

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2016
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NAME OF PROVIDER OR SUPPLIER  SUMMIT PLACE WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 55 N MISSION DR INDIANAPOLIS, IN 46214
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 16 &amp; 17, 2016</p> <p>Facility number: 011840 Provider number: 011840 AIM number: N/A</p> <p>Census bed type: Residential: 53 Total: 53</p> <p>Census payor type: Medicaid: 36 Other: 17 Total: 53</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 2/19/16 by 29479.</p>	R 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find enclosed the plan of correction for the survey ending February 17, 2016.</p> <p>The documentation included serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me.</p> <p>Respectfully,</p> <p>Angela Williams Administrator</p>	
R 0148  Bldg. 00	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and</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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	<p>welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on on observation, interview, and record review, the facility failed to ensure cleaning chemicals were stored in a manner to prevent residents from assessing them for 2 of 2 observations of an unlocked janitor's closet.</p> <p>Finding includes:</p> <p>During an observation on 2/16/16 at 10:08 a.m., the janitor's closet on the first floor, near the dining room, was unlocked. The closet contained High Traffic Carpet Cleaner, High Traffic Floor Finish, and a container of Ecolution Laundry Detergent.</p> <p>During an observation on 2/16/16 at 11:45 a.m., with the Administrator present, the janitor's closet remained unlocked with High Traffic Floor Finish</p>	R 0148	<p>1.No residents were harmed. The knob on the house keeping closet was immediately replaced upon noting in was damaged.</p> <p>2.All residents have the potential to be affected. All potentially hazardous chemicals stored by the facility were checked to ensure they stored securely.</p> <p>3.As a measure of ongoing compliance the Maintenance Director or designee will complete preventative maintenance audits to ensure chemicals are stored and securely daily on regularly scheduled days ongoing. Should findings be noted, corrective measures will be initiated immediately.</p> <p>4.As a measure of quality assurance the Administrator or designee will review and sign said audits weekly ongoing.</p>	03/04/2016

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	<p>and a container of Ecolution Laundry Detergent stored in the closet.</p> <p>During a interview on 2/16/16 at 11:45 a.m., the Administrator indicated that the janitor's closet should have been locked and without chemicals stored inside.</p> <p>The Safety Data Sheet records were provided by the Administrator and identified as current on 2/16/16 at 12:03 p.m., indicated, "Ecolution Laundry Detergent...causes mild skin irritation eye irritation and may be harmful if swallowed...."</p> <p>The Material Safety Data Sheets were provided by the Administrator and identified as current on 2/16/16 at 12:03 p.m., indicated, the High Traffic Floor Finish causes eye and skin irritation and was harmful if swallowed; the High Traffic Carpet cleaner should not be ingested and is hazardous in case of skin and eye contact.</p> <p>A policy titled, "Storage Area And Janitor Closet," was received by the Administrator and identified as current on 2/16/16 at 11:30 a.m., and indicated, "...Chemicals are not to be stored in closets...."</p>			

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R 0241  Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was not administered expired medication for 1 of 5 residents reviewed for medication administration (Resident #12).</p> <p>Finding includes:</p> <p>During an observation on 2/16/16 at 10:20 a.m., Licensed Practical Nurse (LPN) #1 was observed dispensing Humulin insulin from a vial into a syringe. The medication label indicated an open date of 1/6/16. LPN #1 was observed administering the insulin to Resident #12.</p> <p>During an interview on 2/16/16 at 10:20 a.m., LPN #1 indicated insulin expired 28 days from the open date and Resident #12's administered insulin was expired.</p> <p>During an interview on 2/16/16 at 11:27 a.m., the Administrator indicated insulin expired 28 days from the open date and</p>	R 0241	<p>1.Resident # 12 was affected. The resident was not harmed. The nurse was immediately re-educated on insulin expiration dates.</p> <p>2.All residents receiving insulin injections have the potential to be affected. All nurses will be re-educated on the expiration dates for insulin.</p> <p>3.As a measure of ongoing compliance the DON or designee will audit medication carts and refrigerators five times weekly for 30 days,then three times weekly for 30 days, then weekly ongoing to ensure insulin vials are dated when opened and disposed of when expired. Any findings noted will be addressed immediately.</p> <p>4.As a measure of quality assurance the Administrator or designee will review and sign said audits weekly ongoing.</p>	03/04/2016			

