additional measures are warranted.</p>				

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	<p>105.4 lbs on 8/14/12</p> <p>95.5 lbs on 8/22/12 (this was a 9.9 lb weight loss)</p> <p>96.5 lbs on 8/27/12</p> <p>96.5 lbs on 8/28/12</p> <p>A Dietary note, dated 8/16/12 at 10:50 A.M., indicated "...Wt. (weight) 105.4#, without any significant weight change. NPO (nothing by mouth) and nutritional needs are being met via TF (tube feeding)...."</p> <p>A Dietary note, dated 8/20/12 at 4:53 P.M., indicated "...continues without any problems or intolerance noted. Resident is positive for c-diff and receiving treatment for this....TF is meeting 100% of RDI...Wt has been stable with slight gain and currently weights 105.4#."</p> <p>A Dietary note, dated 8/28/12 at 8:29 A.M., indicated "Faxed MD on 8/20 requesting for Arginaid powder...TF continues with good tolerance and weights have been stable. Awaiting re-weight for 8/22/12...." The 9.9 lb weight loss was not addressed.</p> <p>A Nutrition Progress Assessment, dated</p>						

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	<p>8/28/12 (no time recorded), "Significant weight loss of 7.2% in 1 month. Reason for weight loss unknow (sic). TF was meeting 100% of estimated needs for calories and protein and was adjusted for wound healing. Will increase TF to account for weight loss..."</p> <p>During an interview with the Director of Nursing, on 8/28/12 at 3:00 P.M., she indicated "The Registered Dietitian was off last Monday and didn't enter the weight in the computer." The first weight, 7/31/12, was from the hospital and was not sure the weight on 8/14/12 of 105.4 lbs was correct. "Her weight yesterday and Monday was 96.5 lbs."</p> <p>3. The clinical record of Resident #18 was reviewed on 8/29/12 at 2:45 P.M.</p> <p>Diagnoses included, but were not limited to, depression, high blood pressure and arthritis.</p> <p>A Care Plan, dated 6/27/12, indicated Resident #12 had a problem with choking\aspiration and was no a mechanically altered diet. Interventions included, but were not limited to, Monitor and document weight; report a weight loss greater that 3 pounds to dietician.</p> <p>A review of weights entered in the</p>						

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	<p>computer for the months of May, June, July and August 2012, indicated the following weights:</p> <p>146.2 lbs on 5/3/12</p> <p>142.0 lbs on 6/7/12</p> <p>132.6 lbs on 7/6/12 (This was a 9.4 lb weight loss and there was no dietary note)</p> <p>135.7 lbs on 7/13/12 (This was a re-weight for 7/6/12)</p> <p>146.6 lbs on 8/6/12 (This was a 10.9 lb increase in weight and there was no dietary note)</p> <p>136.2 lbs on 8/16/12</p> <p>129.6 lbs on 8/21/12</p> <p>A Nutrition Assessment, dated 6/28/12 (no time recorded), indicated "[name of Resident] is now under hospice care...continues to have wound to coccyx but is healing. Multiple nutritional interventions...other than wound, has been stable nutritionally...weights stable.</p> <p>A Dietary note, dated 7/31/12 as a late entry for 7/26/12, indicated "Spoke with [name of daughter] who stated [name of resident] was having episodes of</p>						

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	<p>"pocketing and choking on liquids." Pt (patient) is currently on Hospice services and notified her that ST (speech therapy) would be the one to change...diet...Also notified her of significant weight loss of 7.6% in 3 months. Current weight is 135.7#..."</p> <p>During an interview with the Director of Nursing, on 8/30/12 at 9:00 A.M., she had no further information regarding Resident #18's weight loss.</p> <p>The clinical record for Resident #3 was reviewed on 8/29/12 at 2:45 P.M.</p> <p>Diagnoses for Resident #3 included, but were not limited to, oropharyngeal dysphagia, congestive heart failure, high blood pressure, type 2 diabetes mellitus, peripheral vascular disease, Alzheimer's disease, general anxiety and depressive disorder, and chronic obstructive pulmonary disease.</p> <p>A report titled "Resident Vital Sign Report" and electronically signed by the Registered Dietician (RD) indicated the following weight results:</p> <p>4/03/12 223.20 pounds 5/21/12 214.50 pounds 6/04/12 229.30 pounds 6/05/12 230.10 pounds (re-weigh) 7/14/12 230.30 pounds</p>						

