

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
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NAME OF PROVIDER OR SUPPLIER MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included a State Residential Licensure survey.</p> <p>Survey dates: February 24, 25, 26, 27 March 2, 3 and 4, 2015.</p> <p>Facility number: 000470 Provider number: 155600 AIM number: 100289210</p> <p>Survey Team: Rita Mullen, RN, TC Bobette Messman, RN Maria Pantaleo, RN</p> <p>Census bed type: SNF: 27 SNF/NF: 107 Residential: 5 Total: 139</p> <p>Census payor type: Medicare: 18 Medicaid: 86 Other: 30 Total: 134</p> <p>Residential sample: 6</p>	F 000	Mulberry Health & RetirementCommunity respectfully request a desk review in lieu of an on site follow upsurvey	

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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F 278 SS=E Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on March 9, 2015.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p>			

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	<p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to correctly code a resident on Hospice as having a prognosis of six months or less on the Minimum Data Set (MDS) assessments for 1 of 1 residents reviewed for Hospice and 3 of 3 residents reviewed for MDS Hospice coding (Residents #38, 128, 147 and 165).</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record of Resident #147 was reviewed on 3/2/15 at 10:30 a.m. Diagnoses included, but were not limited to, late effect CVA (cerebral vascular accident) and major organ failure. <p>A Significant Change MDS, dated 2/4/15, indicated Resident #147 was on Hospice but did not have a prognosis of a life expectancy of less than six months.</p> <p>A Hospice Certification of Terminal Illness, dated 1/27/15 as the start of Hospice care, indicated Resident #147 was terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.</p> <ol style="list-style-type: none"> The clinical record of Resident #128 	F 278	No residents were affected by the alleged deficient practice. The four residents receiving hospice services have had the correct box checked on the minimum data set to reflect receiving these services. MDS Staff will be in serviced by MDS Coordinator to ensure accuracy in identifying those receiving hospice service on the MDS. MDS Coordinator will monitor for compliance by auditing monthly for three months those receiving hospice services, and accurate coding on the MDS. MDS Coordinator will report to the facilities Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% compliance.	04/12/2015

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F 364 SS=F Bldg. 00	<p>was reviewed on 2/26/15 at 1:30 p.m. Diagnoses included, but were not limited to, advanced heart disease and severe general debility.</p> <p>An Annual MDS dated, 2/9/15, indicated Resident #128 was on Hospice but did not have a prognosis of a life expectancy of less than 6 months.</p> <p>A Hospice Recertification Statement for 60-day period, dated 1/27/15, indicated Resident #128 is terminally ill with a life expectancy of six months or less.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure appropriate meal temperatures for 2 of 20 residents interviewed regarding food temperatures. (Residents # 69 and # 111) This deficient practice had the potential to impact 133 of 133 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>During an interview on 2/25/15 at 9:33 a.m., with Resident # 69, she indicated</p>	F 364	No corrective action can be taken for those residents identified in the survey as the situation already occurred. All residents have the potential to be affected. Dietary staff will be in-serviced on ensuring adequate food temps are maintained at the serving line when food is being served, and that the plate warmer is operating at temperature prior to serving. Dietician will be responsible for monitoring serving temps on carts going out to the various units in the facility. A CQI audit tool will be completed weekly for the first 30	04/12/2015

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	<p>that the room trays were not hot on numerous days and at different meal times.</p> <p>During an interview on 2/25/15 at 9:10 a.m., with Resident # 111, she indicated that the room trays were not hot on numerous days and at different meal times.</p> <p>During an interview on 3/3/15 at 2:15 p.m., with Resident # 111, she indicated that she dines in the lunchroom and the food is not hot on numerous days and different meal times.</p> <p>During a kitchen food service test tray observation and demonstration on 3/2/2015 at 12:15 p.m., the Registered Dietician (RD), tested the potato wedges at 114 degrees Fahrenheit (F), the grilled chicken sandwich at 105 degrees F, and the mixed vegetables of peas and carrots at 110 degrees F .</p> <p>During an interview with the RD on 3/3/2015 at 2:30 p.m., she indicated the temperature for the potato wedges should have been 120 degrees For higher, the chicken sandwich 125 degrees F or higher and the mixed vegetables should have been 120 degrees F or higher. She indicated the food trays were at the proper temp leaving the kitchen but the</p>		<p>days and monthly for the next quarter to ensure compliance. Dietician will report to the facilities Quality Assurance committee on results of the audits and any actions necessary to ensure 100% compliance.</p>				

