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
	155775		09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 15, 16, 17, 18, 21, 22, and 23, 2015 Facility number: 000547 Provider number: 155775 AIM number: 100267440 Census bed type: SNF: 24 SNF/NF: 36 Residential: 65 Total: 125 Census payor type: Medicare: 10 Medicaid: 18 Other: 32 Total: 60 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed by 21662 on September 29, 2015.	F 0000	Survey Event ID: 98SW11 The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for licensed residential care facilities in the state of Indiana.To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician of when a medication was administered	F 0157	CORRECTIVE ACTION: The RN Unit Manager reviewed the Medication Administration Record (MAR) for resident #99 to	10/23/2015

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	outside the parameters of the physician's order for 1 of 5 residents reviewed for unnecessary medications. (Resident #99) Findings include: A record review for Resident #99 was completed on 9/21/15 at 1:44 p.m. Diagnoses included but were not limited to: Atrial Fibrillation, Coronary Artery Disease, Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease Exacerbations. Physician orders, dated 7/16/15, indicated "...metoprolol [blood pressure medication] 25 mg [milligram] tablet...give 1 tablet by mouth twice a day for blood pressure...hold for SBP [systolic blood pressure] less than 100 or DBP [diastolic blood pressure] less than 55...." A review of Medication Administration Records (MAR), dated 9/1/15 through 9/30/15, indicated the following: MAR documentation for 9/11/15 indicated Resident #99 was not administered metoprolol with a blood pressure reading of 110/58. No documentation noted as to why the medication was not administered.		determine which nurse held the medication on 9-11-15, 9-13-15 and 9-17-15. An in-service education was provided for that nurse on the policy and procedure for following physician's orders; proper documentation of holding a medication including circling, initialing and an explanatory note on the reserve side of the MAR; and proper physician notification if one dose of a vital medication is held or refused. IDENTIFY OTHER RESIDENTS: The MAR for all residents in the Health Center (HC) is being reviewed to ensure blood pressure medications with parameters were held properly and physician notification was made and documented. MEASURES/SYSTEMIC CHANGES: A Nurse Staff In-service is scheduled for all nurses to review the policy and procedure for following physician's orders; proper documentation of holding a medication including circling, initialing and an explanatory note on the reserve side of the MAR; and proper physician notification if one dose of a vital medication is held or refused. Additionally, the Nursing Unit Managers for the HC will audit the MARs for all HC residents to ensure proper administration of blood pressure medication with parameters including proper documentation if held and physician notification.	

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	MAR documentation for 9/13/15 indicated Resident #99 was not administered metoprolol with a blood pressure reading of 122/58. No documentation noted as to why the medication was not administered. MAR documentation for 9/17/15 indicated Resident #99 was not administered metoprolol with a blood pressure of 112/68. No documentation as to why the medication was not administered. During an interview with the Director of Health Services (DHS) on 09/21/15 at 3:55 p.m., she indicated physician orders should have been followed. She also indicated holding a medication should be documented and physician should be notified. A review of the policy titled "Medication Administration- General Guidelines," dated 2/1/10 obtained from DHS on 9/21/15 at 4:00 p.m. indicated "... 6. If a dose of regularly scheduled medication is withheld, refused, or given at other that the scheduled time...the space provided on the front of the MAR for that dosage administration is (initialed and circled). An explanatory note is entered on the reverse side of the record provided for PRN documentation. If one dose of a		These audits will occur weekly in October, then every other week in November and then monthly for four months. MONITORING CORRECTIVE ACTION: The Nursing Unit Manager audits will be forwarded to the Director of Health Services for review. Any staff nurse found to not follow policy and procedure will receive additional training/counseling. All results of the audits will be reported to the QA/QI Committee for six months.	

