

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 11/21/2014
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NAME OF PROVIDER OR SUPPLIER MCKINNEY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD LOGANSPOUT, IN 46947
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R000000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00158961.</p> <p>Compliant IN00158961- Unsubstantiated due to lack of evidence</p> <p>Survey dates: November 20 and 21,2014</p> <p>Facility Number: 004441 Provider Number: 004441 AIM Number: N/A</p> <p>Survey Team: Maria Pantaleo, RN-TC Rita Mullen, RN Holly Duckworth, RN</p> <p>Census Type: Residential: 53 Total: 53</p> <p>Census Payor Type: Other: 53 Total: 53</p> <p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by</p>	R000000		
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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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R000055	<p>Tammy Alley RN on December 2, 2014.</p> <p>410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations.</p> <p>Based on observation, interview and record review, the facility failed to ensure the privacy of a resident, for 1 of 3 residents interviewed regarding privacy (Resident #4).</p> <p>Findings include:</p> <p>During an interview on 11/20/14 at 10:55 a.m., Resident #4 indicated staff do not respect her privacy and frequently enter her room without knocking.</p> <p>During an observation on 11/20/14 at 11:22 a.m., Certified Nursing Assistant (CNA) #1 was observed to enter Resident #4's room without knocking.</p>	R000055	<p>R 055 410 IAC 16.2-5-1.2(y) (1-4) Residents' Rights</p> <p>1. Individual identified has been counseled. Other Staff have been re-educated on Resident Rights. New staff will continue to be educated on Resident Rights during orientation. Resident Rights will be in-serviced annually and ongoing as needed. If a staff member is observed not upholding Resident Rights, the staff member will be counseled immediately.</p> <p>2. To monitor compliance, Residents will be interviewed monthly regarding Resident Rights by a staff member on the QA team during Quality Checks. Executive Director will review these interviews monthly and</p>	01/19/2015

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R000092	<p>During an interview on 11/20/14 at 3:15 p.m., the Executive Director and Care Services Manager indicated staff should knock before entering a resident's room. The Executive Director indicated all staff were trained in resident rights during orientation.</p> <p>A review of orientation material, titled "Appendix E Indiana State Department of Health - Resident Rights," on 11/21/14 at 2:50 p.m., indicated, "...24. Residents have the right to be treated as individuals with consideration and respect for their privacy...."</p> <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility</p>		<p>provide guidance and counselling to staff as needed. Monitoring to remain in place for one year.</p> <p>1.Completion date: January 19, 2015.</p>	

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	<p>shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure fire drills were completed quarterly on each shift and did not attempt to hold fire drills in conjunction with the local fire department at least every 6 months.</p> <p>Findings include:</p> <p>A record review of facility fire drill documentation was completed on 11/20/14 at 2:00 p.m. The following drills were found for the year 2014:</p> <p>01/07/14 - 1st shift, fire department present 02/18/14 - 2nd shift, no fire department present 04/16/14 - 3rd shift, no fire department present 08/25/14 - 1st shift, no fire department present 09/12/14 - 2nd shift, no fire department present 10/17/14 - 3rd shift, no fire department present</p> <p>The facility did not have fire drill documentation for March, May, June, or July 2014. No 3rd shift drills were</p>	R000092	<p>R 0092 410 IAC 16.2-5-1.3(i) (1-2)Administration and Management</p> <p>1.Beginning August 25, 2014 fire drill was held on first shift. On September 12, 2014 a fire drill was held on second shift. On October 17, 2014 a fire drill was held on third shift and on November 24, 2014 a fire drill was held on first shift and held in conjunction with the Logansport Fire Department.</p> <p>1.Drills will be conducted monthly on varying shiftsby the maintenance tech or another appointed member of the leadership team tofamiliarize all staff with signals and emergency action required under variedconditions. Attempts will be made to hold a fire drill in conjunction with thelocal fire department at least once every six months. All drills will be recorded on drill log and reviewed byExecutive Director quarterly</p> <p>1.Completion date: January 19, 2015.</p>	01/19/2015			

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R000117	<p>conducted during the first quarter, no 1st or 2nd shift drills were conducted during the second quarter, and no 3rd shift drills were conducted during the 3rd quarter.</p> <p>During an interview on 11/20/14 at 2:10 p.m., the Executive Director indicated the fire drills had been completed on a monthly basis since August. Prior to August, the fire drills were not completed on a monthly basis.</p> <p>During an interview on 11/20/14 at 2:20 p.m., the maintenance technician indicated the fire department had not been contacted to participate in fire drills since January.</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred</p>			

