

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 05/27/2016
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NAME OF PROVIDER OR SUPPLIER  BROOKDALE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 SARE RD BLOOMINGTON, IN 47401
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: May 26 and 27, 2016</p> <p>Facility number: 011076 Provider number: 011076 AIM number: N/A</p> <p>Census bed type: Residential: 42 Total: 42</p> <p>Residential Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on June 02, 2016.</p>	R 0000	<p>The 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 the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.</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 welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power</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>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>This rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the commercial dryer was maintained in a clean condition and in good repair for 1 of 1 commercial laundry dryers observed during the environmental tour.</p> <p>Findings include:</p> <p>On 5/27/16 at 11:00 a.m., during a tour of the residential and commercial laundry rooms, the commercial dryer was observed as having corrosion on the water intake pipes and connecting joints, rust around the machine joints at the floor level, and corrosion of parts near the electrical components on the back of the machine. This area of corrosion near the electrical components was partially covered with duct tape, which was coming apart.</p> <p>On 5/27/16 at 11:20 a.m., during an interview the Administrator indicated the maintenance manager was responsible for the upkeep of the commercial dryer, and if any upkeep or repairs were required outside of the maintenance manager's abilities the work would be contracted outside of the facility. The administrator indicated there</p>	R 0148	<p>#R148 Sanitation and Safety Standards1. <b>Corrective Action:</b> There have not been any negative outcomes due to the condition of the commercial laundry dryer. The dryer has been cleaned and repaired so that rust and duct tape are no longer a part of the electrical components.</p> <p><b>2. How to identify other laundry equipment with potential for similar events:</b> Laundry room equipment has been checked and will be observed and audited by MT/designee to verify regulatory standards are being met.</p> <p><b>3. Systematic Changes</b> The MT will be re-educated by the ED on the sanitation and safety standards of dryer equipment. MT will monitor and clean commercial dryer, specifically monitoring the electrical component. MT/designee will provide ED with weekly audit compliance of equipment. This audit will be ongoing to verify regulatory standards are being met.</p> <p><b>4. Quality Assurance</b> The MT/designee will be responsible for weekly updates of the laundry room. The MT will complete weekly audits of laundry room equipment</p>	06/01/2016

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R 0273 Bldg. 00	<p>was no written facility policy regarding the upkeep and repair of the commercial dryer.</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. Based on observation, interview, and record review, the facility failed to ensure as indicated by the facility policy and the 410 IAC-7-24 Retail Food Establishment Sanitation Requirements, staff labeled and stored food in a sanitary manner, maintained a sanitization water chemical level at 200 ppm (parts per million), and stored clean equipment in a sanitary manner for 1 of 1 kitchen which served 75 of 75 residents who resided at the facility.</p> <p>Findings include:</p> <p>The following was observed during a kitchen tour, on 5/26/16 at 10:35 a.m., with the Dietary Manager (DM) present:</p> <p>1. Two packages of opened shredded cheese in the refrigerator with no open date.</p>	R 0273	<p>to verify equipment is in regulatory compliance. The weekly audit form will be provided to the ED for verification and directing additional actions. Date of compliance: 6/1/2016</p> <p><b>#R273 Food and Nutritional Service</b></p> <p><b>1. Corrective Action:</b> There have not been any negative outcomes because of the failure to ensure proper labeling and storage of food in a sanitary manner, storage of mixer and deli slicer. There have also not been any negative outcomes because of low chemical level.</p> <p><b>2. How to identify other storage and labeling issues with potential for similar affects:</b> Labeling, food storage and sanitation will be review with Dinign Services Coordinator to verify standards have been met to meet regulatory compliance.</p> <p><b>3. Systematic changes:</b> The DSC will be reeducated by the ED on the storage, labeling, and ice machine sanitation standards. The DSC will be responsible for completing weekly</p>	06/01/2016

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	<p>2. One package of opened cubed cheese in the refrigerator with no open date. The DM indicated the food should all have an open date and an expiration date.</p> <p>3. A drink pitcher of tea in the refrigerator with a preparation date of 5/22/16. The DM indicated the tea should have been thrown out yesterday.</p> <p>4. A standing mixer and a deli slicer were uncovered on a countertop. The DM indicated the deli slicer has not been in use for over a month. He did not deny there was a potential for contamination.</p> <p>5. A package of frozen food with no identifying label or discard date. The DM indicated it was a package of frozen chicken patties.</p> <p>6. Four oval shaped breaded items wrapped in plastic wrap with no identifying label or discard date. The DM indicated they were chicken cordon bleu. He did not deny the food should be labeled.</p> <p>7. A cleaning bucket with sanitizing solution was tested to have a chemical level of 150 ppm. The DM indicated the solution should be at 200 ppm, however, he had not changed the solution since</p>		<p>audits for verification that all food/drink is properly labeled and stored, and will complete a weekly audit form. This will be immediate and ongoing to ensure regulatory standards are being met.</p> <p><b>4. Monitoring Q and A plan:</b> The DSC will be responsible for weekly updates and audits of food storage, labeling, and ice machine sanitation. The DSC will complete weekly audits to verify company's with regulatory standards. The audit firm will be provided to the ED who will be responsible for directing additional actions.</p> <p>5. Date of compliance: 6/1/2016</p>	