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	<p>8/23/12 236.70 pounds 8/27/12 230.30 pounds 8/31/12 219.90 pounds</p> <p>Nursing notes from 4/03/12 to 8/31/12 and interdisciplinary team (IDT) notes from 5/14/12 to 8/27/12 indicated Resident #3's weight was stable. There were no notes regarding weight loss, weight gain or weight monitoring from the RD.</p> <p>During an interview with the Director of Nursing (DON) on 8/31/12 at 8:40 A.M., she indicated the current weighing procedure is not working and is inconsistent. She indicated that she, personally, weighed Resident #3, earlier that morning. The result was 219.90 pounds. She indicated she did not have an explanation in regards to the inconsistencies of weights.</p> <p>3.1-46(a)(1)</p>						

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F0371 SS=F	<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 observations and interviews, the facility failed to ensure proper thawing techniques for raw meat, covering of food items and cleanliness of dry storage area for 1 of 1 kitchens serving the health care center. This had the potential to affect all residents who received food from this kitchen.</p> <p>Findings include:</p> <p>The kitchen tour was completed on 8/27/12 at 5:50 P.M. , with the Director of Dining Services and the Dietician.</p> <p>During the tour, it was noted there were two large pieces of raw meat thawing on a pan on top of a metal prep table outside of the walk-in refrigerator.</p> <p>The walk-in freezer had two containers of ice cream. The lid to one container was broken and the other container was broken on the side and the lid was not secured on top.</p> <p>One of the serving refrigerators had a pan</p>	F0371	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Immediately following the walkthrough the thawing raw meat, ice cream lids, jello salad, and dry food storage area cleanliness were all corrected.- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in the facility have the potential to be affected by this alleged deficient practice. Food and Beverage Director or designee will ensure that all policy and procedures for safe food handling and preparation are followed at all times.- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Directed in-service training for food and beverage staff on policy and procedures for safe food handling and preparation to be completed by the Food and Beverage Director or designee by October 6, 2012.	10/06/2012			

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	<p>of Jell-o salad with the lid partially open, and the scoop lying inside the pan.</p> <p>On the floor of the dry storage area, underneath the shelves where the baking items such as brown and white sugar, cookies, flour etc. were stored, the following items were found: walnuts, cheerios and some type of cookie.</p> <p>In an interview with the Director of Dining Services on 8/29/12 at 5:54 P.M., he indicated the meat should be kept on the bottom shelf in the pan in the walk-in refrigerator and he was not sure why it was out on the table. He also indicated the scoop should not be inside the pan of Jell-o.</p> <p>In an interview with the Dietician on 8/29/12 at 6:05 P.M., she indicated as far as the ice cream in the freezer, if the container lids are broken the container should have plastic put on top of them and if the container itself is broken, it should be tossed.</p> <p>In an interview with the Executive Chef on 8/29/12 at 7:55 P.M., he indicated the staff cleaned the dry storage area daily and the staff missed the items underneath the shelves when they cleaned.</p>		<p>Any staff member not in serviced by this date will be taken off the schedule until training is complete. Daily Cleaning schedule and rounding forms to be completed by staff and reviewed by Food and Beverage Director or designee. Food safety audit to be completed by managers monthly. Results to be monitored by the facility Quality Assurance Committee.- 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; and Food and Beverage Director or designee will report monitored findings to the Quality Assurance committee on a monthly basis x3 months, then quarterly there-after for 2 quarters. The committee will review the findings to determine if additional measures are warranted.</p>				

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	3.1-21(i)(3)				

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F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the ceiling tiles in the health center were free of water stains and a light fixture free of bugs for 1 of 2 hallways outside the residents' rooms.</p> <p>Findings include:</p> <p>During the environmental tour with the Director of Plant Operations, Tech 1, and the Environmental Services Supervisor on 8/29/12 at 9:05 A.M., three ceiling tiles were noted to have water stains on them in hallway 1. A water stain was located near resident Room #1111, another located near resident Room #1117, and another by Room #1112.</p> <p>In an interview with the Director of Plant Operations at 9:15 A.M., he indicated he was unaware that these areas were that bad and he felt they were from the air conditioning condenser units leaking due to a reaction to all the hot humid weather from earlier in the summer.</p> <p>In hallway 1 outside of the resident Rooms #1111 and 1112, several bugs were observed in the light casing.</p>	F0465	<p>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 8/28/12 Maintenance tech. replaced all stained ceiling tiles in the healthcare center. On 8/28/12 Maintenance tech. cleaned light fixtures where bugs were reported to be seen. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Residents in the Healthcare center have the potential to be affected by this alleged deficient practice.1 on 1 in servicing was completed with all Assisted Living staff during the survey. Skills competency chek-offs were done on staff at this time.- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Directed in-services will be completed with Plant operations staff on the facility policy/ procedure before 10/6/12.Plant Operations Director or designee will check ceiling tiles and light fixtures daily and make any corrections needed at that time.Rounding check off list will be used daily to monitor for</p>	10/06/2012	