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R 0273 Bldg. 00	<p>should not be administered when expired.</p> <p>A policy titled, "Expiration Dating and Document Requirements," dated 10/2010 and identified as current by the Director of Nursing (DON) on 2/16/16 at 11:27 a.m., indicated, "...Expiration dates (suggested)...All types of insulin- 28 days after opening...."</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, interview, and record review, the facility failed to ensure the dishwasher maintained temperatures recommended by the manufacturer's instructions for 1 of 2 observations of dishwashing. This deficient practice had the potential to affect 53 of 53 residents who consumed food from the facility's kitchen.</p> <p>Finding includes:</p>	R 0273	<p>1.No residents were harmed. The dishwasher was immediately serviced upon noting it was not temping properly.</p> <p>2.All residents have the potential to be affected. All kitchen staff will be educated on dishwasher use and temperature requirements.</p> <p>3.As a measure of ongoing compliance the Dietary manager or designee will complete dishwasher temperature monitoring daily on regularly scheduled days ongoing. Any</p>	03/04/2016			

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	<p>During a dishwasher observation on 2/16/16 at 12:30 p.m., the Kitchen Manager indicated the dishwasher wash temperature was 104 degrees Fahrenheit and the rinse water temperature was 117 degrees Fahrenheit.</p> <p>The dishwasher temperature log for February 2016, indicated the breakfast dishwasher rinse temperatures were 100 degrees Fahrenheit for February 1, 2, and 4-14, 2016. The form indicated the breakfast dishwasher rinse temperature on 2/15/15 was 118 degrees Fahrenheit.</p> <p>On 2/16/16 at 4:02 p.m., the Administrator provided the current operation manual for the dishwasher. The manual indicated the dishwasher water temperatures for wash and rinse should be a minimum of 120 degrees Fahrenheit and recommended 140 degrees Fahrenheit.</p> <p>During an interview on 2/16/16 at 12:30 p.m., the Kitchen Manager indicated the dishwasher had been running prior to the temperature reading, and the dishwasher water was slow to warm up. She indicated the dishwasher wash temperature was to be 100 degrees Fahrenheit and the rinse temperature was to be 150 degrees Fahrenheit.</p>		<p>findings noted, will be addressed immediately.</p> <p>4.As a measure of quality assurance the Administrator or designee will review and sign said audits weekly ongoing.</p>				

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	<p>During an interview on /17/16 at 9:20 a.m., the Kitchen Manager indicated the dishwasher rinse temperatures were logged by the cooks at breakfast, lunch, and dinner, and she reviewed the logs at the end of every week. She indicated when the dishwasher was not the correct temperature the staff was to inform her immediately, wash the dishes by hand in the three compartment sink, and she would inform maintenance. She indicated the cooks had not informed her of any problems with the dishwasher temperatures and she was unaware of the low temperatures for breakfast for the month of February.</p> <p>On 2/16/16 at 12:40 p.m., the Administrator provided the current policy titled, "Recording Temperature of Dish Machine." The policy stated, "It is necessary to ensure that appropriate temperatures are maintained in the dish machine for proper cleaning and sanitizing...If the wash or rinse temperatures do not meet the minimum temperatures, repeat the cycle and observe the temperatures. If results are not satisfactory, report to the Dietary Manager...Manufacturer's Guidelines are to be followed explicitly."</p>						

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R 0306  Bldg. 00	<p>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:</p> <ol style="list-style-type: none"> <li>(1) The name of the resident.</li> <li>(2) The name and strength of the drug.</li> <li>(3) The prescription number.</li> <li>(4) The reason for disposal.</li> <li>(5) The amount disposed of.</li> <li>(6) The method of disposition.</li> <li>(7) The date of the disposal.</li> <li>(8) The signature of the person conducting the disposal of the drug.</li> <li>(9) The signature of a witness, if any, to the disposal of the drug.</li> </ol> <p>Based on observation, interview, and record review, the facility failed to establish expiration dates of medications by not labeling the date opened, failed to dispose of medications when they expired, and failed to ensure a witness for destruction of a controlled medication for 2 of 2 observations of medication storage rooms and 1 of 1 observation of destruction of a controlled medication. This deficient practice affected 10 residents (Residents #8, #12, #13, #14, #16, #7, #18, #19, #20, and #21).</p> <p>Finding includes:</p> <p>During an observation on 2/16/16 at 9:35</p>	R 0306	<p>1.No residents were harmed. All expired medications were immediately disposed of. The nurse was immediately re-educated on expiration dates,date open on labels, and the requirement of a witness when disposing of controlled substances.</p> <p>2.All residents have the potential to be affected. All medication carts and refrigerators were immediately audited to ensure there were no expired medications in them. All nurses and QMA's will be re-educated on expiration dates and the narcotic destruction policy.</p> <p>3.As a measure of ongoing compliance the DON or designee will audit medication carts and refrigerators five times weekly for</p>	03/04/2016			