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	<p>(100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff on duty met requirements of first aid for 7 of 54 shifts reviewed.</p> <p>Findings include:</p> <p>A 11/21/14 review of the schedule for 10/26/14-11/22/14 indicated the following:</p> <p>10/26/14- no staff on duty with first aid training on day and evening shifts 10/31/- no staff on duty with first aid training on second shift 11/3/14- no staff on duty with first aid training on second shift 11/8/14-no staff on duty with first aid training on second shift 11/9/14- no staff on duty with first aid training on second shift 11/17/14- no staff on duty with first aid training on second shift</p> <p>During an interview with the Care Services Manager on 11/21/14 at 11:00 a.m., she indicated she was aware there</p>	R000117	<p>R 0117 410 IAC 16.2-5-1.4 (b) Personnel</p> <p>1. Training will occur for staff members in order to have at least one staff member on duty who is CPR and First Aid certified.</p> <p>2. The Care Services Manager and/or the Executive Director will monitor daily staffing to ensure that a CPR and First Aid certified employee is on duty at all times.</p> <p>3. Completion date: January 19, 2015.</p>	01/19/2015

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R000120	<p>was no verification of first aid training for staff members.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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: (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. (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. (3) Inservice records shall be maintained and shall indicate the following: (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</p>			

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	<p>by written signature.</p> <p>Based on record review and interview, the facility failed to ensure staff were inserviced annually regarding Resident Rights for 2 of 8 staff members reviewed for Resident Rights (Dietary Employee #3 and LPN #4).</p> <p>Findings include:</p> <p>1. The personnel record of Dietary Employee #3 was reviewed on 11/21/14 at 10:15 a.m. Dietary Employee's start date was 10/4/13.</p> <p>A review of inservicing for the last twelve months indicated Dietary Employee #3 had not received instruction regarding Resident rights.</p> <p>2. The personnel record of LPN #4 was reviewed on 11/21/14 at 10:20 a.m. LPN #4's start date was 7/6/12.</p> <p>A review of inservicing for the last twelve months indicated LPN #4 had not received annual instruction regarding Resident rights.</p> <p>During an interview with the Executive Director on 11/21/14 10:30 a.m., she indicated the facility follows the state guidelines for inservicing but no record was found regarding Resident rights for</p>	R000120	<p>R 0120 410 IAC 16.2-5-1.4(e) (1-3) Personnel</p> <p>1. Staff have been re-educated on Resident Rights. New staff will o be educated on Resident Rights during orientation. Resident Rights will be in serviced annually and ongoing as needed. If a staff member is observed not upholding Resident Rights, the staff member will be counseled immediately.</p> <p>1. Organized in-service education and training program will be provided for all personnel in all departments annually. Training will include, but not limited to, residents' rights. Executive Director and/or Care Services Manager will monitor quarterly to ensure compliance.</p> <p>1. Completion date: January 19, 2015.</p>	01/19/2015			

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R000121	<p>these two employees.</p> <p>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:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. 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.</p> <p>(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.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(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</p>			
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R000148	<p>loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure staff were tested for tuberculosis (TB) prior to resident contact using the two step mantoux skin test for 1 of 8 staff members reviewed for TB skin testing (laundry Employee #2).</p> <p>Findings include:</p> <p>The personnel record of Laundry employee #2 was reviewed on 11/21/14 at 10:00 a.m. Laundry employee #2's start date was 9/22/14.</p> <p>The TB testing record indicated a TB skin test was administered on 9/18/14. There was no second step TB skin test within the three week time period as required. The two step TB skin test was reinitiated again on 11/3/14 and completed on 11/12/14.</p> <p>During an interview with the Executive Director on 11/21/14 10:30 a.m., she indicated the facility follows the state guidelines and the second step TB skin test for Laundry Employee #2 was not done.</p> <p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings,</p>	R000121	<p>R 0121 410 IAC 16.2-5-1.4(f) (1-4) Personnel</p> <p>1.The community will ensure staff members are tested for TB using the two step Mantoux test, in accordance with our policy. Care Services Manager has conducted an audit to ensure all staff are current and in compliance.</p> <p>1.The Care Service Manager or Designee will be responsible for monitoring all new hires to ensure compliance with policy.</p> <p>1.Completion date: January 19, 2015.</p>	01/19/2015

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	<p>grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and 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 observation and interview, the facility failed to maintain common areas in a state of good repair and clean condition for 5 of 5 common hallways and 1 of 1 dining areas.</p> <p>Findings include:</p> <p>During an environmental tour with the maintenance technician on 11/21/2014 at 8:45 a.m., the following was observed:</p> <p>1. Floors:</p> <p>a.) A 4" carpet stain in the east hall near the massage therapy room</p> <p>b.) A 4" carpet stain in the east hall near the activities room</p>	R000148	<p>R 0148 410 IAC 16.2-5-1.5(e) (1-4) Sanitation and Safety Standards</p> <p>1.Common areas listed have been addressed. Community has established and implemented a written program for maintenance to ensure the continued upkeep of the community.</p> <p>1.Monthly Quality Checks will be done by a member of the QA committee in all common areas to ensure the continued upkeep of the community.</p> <p>1.Completion date: January 19, 2015.</p>	01/19/2015			