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	In an interview with the Environmental Services Supervisor on 8/29/12 at 9:17 A.M., she indicated they usually clean those areas monthly and was not aware of this light having bugs in it. 3.1-19(f)		compliance. - 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; and Plant operations Director or designee will monitor and report findings to facility QA committee monthly x3 months then quarterly as needed. QA committee will determine if further corrective measures are needed.		

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F9999	<p>STATE FINDINGS</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording 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 tuberculin skin test must be read prior to the employee starting work. 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. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12)</p>	F9999	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The contracted Registered Dietician from Sodexo was asked to leave immediately and go have a chest x-ray completed per facility policy. This was completed on 8/29/12.- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Residents in the facility have the potential to be affected by this alleged practice. The contracted Registered Dietician from Sodexo was asked to leave immediately and go have a chest x-ray completed per facility policy. This was completed on 8/29/12.- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Contracted vendors will be notified of their responsibilities to ensure their employees are in full compliance with the facilities policies and procedures on TB testing.- 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; and Human Resource Director or designee will monitor and report findings to facility QA committee monthly x3 months	10/06/2012

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	<p>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>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure an employee had an annual tuberculosis screening. (Registered Dietician)</p> <p>Findings include:</p> <p>The employee records were reviewed at 8:40 A.M. on 8/30/12. The Registered Dietician (RD) was found to be without an annual tuberculosis screening. The RD had a history of positive tuberculin skin test results. Chest x-ray results from April 2010 were negative. The last tuberculin risk assessment was dated 4/25/11.</p> <p>During an interview with the Human Resources Assistant, on 8/30/12 at 1:45 P.M., she indicated she was aware the RD was due for a tuberculosis screening in April 2012 and that she told the RD to schedule a chest x-ray in April 2012.</p>		then quarterly as needed. QA committee will determine if further corrective measures are needed.		

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	<p>However, a chest x-ray or a tuberculosis screening was not completed.</p> <p>A facility policy, dated 7/1/2009, and titled "Tuberculosis- Employee Screening" stated the following, "...If the (employee's) chest x-ray is negative.....(e.) An annual symptom questionnaire will be required to replace the annual TST (tuberculin skin test) for those associates excluded from the annual TST."</p> <p>3.1-14(t)(1)</p>				

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R0000	The following Residential deficiencies were cited in accordance with 410 IAC 16.2.	R0000	University Place ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.		

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a First Aid certified staff member was scheduled to work, at all times, during the month of August 2012. A total of four, 12 hour evening/night shifts (7:00 P.M. to 7:00 A.M.) were affected. (August 8, 17, 22 and 27, 2012) This had the potential to affect all 36 residents living in the residential area.</p>	R0117	<p>University Place ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby</p>	10/06/2012			

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	<p>Findings include:</p> <p>The August 2012 staffing schedule was reviewed at 1:00 P.M. on 8/30/12. Four shifts were found to lack a staff person on duty that had current First Aid certification. Those shifts included the following evening/night shifts (7:00 P.M. to 7:00 A.M.): August 8, 17, 22, and 27, 2012.</p> <p>During an interview with the Director of Residential Services on 8/31/12 at 9:15 A.M., she indicated the facility had recently gone through staffing shift changes, going from 8 hour shifts to 12 hour shifts. During this change, four, 12 hour shifts were not staffed with employees who were currently trained in First Aid. She indicated the evening/night shifts (7:00 P.M. to 7:00 A.M.) on the following dates were affected: August 8, 17, 22 and 27, 2012.</p>		<p>reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All licensed nurses and QMA's who were not CPR/ first aid trained at the time of the survey have been required to be trained appropriately. Any staff not compliant with the Training requirement has been taken off the schedule as of Spetember 20, 2012. Having 100% compliance with the training requirement will ensure the residents will always have at least one licensed nurse or QMA with current CPR/ first aid certification on-site at all</p>		