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	<p>a.m., with Licensed Practical Nurse (LPN) #2 present, the main floor medication storage room was observed. The following discontinued medications and medications without indication of a date opened were observed:</p> <p>a. Resident #8's Neomycin/Polymyxin/Dexamethasone (medication for the eyes) label indicated the medication should have been administered for five days. The label indicated the medication was dispensed from the pharmacy on 1/29/16. The medication lacked indication of an open date.</p> <p>b. Resident #16's Sulfacetamide Sodium (medication for the eyes) label indicated the medication should have been administered for seven days. The label indicated an open date of 7/3/15. Resident #16's had another bottle of Sulfacetamide Sodium ophthalmic (eye drops) solution 10 %. The label indicated the medication should have been administered for seven days. The label indicated the medication was dispensed from the pharmacy on 12/29/15. The medication lacked indication of an open date.</p> <p>c. Resident #17's Latanoprost (eye medication) label indicated the medication was dispensed from the pharmacy on 10/16/15. The medication</p>		<p>30 days, then three times weekly for 30 days, then weekly ongoing to ensure insulin vials are dated when opened and disposed of when expired. The DON or designee will also audit narcotic count sheets for destroyed medications and ensure there are two signatures to denote there was a witness weekly ongoing. Any findings noted will be addressed immediately.</p> <p>4. As a measure of quality assurance the Administrator or designee will review and sign said audits weekly ongoing.</p>				

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	<p>lacked indication of an open date.</p> <p>d. Resident #18's Lotemax (eye medication) label indicated the medication was dispensed from the pharmacy on 11/23/15. The label lacked indication of an open date.</p> <p>e. Resident #19's Refresh Tears (eye medication) label indicated the medication was dispensed from the pharmacy on 1/6/16. The label lacked indication of an open date.</p> <p>f. Resident #20's Refresh Tears (eye medication) label lacked indication of a date dispensed or an open date.</p> <p>g. Resident #21's Artificial Tears (eye medication) label indicated the medication was dispensed on 12/11/15. The label lacked indication of an open date.</p> <p>During an observation on 2/16/16 at 9:55 a.m., with Licensed Practical Nurse (LPN) #1 present, the second floor medication storage room was observed. The following medications were observed expired or without indication of open dates:</p> <p>a. Resident #12's Lantus and Humulin insulin labels indicated an open date of 1/6/16.</p> <p>b. Resident #13's Sodium Chloride eye ointment label indicated the medication was dispensed from the pharmacy on</p>			

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	<p>1/7/16. The label lacked indication of an open date.</p> <p>c. Resident #14's Novolog insulin label indicated an open date of 1/6/16.</p> <p>d. Resident #15's Lantus insulin label indicated an open date of 1/6/16.</p> <p>During an observation on 2/16/16 at 10:15 a.m., Licensed Practical Nurse (LPN) #1 was observed in the upstairs medication room dispensing medication for Resident #12. LPN #1 dropped an alprazolam (anti-anxiety) 0.5 milligram tab on the floor. LPN #1 retrieved the tab from the floor and disposed of the medication in the sharps container. A witness to the destruction of a controlled substance was not observed.</p> <p>During an interview on 2/6/16 at 9:40 a.m., LPN #2 indicated Resident #8's Neomycin/Polymyxin/Dexamethasone and Resident #16's Sulfacetamide Sodium eye medications had been discontinued and should have been removed from the medication cart and disposed of. She further indicated eye medications should have been tabled with an open date. She indicated she was unsure when eye medications expired.</p> <p>During an interview on 2/6/16 at 10:20 a.m., LPN #1 indicated eye medications should have been labeled with an open</p>						

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	<p>date and all insulin expired 28 days after it was opened. She indicated she was unsure when eye mediations expired.</p> <p>An expiration dating and document requirements policy, identified as current by the Director of Nursing on 2/16/16 at 11:22 a.m., indicated, "...All types of insulin-28 days after opening. Must keep refrigerated until opened... If a "Date Opened" is not indicated, it is noted that the open date must be the earliest possible date. For Example, if an eye drop was dispensed on 10/1/09, the earliest the eye drop was opened is 10/1/09. If facility is unclear on expiration date, please contact your consultant pharmacist or dispensing pharmacy."</p> <p>A destruction of medications policy, identified as current by the Director of Nursing on 2/16/16 at 11:27 a.m., indicated, "Any medication for which there is no active order shall be destroyed a the nursing facility as soon as possible, but no later than seven (7) days of becoming active... Schedule II controlled drugs are handled in a similar fashion except that: Destruction must be performed by two (2) licensed personnel (i.e. two (2) nurses or one (1) licensed nurse and the consultant pharmacist)...."</p>						