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R 0300  Bldg. 00	<p>7:30 a.m.</p> <p>On 5/27/16 at 11:56 a.m., the Administrator provided the facility's policy, "Labeling," revised 5/10, and indicated it was the policy currently being used by the facility. The policy indicated, "... 2. All prepared items ... must have a label with the name of item, date prepared, by whom, and date of discard. ..."</p> <p>On 5/31/16 at 10:24 a.m., a review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT MANUAL: 410 IAC 7-24-180," dated November 13, 2004, indicated, " .... Food Labels... (b) Label information shall include the following: (1) The common name of the food ... adequately descriptive identity statement ..."</p> <p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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.</p>	R 0300	#R300 PharmaceuticalServices <b>1. Corrective Action:</b>	06/01/2016

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	<p>Based on observation, interview, and record review, the facility failed to ensure a Humalog (multi-dose insulin pen) included an open date as indicated by facility policy for 1 of 1 resident observed during a medication administration. (Resident #8)</p> <p>Findings include:</p> <p>During medication observation on 5/27/2016 at 11:45 a.m., License Practical Nurse (LPN) #1 was observed to load 10 units of insulin onto an already opened Humalog insulin pen, and administer to Resident #8. No open date was observed on the Humalog insulin pen.</p> <p>Physician's order dated 5/1/2016-5/31/2016 indicated, Resident #8's medications included, but were not limited to Humalog (insulin) 100 units/milliliter (ML), inject 6 units three times a day before meals, and Humalog 100 units/ML per sliding scale (based on blood sugar).</p> <p>During an interview on 5/27/2016 at 11:48 a.m., LPN #1 indicated she didn't know when the insulin was delivered, but she believed it was around the first of May. She further indicated the insulin pen was good for approximately 28 days</p>		<p>There have not been any negative outcomes because of the failure to ensure proper labeling of open dates upon opening a multi-dose container.</p> <p><b>2. How to identify other storage and labeling issues with potential for similar affects:</b> Health and Wellness Director (HWD) will complete an audit insulin containers to ensure open containers are dated. HWD will provide ED with audit compliance of containers. The audit will be ongoing to verify regulatory standards are being met.</p> <p><b>3. Systematic changes:</b> The HWD will review insulin policy and will be responsible for completing weekly audits for verification that all open insulin containers are dated. This will be immediate and ongoing to ensure regulatory standards are being met.</p> <p><b>4. Monitoring Q and A plan:</b> The HWD will be responsible for weekly audits of insulin open dates. The HWD will complete weekly audits to verify regulatory standards are being met. The audit form will be provided to the ED who will be responsible for directing additional actions.</p> <p>5. Date of Compliance: 6/1/2016</p>				

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R 0410 Bldg. 00	<p>after it had been opened.</p> <p>During an interview on 5/27/2016 at 11:55 a.m., LPN #1 indicated she contacted the pharmacy and the pharmacy indicated 5 Humalog pens were sent on 2/22/2016. There were currently 3 Humalog pens left in the medication cart. LPN #1 indicated the unopened Humalog pen had 300 units of insulin in it, but there is no way to tell how much is left once the insulin pen has been used.</p> <p>On 5/27/2016 at 12:30 p.m., LPN #1 provided the policy "Medication and Treatment-Administration Assistance" with a revised date of 10/2015, and indicated it was the one currently being used by the facility. The policy indicated, "...6 ...When opening a multi-dose container, place the date opened on the container ..."</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)</p>						

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	<p>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.</p> <p>(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 two-step tuberculin skin test was completed prior to or upon admission for 1 of 7 residents reviewed for completion of tuberculin (TB) health screening. (Resident #4)</p> <p>Findings include:</p> <p>On 5/27/16 at 9:12 a.m., Resident #4's clinical record was reviewed. The resident was admitted on 11/1/15.</p> <p>Resident #4's clinical record indicated a tuberculin skin test was administered on 11/1/15 and read on 11/4/15. The resident's clinical record lacked documentation of a second step tuberculin skin being completed.</p> <p>On 5/27/16 at 10:23 a.m., the Administrator indicated Resident #4 did not have a second tuberculin skin test completed.</p>	R 0410	<p>#R410 InfectionControl</p> <p><b>1. CorrectiveAction: Food and Nutritional Services</b></p> <p>There have not been any negativeoutcomes because of the failure to ensure resident #4 completion of tuberculinskin test was complete. Residentreceived TB skin test series. TBSurveillance form has been completed by the registered nurse and the residentwas found to be asymptomatic for risk factors at this time.</p> <p><b>1. Howto identify other personnel with the potential for similar events:</b></p> <p>Other residents have the potential to beaffected by the alleged deficient practice. The Health and Wellness Director (HWD) will complete an audit ofresident records to verify other residents have received TB testing as requiredupon move-in.</p> <p><b>2.Systematic Changes</b></p> <p>The HWD/designee will be re-educated on theTB testing</p>	06/01/2016			

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	On 5/27/16 at 11:54 a.m., the Administrator provided the facility policy, "Tuberculosis Screening/Testing Policy," dated 7/1/03, and indicated it was the policy currently being used by the facility. The policy indicated, ".... For residents who have not had a documented negative TB skin test during the preceding 12 months, the baseline TB shall employ the 2-step method. If the 1st step is negative, a 2nd step shall be performed within 1-3 weeks after the 1st test ..."		requirements for new residents and the use of a monthly schedule for new and existing residents, which will indicate monthly due dates for TB tests. The audit tool will be monitored monthly by the ED to verify compliance with regulatory standards.  <b>3. Quality Assurance</b> The HWD will be responsible for ensuring all initial and annual TB testing is completed for new and current residents. The HWD will provide audit results to the ED on a monthly basis and the ED will be responsible for directing additional actions.  4. Date of compliance: 6/6/2016				