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F 371 SS=F Bldg. 00	<p>tray delivery to the resident was too cold to be served.</p> <p>The policy for "Proper Temperatures for Meal Preparation and Service," not dated, received on 3/4/2015 at 2 p.m., from the RD, indicated " Holding Temperatures: -Hot foods should be held at a temperature of greater than 135 degrees F...."</p> <p>3.1-21(a)(2)</p> <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</p>			

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	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, and interview, the facility failed to ensure that food was prepared under sanitary conditions in one of one kitchens in the facility. This deficient practice had the potential to affect 133 of 133 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 2/24/2015 at 8:55 a.m., with the Registered Dietician(RD) and Dietary Manager, the following observations were made:</p> <ol style="list-style-type: none"> 1. The vent on the compressor for the juice machine was dirty with debris. 2. The oven doors and sides were dirty with spillage. 3. The floor under the stove was dirty with debris. 4. The wall behind the handwashing sink had a large stain of dried soap running the length of the wall to the floor of the kitchen. 5. The floor under the coffee and ice machines was wet, stained and had 	F 371	<p>The items indentified in the survey were cleaned immediately after being pointed out by the surveyor. No further corrective action is necessary. No residents had the potential to be harmed by the issue identified in the survey. All Dietary Staff will be In-serviced on the cleaning schedule for the kitchen. Dietician will be responsible for monitoring sanitation in the kitchen. A CQI audit tool will be completed weekly for the first 30 days and monthly for the next quarter to ensure compliance. Dietician will report to the facilities Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% compliance.</p>	04/12/2015			

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	<p>debris.</p> <p>6. The fan above the handwashing sink was dirty with dust and debris.</p> <p>7. The electrical cord connecting the fan to the electrical socket was dirty with dust.</p> <p>8. The large vent next to the handwashing sink was dirty with dust and debris.</p> <p>During an interview on 2/24/2015 at 10:00 a.m., with the Dietary Manager and RD, the RD indicated all areas should be free of dust and debris.</p> <p>During an interview with the RD on 3/4/2015 at 2:00 p.m., she indicated the facility had been addressing sanitation in the kitchen area and she was looking for a policy or procedure. No policy or procedure was found.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F 431 SS=F Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under</p>			

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	<p>proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview the facility failed to ensure expired medications were removed from medication storage areas. This affected 4 of 4 medication rooms reviewed for expired medications.</p> <p>Findings include:</p> <p>During a medication storage review conducted on 3/2/15 at 1:30 p.m., the following was observed:</p> <p>1. In the 300 corridor refrigerator, an opened Tubersol (purified protein derivative used for Tuberculosis skin testing) vial was found with an opened date of 12/27/14 on the vial.</p> <p>A review of the policy titled "PPD- Intradermal Tuberculin Testing" dated March, 2003, indicated "...expiration date which expires 28 days after opening,</p>	F 431	<p>The medications identified as out dated were immediately destroyed. No additional action is necessary as no resident received any of the out dated medication. Nursing staff will be in-serviced on the medication destruction policy for the facility. Nursing administration will monitor for compliance. A CQI audit tool will be completed weekly for the first 30 days and monthly for the next quarter to ensure compliance. Nursing Management will report to the facilities Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% compliance.</p>	04/12/2015