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	vital medication are withheld or refused, the physician is notified ...." 3.1-5(a)(3)			
F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review and interview, the facility failed to provide a call light within reach of the resident for 1 of 30 residents observed for the call light location (Residents # 104). Findings included: During an observation on 9/21/2015 at 3:53 p.m., Resident # 104 was attempting to get out of his recliner to assist his roommate, the call light was located wrapped around the residents bed rail on the opposite side of his bed and not within reach for the resident. During an observation on 9/23/2015 at	F 0246	CORRECTIVE ACTION: Resident #104 was provided a call light within reach immediately upon notification by the surveyor. Resident #104 was placed on 15 minute checks for 24 hours to ensure that his call light was within reach. The CNA did receive verbal education at the time the call light was found not within reach regarding the importance of all residents having a call light within reach. IDENTIFYING OTHER RESIDENTS: On 9-23-15 the MDS Nurse and the Nursing Unit Manager conducted hourly rounds on the Health Center (HC) unit where resident #104 resides to ensure call lights were within reach. No other residents were	10/23/2015

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	9:30 a.m., Resident # 104 was in his wheel chair attempting to remove his oxygen nasal tubing, the call light was located wrapped around the residents bed rail on the opposite side of his bed near the floor and not within reach for the resident. During an interview on 9/23/2015 at 10:30 a.m., with Unit Manager # 2, she indicated the resident should have had his call light within reach for easy access and utilization. She indicated Residents #104 needed assistance for mobility. The Care Plan for Resident # 104 received on 9/18/2015 at 1:35 p.m., from Unit Manager #2, indicated "...Keep my call light and frequently used items with easy reach to prevent me from overstretching...." The policy titled "Guidelines for Answering Call Lights", not dated, received on 9/23/2015 at 1:58 p.m., from the Executive Director indicated ".....2. Ensure the call light is plugged in securely to the outlet and in reach of the resident ...." 3.1- 3(v)(1)		noted to be affected. All care plans for HC residents will be reviewed to identify those with potential to be affected due to a need for assistance for transfer and ambulation. MEASURES/SYSTEMIC CHANGES: Once weekly in October a focused hourly round audit will be completed and documented for 24 hours to ensure the availability and accessibility of call lights for all residents with a need for assistance for transfer and ambulation. This focused hourly round audit will take place every other week in November and then monthly for four months. Any resident found without a call light during the focused hourly round audits will be immediately corrected and then reported to the Director of Health Services(DHS)/designee for further training/counseling. MONITORING CORRECTIVE ACTION: The DHS will receive and review all audit results for the hourly rounds as well as any corrective action required. Should any negative trends be noted during the audit cycle, the frequency of audits will be increased till compliance is achieved. All audit results will be reported to the QA/QI Committee for six months.	

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to administer medication within the written parameters of the physician's order for 1 of 5 residents reviewed for unnecessary medications. (Resident #99) Findings include: A record review for Resident #99 was completed on 9/21/15 at 1:44 p.m. Diagnoses included but were not limited to: Atrial Fibrillation, Coronary Artery Disease, Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease Exacerbations. Physician orders, dated 7/16/15, indicated "...metoprolol [blood pressure medication] 25 mg [milligram] tablet...give 1 tablet by mouth twice a day for blood pressure...hold for SBP	F 0282	CORRECTIVE ACTION: The RN Unit Manager reviewed the Medication Administration Record (MAR) for resident #99 to determine which nurse held the medication on 9-11-15, 9-13-15 and 9-17-15. An in-service education was provided for that nurse on the policy and procedure for following physician's orders; proper documentation of holding a medication including circling, initialing and an explanatory note on the reserve side of the MAR; and proper physician notification if one dose of a vital medication is held or refused. IDENTIFY OTHER RESIDENTS: The MAR for all residents in the Health Center (HC) is being reviewed to ensure blood pressure medications with parameters were held properly and physician notification was made and documented. MEASURES/SYSTEMIC CHANGES: A Nurse Staff	10/23/2015