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			times. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in Assisted Living have the potential to be affected by this alleged deficient practice. Facility will ensure residents will always have at least one awake staff person with current CPR/ first aid certification on-site at all times.- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Facility will review the licensed nurses and QMA's CPR/ first aid certifications monthly to ensure that the deficient practice does not recur.Staffing and hiring Policy will be revised to require all assisted living nurses/ QMA's to be certified in CPR/ first aid.Directed inservice on policy and procedure will be completed no later than september 24, 2012. - 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; and Director of Resident Services or Designee will report monitoreed findings to the Quality Assurance committee on a monthly basis x3 months, then quarterly there-after for 2 quarters. The committee will review the findings to determine if additional measures are		

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R0302	<p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.</p> <p>Based on observation and interview, the facility failed to follow facility policy in regards to the labeling of over the counter drugs for 1 of 5 residents observed during the medication pass. [Resident #44]</p> <p>Findings include:</p> <p>The medication pass was completed with LPN #1 on 8/28/12 at 9:10 A.M. Resident #44 had a bottle of over the counter aspirin that had a first name and last initial and something written on the lid that was illegible.</p> <p>In an interview with the Director Of Residential Services (DRS) on 8/29/12 at 10:15 A.M., she indicated the bottles of over the counter drugs should have labels on them per their policy.</p> <p>A policy was provided by the DRS on 8/29/12 at 10:30 A.M. The document was titled, "Medication Labeling" and dated 05/01/07. The policy indicated, "...Non-prescription (over-the-counter) medications are kept in the manufacturer's</p>	R0302	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Corrective action for resident #44 was completed at the time of survey (8/28/12), by correctly labeling the over the counter medication as per facility policy. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing in Assisted Living have the potential to be affected by this alleged deficient practice. Director of Resident Services or Designee will complete medicine cart audits monthly x3 months then quarterly x2 quarters to ensure the same deficient practice does not affect any residents. - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Directed inservice training for licensed nurses and QMA's will be completed before september 24, 2012. - how the corrective action(s) will be monitored to ensure the deficient practice will	10/06/2012			

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	original container and identified with the resident's name and apartment/room number. Non-prescription (over-the-counter) medications dispensed pursuant to a physician/prescriber order are labeled in accordance with the requirements for a prescription label."		not recur, i.e., what quality assurance program will be put into place; and Director of Resident services or designee will report medicine cart monitoring findings to the facility QA committee monthly x3 months then quarterly as needed. QA committee will review findings to determine if additional measures are warranted.		

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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 staff followed facility policy for the practice of handwashing or use of a sanitizer with residents for 5 of 5 residents observed being given medications.</p> <p>Findings include:</p> <p>During observation of the medication pass with LPN # 1 on 8/28/12 from 9:15 A.M. through 11:15 A.M., LPN # 1 administered medications to Resident # 41 and did not wash or sanitize hands before starting to prepare and pass medications for Resident #42.</p> <p>LPN #1 went to pass medications to Resident #44. She knocked on the door, walked into apartment to find they were not there. She proceeded to place Resident #44's medications back in medication cart and then prepared Resident #45's medications and then took the medications to Resident #45.</p> <p>LPN #1 washed her hands for only 5 seconds prior to doing a glucose check on</p>	R0414	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; LPN #1 was inserviced on proper handwashing during the survey on 8/29/12. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Residents in Assisted Living have the potential to be affected by this alleged practice. 1 on 1 inservicing was completed with all Assisted Living staff during the survey. Skills competency check-offs were done on staff at this time.- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Directed inservices will be completed with assisted living staff on the handwashing policy/ procedure before September 24, 2012. Monthly random skills check-offs will be completed by Director of Resident Services and results will be reviewed monthly x3 months at QA committee meetings. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality	10/06/2012			

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	<p>Resident #32 at 11 A.M.</p> <p>In an interview on 8/29/12 at 10:15 A.M., with the Director Of Residential Services (DRS), she indicated the nurses are to wash their hands before giving medications and can also utilize the hand sanitizers built into the walls outside all the residents apartments.</p> <p>Director Of Residential Services provided a handwashing policy, dated 7/1/09, on 8/29/12 at 12:36 P.M.</p> <p>The policy indicated, "...Employees may use an alcohol-based hand rub...for all the following situations...d. Before preparing or handling medications...Hand washing Procedure...2. Rub hands together with vigorous friction for 20 seconds, covering all surfaces of the hands and wrists, including fingertips and between the fingers..."</p>		<p>assurance program will be put into place; and Director of Resident Services or designee will monitor and report findings to facility QA committee monthly x3 months then quarterly as needed. QA committee will determine if further corrective measures are needed.</p>		