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	<p>c.) A 2" carpet stain outside of room 117</p> <p>d.) A 4" carpet stain outside of room 120</p> <p>e.) A 7" carpet stain outside of room 121</p> <p>f.) A brown substance on the carpet outside of room 125</p> <p>g.) Five 6" stains on carpet outside of room 138</p> <p>h.) Laundry room in the west hall: floor covering around the drain had a 5" tear in the linoleum</p> <p>2. Walls:</p> <p>a.) Exit door #3 in the east hall had corner molding coming off of the wall at the top of the door frame</p> <p>b.) The activity room in the east hall had gouges in the paint and had 9 filled holes with white spackle present on the walls.</p> <p>c.) Gouges in the wall on the south hallway near room 151</p> <p>d.) Gouges in the wall on the west hallway near room 155</p> <p>e.) Chipped plaster on the wall corner and</p>			

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	<p>baseboard in the east hallway near room 126</p> <p>f.) Walls and baseboards along west hallway were dirty and marred throughout the hallway</p> <p>g.) Chipped plaster, down to the metal reinforcement, on a corner post in the north hallway near the dining room.</p> <p>h.) Walls in north hallway, along the outside of the dining room, were marred and dirty</p> <p>3. Doors:</p> <p>a.) The lower portion of the medication room door along the north hallway was marred and gouged</p> <p>b.) The doors of resident rooms were marred and gouged on the lower halves of the doors. West hall: Room #s 111, 113, 116, and 153 Middle hall: Room #s 119, and 120 East hall: Room #s 125, 127, 129, and 131 South hall: Room #s 144, 145, 146, 147, and 148</p> <p>Vents/Lighting:</p>						

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NAME OF PROVIDER OR SUPPLIER MCKINNEY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD LOGANSPOUR, IN 46947
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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
R000246	<p>a.) 1 of 3 fire dampers in the north hall, near the dining room, had visible debris</p> <p>b.) 8 of 26 hanging lights in the dining room had visible cobwebs</p> <p>During an interview on 11/20/14 at 2:20 p.m., the maintenance technician indicated there is no current written program for maintenance to ensure the upkeep of the facility.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure a Qualified Medication Aide (QMA) received permission from a nurse prior to the administration of PRN (as needed) medications for 2 of 7 resident charts reviewed for appropriate PRN medication usage (Residents #C and #5).</p> <p>Findings include:</p>	R000246	<p>R 0246 410 IAC 16.2-5-4(e)(6) Health Services</p> <p>1.QMA listed no longer is employed at the community. Existing QMA's employed by the community have be in-serviced on scope of practice.</p> <p>1.The Care Service Manager or Designee will be responsible for reviewing PRN Medications for appropriate PRN medication</p>	01/19/2015

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	<p>1. The clinical record of Resident #5 was reviewed on 11/20/14 at 9:00 a.m. Diagnosis included dementia, high blood pressure and depression.</p> <p>A Medication Administration Record (MAR), dated for the month of October 2014, indicated QMA #5 gave Resident #5 a hydrocodone-APAP (a narcotic pain medication) 5-325 mg (milligram) on 10/27/14 at 7:00 a.m. There was no evidence of consultation with a licensed nurse prior to administration on the MAR.</p> <p>A review of Nursing notes, dated 10/27/14 at 7:00 a.m., indicated Resident #5 had asked for a PRN pain medication for low back pain. There was no evidence the licensed nurse was consulted prior to the administration of the PRN pain medication. 2. The clinical record of Resident #C was reviewed on 11/20/14 at 10:30 a.m., Diagnoses include but not limited to impaired cognition, depression, respiratory insufficiency.</p> <p>A MAR, dated for the month of September, indicated QMA #5 gave Resident #C alprazolam 0.5 mg on 9/18/14 at 9:30 a.m. There was no evidence of consultation with a licensed</p>		<p>usage and to ensure QMA's are working within their scope of practice. The Care Service Manager or Designee will provide education ongoing and as needed. The Care Service Manager will conduct a monthly audit of PRN Medication Administration.</p> <p>1.Completion date: January 19, 2015</p>	

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	<p>nurse prior to administration on the MAR.</p> <p>A review of hospice notes dated 9/18/14 indicated the resident was given a alprazolam by the facility to calm the patient down.</p> <p>During an interview with QMA #6 on 11/21/14 at 9:45 a.m., she indicated " Before a QMA can give a PRN medication we have to get permission from the nurse and she has to sign off on it."</p> <p>During an interview with the Care Services Manager, on 11/21/14 at 2:00 p.m., she indicated the facility became aware of QMA #5's lack of compliance regarding notifying the licensed nurse prior to administration of PRN medications and she is no longer employed at this facility.</p>						