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	[systolic blood pressure] less than 100 or DBP [diastolic blood pressure] less than 55...." A review of Medication Administration Records (MAR), dated 9/1/15 through 9/30/15, indicated the following: MAR documentation for 9/11/15 indicated Resident #99 was not administered metoprolol with a blood pressure reading of 110/58. No documentation noted as to why the medication was not administered. MAR documentation for 9/13/15 indicated Resident #99 was not administered metoprolol with a blood pressure reading of 122/58. No documentation noted as to why the medication was not administered. MAR documentation for 9/17/15 indicated Resident #99 was not administered metoprolol with a blood pressure of 112/68. No documentation as to why the medication was not administered. During an interview with the Director of Health Services (DHS) on 09/21/15 at 3:55 p.m., she indicated physician orders should have been followed. She also indicated holding a medication should be		In-service is scheduled for all nurses to review the policy and procedure for following physician's orders; proper documentation of holding a medication including circling, initialing and an explanatory note on the reserve side of the MAR; and proper physician notification if one dose of a vital medication is held or refused. Additionally, the Nursing Unit Managers for the HC will audit the MARs for all HC residents to ensure proper administration of blood pressure medication with parameters including proper documentation if held and physician notification. These audits will occur weekly in October, then every other week in November and then monthly for four months. MONITORING CORRECTIVE ACTION: The Nursing Unit Manager audits will be forwarded to the Director of Health Services upon completion for review. Any staff nurse found to not follow policy and procedure will receive additional training/counseling. All results of the audits will be reported to the QA/QI Committee for six months.	

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	documented and physician should be notified. A review of the policy titled "Medication Administration- General Guidelines," dated 2/1/10 obtained from DHS on 9/21/15 at 4:00 p.m. indicated "... 6. If a dose of regularly scheduled medication is withheld, refused, or given at other that the scheduled time...the space provided on the front of the MAR for that dosage administration is (initialed and circled). An explanatory note is entered on the reverse side of the record provided for PRN documentation. If one dose of a vital medication are withheld or refused, the physician is notified ...." 3.1-35(g)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure	F 0371	CORRECTIVE ACTION: During the kitchen tour on 9-15-15 any	10/23/2015

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	food was covered, labeled and dated in the refrigerators, freezer, and the open kitchen area, food was disposed of after date of expiration, and food was served following temperature-taking procedures in 1 of 1 kitchens and 3 of 3 kitchenettes in the facility. This deficient practice had the potential to affect 58 of 58 residents receiving food from the kitchen. Findings include: During the tour of the main kitchen and kitchenettes on 9/15/2015 at 9:10 a.m., with the Dietary Manager, the following observations were made: 1.) The kitchen area was observed to have expired, open, and not dated items: a.) a package of bread buns was opened and not dated b.) container of cinnamon was opened and not dated c.) mustard container was opened and not dated d.) a container of flour was opened and not dated e.) a package of raisin bread was opened and not dated 2.) The cooler was observed to have expired items which had not been discarded and had open and not dated items:		perishable items noted without a date or outdated/expired were immediately disposed of. The spices/condiments not dated were verified with the manufacturer and properly dated on 9-15-15. The area in the Comprehensive kitchenette behind the juice and coffee dispensers was cleaned on 9-15-15. The cook that did not properly clean the thermometer probe was re-educated on 9-15-15 about the proper sanitizing of thermometers between food items. IDENTIFY OTHER RESIDENTS: All Health Center (HC) residents in the facility were identified in the original deficiency. No other residents are identified. MEASURES/SYSTEMIC CHANGES: In-service training will be completed for all Dining Services staff regarding the policy and procedure for labeling and dating of food items and food storage. In-service training for cooks will be completed to ensure proper cleaning of the thermometer probes while taking food temps. The Executive Director (ED) will write a Family Letter educating family members on the importance of bringing any food items to the kitchen for proper labeling, dating and storage. The ED will also write an Employee Letter to all employees emphasizing the importance of guiding family members bringing in food items	