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	<p>place date upon opening vial...."</p> <p>2. In the 200 corridor refrigerator, an opened vial of Tubersol was found with no open date on the vial.</p> <p>Two multidose bottles of Vancomycin (an antibiotic) HCL Solution 50 MG/ML (milligrams/milliliters) ordered for Resident #147 on 1/2/15 and discontinued on 2/6/15 were opened with an expiration date of 2/26/15.</p> <p>3. In the 400 corridor refrigerator, a package of Dulcolax suppositories (a medication for constipation) was found with an expiration date of 9/3/14 on the affixed pharmacy label. The medication inside the pharmacy envelope had an expiration date of 4/2016. The discrepancy was not questioned by the staff.</p> <p>4. In the 100 corridor refrigerator, two packages of Ducolax suppositories were found with an expiration date of 2/25/15.</p> <p>During an interview with Unit Manager of 400 Corridor on 3/2/15 at 2:35 p.m., she indicated the night shift nurses are responsible for checking refrigerators and disposing of expired medications.</p> <p>A review of a policy titled</p>			

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F 465 SS=E Bldg. 00	<p>"Medication/Drug Disposal" dated July, 2014 indicated the purpose of the policy to communicate proper disposal of all unused portions of a resident's prescriptions, including controlled drugs, expired medications. Procedure "... remove medicine from the med box or cart refrigerator.."</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 a clean, sanitary, and home like environment related to 6 of 37 resident rooms (walls, floors, doors, bathroom fixtures and furniture), (Room's # 7, 11, 14, 320, 322, and 416).</p> <p>Findings include:</p> <p>During resident room observations on 2/24/2015, 2/25/2015, and 2/26/2015 the following were observed:</p> <p>1. Room 7 on 2/25/2015 at 9:37 a.m., bedroom door was gouged, marred and chipped .</p>	F 465	No residents were affected by the alleged deficient practice. All items identified in the survey have already been resolved. All staff will be in-serviced on filling out maintenance request slips when issues are identified that need addressed. Maintenance supervisor will monitor for compliance by making rounds throughout all units of the facility to identify issues that may not have been addressed. A CQI audit tool will be completed weekly for the first 30 days and monthly for the next quarter to ensure compliance. Maintenance Supervisor will report to the facilities Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% compliance.	04/12/2015

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	<p>2. Room 11 on 2/25/2015 at 9:47 a.m., the closet and bathroom doors were gouged, chipped, cracked, marred and peeling.</p> <p>3. Room 14 on 2/25/2015 at 10:27 a.m., the bathroom and bedroom walls were chipped, marred, gouged and peeling, the closets were gouged, chipped and cracked, the toilet seat was chipped, cracked, and peeling, and the sink area around the water faucet was stained.</p> <p>4. Room 320 on 2/24/2015 at 2:58 p.m., the walls and door frame in the bathroom were gouged chipped and peeling and the bedroom wall, near the bed was cracked chipped and peeling.</p> <p>5. Room 322 on 2/2/25/2015 at 10:06 a.m., the bedroom wall behind the bed had a 2 foot gouge and the wall was also chipped and peeling.</p> <p>6. Room 416 on 2/26/2015 at 9:57 a.m., the wall behind the recliner chair had gouges, was marred, chipped and peeling.</p> <p>During the environmental tour, on 2/27/2015 at 10:00 a.m., with the Maintenance Director and Environmental Services Director, the Maintenance Director indicated a work request system was in place and all staff are aware how</p>			

