

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 11/08/2011
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 2601 VALPARAISO ST VALPARAISO, IN46383
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R0000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: November 4, 7, and 8, 2011</p> <p>Facility number: 010757 Provider number: 010757 AIM number: N/A</p> <p>Survey Team: Kelly Sizemore, RN-TC Sheila Sizemore, RN Regina Sanders, RN Marcia Mital, RN</p> <p>Census bed type: Residential: 56 Total: 56</p> <p>Census payor type: Other: 56 Total: 56</p> <p>Sample: 7 Supplemental sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/09/11 by Suzanne Williams, RN</p>	R0000	<p>The following is the Plan of Correction for Sterling House and Clare Bridge of Valparaiso in regards to the Statement of Deficiencies for the annual survey completed on November 8, 2011. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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R0117	<p>(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.</p> <p>Based on record review and interview, the facility failed to ensure the facility had one staff member with a current first aid certificate scheduled for 6 midnight shifts. (October 30 and 31, 2011, November 1, 5, 6, and 7, 2011)</p> <p>Findings include:</p> <p>Review of the nursing schedule, dated 10/30/11 through 11/12/11, and employee records, on 11/08/11 at 9:30 a.m., lacked documentation to indicate a staff member</p>	R0117	<p>R117 First Aid training What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <ul style="list-style-type: none"> ·No residents were noted to have been affected by the alleged deficient practice. ·At this community, Nurses and QMA's are typically provided First Aid training as soon as possible following orientation. ·In response to the finding, the named associates have completed the required First Aid training. This training was provided by a Certified Trainer. <p>How will the facility identify other residents with the potential to be affected by the same alleged</p>	12/07/2011

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	<p>with a current first aid certificate had been scheduled for the 10 p.m. to 6 a.m. shift on October 30 and 31, 2011, November 1, 5, 6, and 7, 2011.</p> <p>During an interview on 11/08/11 at 10:10 a.m., the Health and Wellness Director indicated the Business Office Manager does the schedule and keeps track of the certificates.</p> <p>During an interview on 11/08/11 at 10:12 a.m., the Business Office Manager indicated she knew a staff member had to be certified in first aid and CPR (cardiopulmonary resuscitation). She indicated she was aware there were several certificates which were expired and she had informed the Executive Director. She indicated she did not check for certificates when she did the schedule.</p>		<p>deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> -Existing in-service records and Orientation documentation regarding First Aid Training has been audited by the Business Office Coordinator/Executive Director and/or Designee for compliance. -Associates noted to be in need of First Aid Training to meet the state requirement will be scheduled to attend the mandatory training within the proper timeframe. <p>What measures will be put into place or what systemic changes will the community make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> -A tickler file will be utilized as an audit tool by the Business Office Coordinator/Designee to monitor attendance dates for Dementia training. -The Business Office Coordinator (BOC) will be provided documentation by the various department heads as training occurs. -The BOC/Designee will be responsible for data entry. <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p> <ul style="list-style-type: none"> - The Executive Director/Health and Wellness Director/Designee will be responsible for reviewing compliance and training audits monthly and having a designees schedule affected associates First Aid training accordingly to maintain compliance. - Executive Director and Health and Wellness Director/Designee will be responsible for scheduling the appropriate number of associates to attend the mandatory training sessions, and providing proof of attendance to the BOC/Designee for input of data onto the 				

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R0120	<p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure facility staff</p>	R0120	<p>tickler file.</p> <p>R 117 - State required dementia training: <i>What corrective action(s) will be accomplished</i></p>	12/07/2011			

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	<p>received the required hours of dementia specific training annually for 28 of 41 employees who had been employed at the facility for more than six months. (Employees LPNs #1, #2, #3, #4, #5, and #6, RN #7, Cooks #8, #9, #10, #11, Life Enrichment #12, Maintenance #13, Business Office Manager #14, Executive Director #15, QMAs #16, #17, #18, and #19, Resident Care Aides #20, #21, #22, #23, #24, #25, #26, #27, and #28)</p> <p>Findings include:</p> <p>Records of 41 employees who had been employed by the facility for over four months were reviewed on 11/07/11 at 11:30 a.m. There was a lack of documentation in the facility's dementia training inservices to indicate 28 of the 41 employees (Employees LPNs #1, #2, #3, #4, #5, and #6, RN #7, Cooks #8, #9, #10, #11, Life Enrichment #12, Maintenance #13, Business Office Manager #14, Executive Director #15, QMAs #16, #17, #18, and #19, Resident Care Aides #20, #21, #22, #23, #24, #25, #26, #27, and #28) had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2010.</p> <p>During an interview on 11/07/11 at 12:05 p.m., the Business Office Manager</p>		<p>for those residents found to have been affected by the alleged deficient practice?</p> <ul style="list-style-type: none"> No residents were noted to have been affected by the alleged deficient practice. At this community, associates are typically provided a minimum of 6 hours of initial Dementia Training within 6 months of hire as part of their 3 day Foundations (Orientation) training. Associates are then scheduled for a minimum of 3 hours of Dementia training annually thereafter. In response to the finding, the named associates have completed the required dementia training. This training was provided by the Executive Director/Health and Wellness Director and other designees. <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Existing in-service records and Orientation documentation regarding Dementia Training has been audited by the Business Office Coordinator/Executive Director and/or Designee for compliance. Associates noted to be in need of Dementia Training will be scheduled by department heads to attend the mandatory training within the proper timeframe. <p>What measures will be put into place or what systemic</p>				

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	<p>indicated she was aware the staff required three hours of dementia training yearly. She indicated there were a lot of staff without the training. She indicated the Executive Director was responsible to ensure the training was getting done as required.</p> <p>During an interview on 11/07/11 at 12:35 p.m., the Executive Director indicated there was a miscommunication between her and the person tracking the hours.</p>		<p>changes will the community make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> · A tickler file will be utilized as an audit tool by the Business Office Coordinator/Designee to monitor attendance dates for Dementia training. · The Business Office Coordinator will be provided documentation by the various department heads as training occurs. · The BOC/Designee will be responsible for data entry. <p>.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p> <ul style="list-style-type: none"> · The Executive Director/Designee will be responsible for reviewing compliance and training audits monthly and having a designees schedule affected associates for dementia training accordingly to maintain compliance. · Each department head or Designee will be responsible for scheduling their associates to attend the mandatory training sessions, and providing proof of attendance to the Business Office Coordinator/Designee for input of data onto the tickler file. 				