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	a.) a container of salad dressing expired on 8/29/2015 b.) a container of Italian dressing was opened and not dated 3.) The comprehensive dining room kitchenette was observed to have open and not dated items and an area of dust and debris: a.) a frozen container of 4 french toasts was open and not dated b.) a package of 4 tortillas was opened and not dated c.) a package of 4 chicken breasts was opened and not dated d.) a container of cooked green beans was opened and not dated e.) the area behind the juice and coffee dispensers was dirty with dust and debris 3.) The Pines dining room kitchenette was observed to have open and not dated items: a.) an ice cream container was opened and not dated b.) a pasta container was open and not dated c.) a package of shredded cheese was open and not dated During the observation of food temperature readings for the lunch meal on 9/15/2015 at 11:35 a.m., Cook #1 was observed to temperature test the		for residents to take them to the kitchen for proper labeling, dating and storage. Daily assignment sheets for Dining Staff are being revised to ensure staff are auditing all items in the refrigerator/freezers to ensure they are dated, labeled, properly stored and not expired. MONITORING CORRECTIVE ACTION: The Director of Food Service (DFS) will audit each week the daily assignment sheets to ensure Dining staff are completing the daily audits. Any negative trends will result in further training/counseling. The results of these weekly audits will be reported to the QA/QI committee monthly for six months. The DFS will conduct twice monthly unannounced spot audits to observe cooks using thermometer probes to ensure proper cleaning of the thermometer probes is being completed. The results of these audits will be reported to the QA/QI Committee monthly for six months.	

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	vegetables and then to not wipe clean the used temperature thermometer before temperature testing the cooked ham. During an interview on 9/15/2015 at 11:40 a.m., with Cook #1, she indicated she did not have any wipes to clean the temperature probe which was the facility procedure. During an interview on 9/15/2015 at 12:10 p.m., with the Dietary Manager, she indicated that all open items should have been dated, that expired items should have been discarded, and Cook #1 should have used wipes to clean the temperature probes during testing. The policy titled "Food Temperature-Serving Line," dated 07/2013, received 9/16/2015 at 11:30 a.m., from the dietary manager, indicated "...3. Temperatures are taken prior to service to ensure hot foods and cold foods are maintained ...B. Thermometers are clean, rinsed and sanitized before, after, and in between use. An alcohol swab may be used to sanitized the thermometer between uses at one meal...." The policy titled "Food Production Guidelines-Sanitation & Safety," dated 2009, received on 9/16/2015 at 11:30			

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	a.m., from the Dietary Manager, indicated "... 6. Leftovers must be dated, labeled, covered and immediately refrigerated or frozen for later use. Leftovers must be used within 72 hours...7. Food prepared in advance must be covered, labeled, dated and refrigerated...." The policy titled "Leftover Food Storage," dated 9/2012, received on 9/16/2015 at 11:30 a.m., from the Dietary Manager, indicated "... 2. Date all food and use or discard within three days...." The policy titled "Storage Procedures," dated 2009, received on 9/16/2015 at 11:30 a.m., from the Dietary Manager, indicated " ...6. Open packages are labeled, dated, and stored in closed containers...." 3.1-21(i)(2) 3.1-21(i)(3)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 5 of 30 resident rooms (Room's # 107,114, 117, 328, and 329). Findings include; 1. During resident room observations on 9/15/2015 and 9/16/2015, the following was observed: a.) Room # 107 on 9/15/2015, at 2:13 p.m., the bathroom walls were gouged,	F 0465	CORRECTIVE ACTION: The bathroom walls in room 107 and 117 were painted on 9-22-15. The door handle to room 114 was repaired on 9-16-15. The window trim/sill in room 328 and 329 was repaired and painted on 9-22-15. IDENTIFY OTHER RESIDENTS: An audit is being completed for all resident rooms to ensure the bathroom walls and window trim/sill are in good repair. Any concerns noted will be documented on a work order that will be completed promptly. MEASURES/SYSTEMIC CHANGES: An in-service will be completed with all departments	10/23/2015