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R 000 Bldg. 00	<p>to request repairs in the facility.</p> <p>During an interview on 2/27/2015 at 11:00 a.m., with the Maintenance Director, he indicated he was not aware the resident rooms needed repair, and the work request system did not include these rooms.</p> <p>During an interview on 3/3/2015 at 2:30 p.m., with the Administrator, he indicated the facility did not have a written procedure for the maintenance request system but all staff are advised of the system during orientation.</p> <p>3.1-19(f)</p>	R 000	Mulberry Health & RetirementCommunity respectfully request a desk review in lieu of an on site follow upsurvey	
R 272 Bldg. 00	<p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, record review, and interview, the facility failed to ensure appropriate meal temperatures for 5 of 5 residents that received meals from the kitchen.</p>	R 272	No corrective action can be taken for those residents identified in the survey as the situation already occurred. All residents have the potential to be affected. Dietary staff will be in-serviced on	04/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155600		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2015	
NAME OF PROVIDER OR SUPPLIER MULBERRY HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058			
(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			
	<p>Findings include:</p> <p>During an interview on 3/4/15 at 9:45 a.m., with Resident # 220, she indicated that the room trays are cold more times than hot on numerous days and at different meal times.</p> <p>During a kitchen food service test tray observation and demonstration on 3/2/2015 at 12:15 p.m., the Registered Dietician (RD), tested the potato wedges at 114 degrees Fahrenheit (F), the grilled chicken sandwich at 105 degrees F, and the mixed vegetables of peas and carrots at 110 degrees F.</p> <p>During an interview with the RD on 3/3/2015 at 2:30 p.m., she indicated the temperature for the potato wedges should have been 120 degrees F or higher, the chicken sandwich 125 degrees F or higher and the mixed vegetables should have been 120 degrees F or higher. She indicated the food trays were at the proper temp leaving the kitchen but the tray delivery to the resident was too cold to be served.</p> <p>The policy for Proper Temperatures for Meal Preparation and Service, not dated, received on 3/4/2015 at 2:00 p.m., from the RD, indicated, " Holding</p>		<p>ensuring adequate food temps are maintained at the serving line when food is being served, and that the plate warmer is operating at temperature prior to serving. Dietician will be responsible for monitoring serving temps on carts going out to the various units in the facility. A CQI audit tool will be completed weekly for the first 30 days and monthly for the next quarter to ensure compliance. Dietician will report to the facilities Quality Assurance committee on results of the audits and any actions necessary to ensure 100% compliance.</p>				

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NAME OF PROVIDER OR SUPPLIER MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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R 273 Bldg. 00	<p>Temperatures -Hot foods should be held at a temperature of greater than 135 degrees F...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure that food was prepared under sanitary conditions in one of one kitchens in the facility. This deficiency had the potential to affect 5 of 5 residents who received meals in the facility.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 2/24/2015 at 8:55 a.m., with the Registered Dietician (RD) and Dietary Manager, the following observations were made:</p> <ol style="list-style-type: none"> 1. The vent on the compressor for the juice machine was dirty with debris. 2. The oven doors and sides were dirty with spillage. 3. The floor under the stove was dirty 	R 273	The items indentified in the survey were cleaned immediately after being pointed out by the surveyor. No further corrective action is necessary. No residents had the potential to be harmed by the issue identified in the survey. All Dietary Staff will be In-serviced on the cleaning schedule for the kitchen. Dietician will be responsible for monitoring sanitation in the kitchen. A CQI audit tool will be completed weekly for the first 30 days and monthly for the next quarter to ensure compliance. Dietician will report to the facilities Quality Assurance committee on results of the audits, and any actions necessary to ensure 100% compliance.	04/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155600	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
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	<p>with debris.</p> <p>4. The wall behind the handwashing sink had a large stain of dried soap running the length of the wall to the floor of the kitchen.</p> <p>5. The floor under the coffee and ice machines was wet, stained and had debris.</p> <p>6. The fan above the handwashing sink was dirty with dust and debris.</p> <p>7. The electrical cord connecting the fan to the electrical socket was dirty with dust.</p> <p>8. The large vent next to the handwashing sink was dirty with dust and debris.</p> <p>During an interview on 2/24/2015 at 10:00 a.m., the Dietary Manager and RD, the RD indicated all areas should be free of dust and debris.</p> <p>During an interview with the RD on 3/4/2015 at 2:00 p.m., she indicated the facility had been addressing sanitation in the kitchen area and she was looking for a policy or procedure. No policy or procedure was found.</p>			