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R 0406 Bldg. 00	<p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented during the administration of injectable medications for 1 of 2 residents observed for injections (Resident #15).</p> <p>Finding includes:</p> <p>During an observation on 2/16/16 at 11:00 a.m., Licensed Practical Nurse (LPN) #1 was observed injecting insulin into Resident #15's abdomen. LPN #1 was not observed wearing gloves during the procedure.</p> <p>During an interview on 2/16/16 at 11:05 a.m., LPN #1 indicated she was unsure whether she was required to wear gloves when giving injections.</p> <p>During an interview on 2/16/16 at 11:15 a.m., the Administrator indicated gloves should be worn during injections.</p>	R 0406	<p>1. Resident #15 was affected. The resident was not harmed. The nurse involved was immediately re-educated on glove use and the insulin administration policy.</p> <p>2. All residents receiving insulin injections have the potential to be affected. All nurses will be re-educated on glove use and the insulin administration policy.</p> <p>3. As a measure for ongoing compliance the DON or designee will complete five insulin administration observations weekly for 30 days, then five insulin administration observations monthly ongoing to ensure gloves are worn. Any findings will be addressed immediately.</p> <p>4. As a measure of quality assurance the Administrator or designee will review and sign said audits weekly ongoing.</p>	03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2016
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NAME OF PROVIDER OR SUPPLIER  SUMMIT PLACE WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 55 N MISSION DR INDIANAPOLIS, IN 46214
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	<p>An insulin injection policy identified as current by the Director of Nursing on 11:27 a.m., indicated, "...Administering Insulin...Wear gloves as indicated by Standard Precautions...."</p> <p>A Standard Precautions policy identified as current by the Administrator on 2/16/16 at 12:27 p.m., indicated, "...Standard Precautions are the minimum infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status of the residents, in any setting where healthcare is delivered. The practices are designed to both protect health care workers and prevent health care workers from spreading infections among residents. Facility personnel will provide care with an approach to infection control in accordance with implementation of Standard Precautions including: 1) hand hygiene, 2) use of personal protective equipment (e.g., gloves, gowns, masks), 3) safe injection practices, 4) safe handling of potentially contaminated equipment or surfaces in the resident environment...The selection PPE (personal protective Equipment) is based on the nature of the resident interaction and potential for exposure to blood, body fluids or infectious agents. Examples of appropriate use of PPE for adherence to</p>			

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R 0410 Bldg. 00	<p>Standard Precautions include: use of gloves in situations involving possible contact with blood or body fluids, mucous membranes, non intact skin or potentially infectious material...."</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure a Mantoux skin test was administered to a resident upon admission to the facility for 1 of 5 residents reviewed for annual Mantoux testing (Resident #7).</p>	R 0410	<p>1.Resident #7 was affected. The resident was not harmed.The resident had a CXR on file indicating no active disease prior to admission to the facility. The resident did not exhibit any signs or symptoms of tuberculosis. The resident did receive her 1st step PPD.</p>	03/04/2016

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	<p>Finding includes:</p> <p>Resident #7's record was reviewed on 2/16/16 at 2:45 p.m. The record lacked documentation Resident #7 was administered her Mantoux skin test prior to or on her date of admission to the facility.</p> <p>During an interview on 2/17/2016 at 11:26 a.m., the Director of Nursing (DON) indicated the facility was not staffed with an employee able to administer the Mantoux skin test to Resident #7 on her admission date. She indicated Resident #7 received her Mantoux skin test two days after her admission to the facility.</p> <p>During an interview on 2/17/16 at 11:26 a.m., the Administrator indicated residents should receive their Mantoux skin test upon admission.</p> <p>A policy titled, "TB Skin Testing," dated 10/2015 and identified as current by the Administrator on 2/16/16 at 11:30 a.m., indicated, "The facility will administer and interpret tuberculin skin tests (TST) in accordance with recognized guidelines and pertinent regulations...."</p>		<p>2.All new admissions have the potential to be affected. All nurses will be re-educated on the PPD administration process. Additionally a basic tuberculosis skin test course will be completed with facility nurses.</p> <p>3.As a measure of ongoing compliance the DON or designee will complete an audit weekly ongoing to ensure all new admissions receive their 1st step PPD upon administration.</p> <p>4.As a measure of quality assurance the Administrator or designee will review and sign said audits weekly ongoing.</p>	