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	marred, chipped and peeling. b.) Room # 114 on 9/16/2015 at 11:36 a.m., the front door handle was loose and would not allow door to remain closed. c.) Room # 117 on 9/16/2015, at 11:51 a.m., the bathroom walls were chipped, marred, and peeling. d.) Room # 328 on 9/15/2015 at 3:17 p.m., the window edging was gouged and dented. e.) Room # 329 on 9/15/2015 at 2:19 p.m., the window edging was gouged and dented. During the environmental tour on 9/21/2015 at 1:45 p.m., with the Director of Plant Operations, and the Environmental Service Leader, the Director of Plant Operations indicated the facility had a policy/procedure to report environmental concerns. The Environmental Service Leader indicated she was not aware of the areas of concern for rooms # 107,114,117, 328, and 329. The policy titled "PROCEDURE FOR WORK ORDERS:" not dated was received on 9/22/2015 at 1:40 p.m., from the Director of Plant Operations indicated "...1. Staff members within the facility		regarding the importance of completing work order tickets for any plant related concerns that arise, including door handles loose, gouges and mars in the walls, etc. A monthly audit by Plant Operations staff will be completed for all HC rooms/bathrooms as part of the preventative maintenance program. The audit will inspect doors, walls and window sills in each resident suite on HC. MONITOR CORRECTIVE ACTION: The monthly audits will be reviewed by the Director of Plant Operations, who is responsible to ensure corrective action has been completed for any concerns noted on the audit. The DPO will report audit findings monthly to the QA/QI Committee for six months.	

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	other than maintenance staff shall generate manual work orders for the Maintenance Department unless a safety issue is present that requires immediate attention. If the need is serious the staff are to call the Plant Director or the on-call staff after hours for prompt response and resolution...." 3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 65 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Survey Event ID: 98SW11 The submission of this POC does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Cumberland Pointe Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for licensed residential care facilities	

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			in the state of Indiana.To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.			

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	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview the facility failed to adequately screen 1 of 5 employees reviewed for Tuberculosis (TB). (RCA #1) Findings include: During a review of RCA #1's health records on 9/18/15 at 9:00 a.m., the records indicated a hire date of 4/7/03. A TB screening questionnaire dated 10/7/14 was reviewed and a chest x-ray (CXR) dated 3/31/03 was reviewed. During an interview with the ED on 9/18/15 at 11:50 a.m., she indicated she was unable to locate a recent CXR for RCA #1. During review of a policy titled "Guidelines for TB Results Summary Documentation: Staff" dated 3/24/08 received from the Executive Director on	R 0121	CORRECTIVE ACTION: The employee had completed annual screenings for TB with no signs or symptoms of active disease. The employee was referred for a chest x-ray that was completed on 9-24-15 with negative results. All other health files for employees with positive PPD results requiring a chest x-ray were reviewed to ensure a chest x-ray that had been completed within the last 4-5 years was on file. IDENTIFY OTHER RESIDENTS: All residents in the facility were identified in the original finding. No other residents would be identified. MEASURES/SYSTEMIC CHANGES: An in-service education on the policy and procedure for employee guidelines for TB results is being completed for all Department Leaders and AP/Payroll, who monitors employee files including annual screenings. MONITORING CORRECTIVE	10/23/2015

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	9/18/15 at 9:30 a.m., the policy indicated "...8. Facilities will also have a CXR administered no less than every 4-5 years for each employee who has had a positive Mantoux (TB skin test) reaction...."		ACTION: Monthly AP/Payroll will provide a report to the Executive Director and Director of Health Services that will report on the employees due for health screenings that month and the date of their most recent chest x-ray. The results of those reports will be provided to the QA/QI Committee for six months.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, record review, and interview, the facility failed to dispose of expired medication within the recommended pharmaceutical guidelines which resulted in a medication error for Resident #110. This was observed in 1 of 3 medication carts reviewed for storage. Finding include: During observation of medication storage on 9/16/15 at 2:45 p.m., the 300 hall medication cart contained a vial of Novolog insulin belonging to Resident #110 with an opened date of 8/13/15. During review of the Medication Administration Record (MAR) on 9/17/15 at 9:15 a.m., indicated a	R 0247	CORRECTIVE ACTION: The nurse on the Assisted Living unit immediately discarded the outdated medication per the facility policy and procedure for destruction of medications. A new vial of Novolog insulin belonging to Resident #10 was placed in the medication cart after the date opened was applied. IDENTIFY OTHER RESIDENTS: All medications in the medication carts were reviewed by the surveyor and no other medications were noted to be outdated so no other residents were identified. MEASURES/SYSTEMIC CHANGES: The Assistant Director of Health Services (ADHS) will audit all Assisted Living medication carts for outdated medications once	10/23/2015

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	physicians order dated 8/12/13 for Accu-checks before breakfast and evening meal with sliding scale coverage. Novolog 100 units/ml was used based on blood sugar results. The expired Novolog 100 units/ml was used on the following dates: 9/10/15 at dinner 3 units were given 9/11/15 at breakfast 2 units were given 9/11/15 at dinner 6 units were given 9/12/15 at breakfast 2 units were given 9/12/15 at dinner 7 units were given 9/13/15 at breakfast 1 unit was given 9/13/15 at dinner 4 units were given 9/16/15 at breakfast 1 unit was given During an interview with LPN #2 on 9/16/15 at 2:46 p.m., she indicated the open date written on the vial was 8/13/15. She indicated the medication was expired and she was going to destroy the medication and open a new vial. During an interview with District Consulting Nurse on 9/18/15 at 1:32 p.m., she indicated this was considered a medication error by corporate standards. Review of a document titled "PCA Pharmacy Expiration Dates" dated 11/2014 received from the Executive Director on 9/17/15 at 3:50 p.m., indicated Novolog vials expire 28 days		weekly for four weeks in October and then every other week in November and monthly for four months. This audit will be in addition to the monthly audit currently conducted by the Registered Pharmacist. MONITORING CORRECTIVE ACTION: The results of audits completed by the ADHS will be forwarded to the DHS for review. Any non-compliance will result in in-service education and increased monitoring frequency. All audit results will be reported to the QA/QI Committee monthly for six months.	

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	after opening. Review of the policy titled "Medication Storage In The Facility" dated 9/1/13 received from the Comprehensive HC Nursing Manager on 9/17/15 at 4:35 p.m., indicated "...L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...."			
R 0273 Bldg. 00	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. Based on observation, record review and interview, the facility failed to ensure food was covered, labeled and dated in the refrigerators, freezer, and the open kitchen area, food was disposed after date of expiration, and food was served following temperature-taking procedures in 1 of 1 kitchens and 3 of 3 kitchenettes in the facility. This deficient practice had the potential to affect 65 of 65 residents	R 0273	CORRECTIVE ACTION: During the kitchen tour on 9-15-15 any perishable items noted without a date or outdated/expired were immediately disposed of. The spices/condiments not dated were verified with the manufacturer and properly dated on 9-15-15. The area in the Comprehensive kitchenette behind the juice and coffee dispensers was cleaned on 9-15-15. The cook that did not	10/23/2015

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	receiving food from the kitchen. Findings include: During the tour of the main kitchen kitchenettes on 9/15/2015 at 9:10 a.m., with the Dietary Manager, the following observations were made: 1.) The kitchen area was observed to have expired, open, and not dated items: a.) a package of bread buns was opened and not dated b.) container of cinnamon was opened and not dated c.) mustard container was opened and not dated d.) a container of flour was opened and not dated e.) a package of raisin bread was opened and not dated 2.) The cooler was observed to have expired items which had not been discarded and open and not dated items: a.) a container of salad dressing expired on 8/29/2015 b.) a container of Italian dressing was opened and not dated 3.) The assisted living kitchenette was observed to have open and not dated items: a.) a ham and cheese sandwich was		properly clean the thermometer probe was re-educated on 9-15-15 about the proper sanitizing of thermometers between food items. IDENTIFY OTHER RESIDENTS: All Health Center (HC) residents in the facility were identified in the original deficiency. No other residents are identified. MEASURES/SYSTEMIC CHANGES: In-service training will be completed for all Dining Services staff regarding the policy and procedure for labeling and dating of food items and food storage. In-service training for cooks will be completed to ensure proper cleaning of the thermometer probes while taking food temps. The Executive Director (ED) will write a Family Letter educating family members on the importance of bringing any food items to the kitchen for proper labeling, dating and storage. The ED will also write an Employee Letter to all employees emphasizing the importance of guiding family members bringing in food items for residents to take them to the kitchen for proper labeling, dating and storage. Daily assignment sheets for Dining Staff are being revised to ensure staff are auditing all items in the refrigerator/freezers to ensure they are dated, labeled, properly stored and not expired. MONITORING CORRECTIVE ACTION: The Director of Food	

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	opened and not dated b.) a container with salami and cheese slices was opened and not dated c.) a frozen waffle was opened and not dated 4.) During the observation of food temperature readings for the lunch meal on 9/15/2015 at 11:35 a.m., Cook #1 was observed to temperature test the vegetables and then to not wipe clean the used temperature thermometer before temperature testing the cooked ham. During an interview on 9/15/2015 at 11:40 a.m., with Cook #1, she indicated she did not have any wipes to clean the temperature probe which was the facility procedure. During an interview on 9/15/2015 at 12:10 p.m., with the Dietary Manager, she indicated that all open items should have been dated, that expired items should have been discarded, and Cook #1 should have used wipes to clean the temperature probes during testing. The policy titled "Food Temperature-Serving Line", dated 07/2013, received 9/16/2015 at 11:30 a.m., from the dietary manager, indicated "...3. Temperatures are taken prior to service to ensure hot foods and cold		Service (DFS) will audit each week the daily assignment sheets to ensure Dining staff are completing the daily audits. Any negative trends will result in further training/counseling. The results of these weekly audits will be reported to the QA/QI committee monthly for six months. The DFS will conduct twice monthly unannounced spot audits to observe cooks using thermometer probes to ensure proper cleaning of the thermometer probes is being completed. The results of these audits will be reported to the QA/QI Committee monthly for six months.	

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	foods are maintained ...B. Thermometers are clean, rinsed and sanitized before, after, and in between use. An alcohol swab may be used to sanitized the thermometer between uses at one meal....: The policy titled "Food Production Guidelines-Sanitation & Safety", dated 2009, received on 9/16/2015 at 11:30 a.m., from the Dietary Manager, indicated "... 6. Leftovers must be dated, labeled, covered and immediately refrigerated or frozen for later use. Leftovers must be used within 72 hours...7. Food prepared in advance must be covered, labeled, dated and refrigerated...." The policy titled "Leftover Food Storage", dated 9/2012, received on 9/16/2015 at 11:30 a.m., from the Dietary Manager, indicated "... 2. Date all food and use or discard within three days...." The policy titled "Storage Procedures", dated 2009, received on 9/16/2015 at 11:30 a.m., from the Dietary Manager, indicated " ...6. Open packages are labeled, dated, and stored in closed containers...."			

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R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation and interview, the facility failed to dispose of expired medication within the recommended pharmaceutical guidelines in 1 of 3 medication carts reviewed. (Resident #110) Finding include: During observation of medication storage on 9/16/15 at 2:45 p.m., the 300 hall medication cart contained a vial of Novolog insulin belonging to Resident #110 with an opened date of 8/13/15.	R 0306	CORRECTIVE ACTION: The nurse on the Assisted Living unit immediately discarded the outdated medication per the facility policy and procedure for destruction of medications. A new vial of Novolog insulin belonging to Resident #10 was placed in the medication cart after the date opened was applied. IDENTIFY OTHER RESIDENTS: All medications in the medication carts were reviewed by the surveyor and no other medications were noted to be outdated so no other residents were identified. MEASURES/SYSTEMIC CHANGES: The Assistant	10/23/2015

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	During an interview with LPN #2 on 9/16/15 at 2:46 p.m., she indicated the open date written on the vial was 8/13/15. She indicated the medication was expired and she was going to destroy the medication and open a new vial. Review of a document titled "PCA Pharmacy Expiration Dates" dated 11/2014 received from the Executive Director on 9/17/15 at 3:50 p.m., indicated Novolog vials expire 28 days after opening. Review of the policy titled "Medication Storage In The Facility" dated 9/1/13 received from the Comprehensive HC Nursing Manager on 9/17/15 at 4:35 p.m., indicated "...L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...."		Director of Health Services (ADHS) will audit all Assisted Living medication carts for outdated medications weekly for four weeks in October and then every other week in November and monthly for four months. This audit will be in addition to the monthly audit currently conducted by the Registered Pharmacist. MONITORING CORRECTIVE ACTION: The results of audits completed by the ADHS will be forwarded to the DHS for review. Any non-compliance will result in in-service education and increased monitoring frequency. All audit results will be reported to the QA/QI Committee monthly for six months.	