

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/08/2016
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE HEALTH CENTER AND ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey. This visit included the Investigation to Complaint IN00201439.</p> <p>Complaint IN00201439 - Unsubstantiated- due to lack of evidence.</p> <p>Survey dates: August 1, 2, 3, 4, 5, and 8, 2016</p> <p>Facility number: 003673 Provider number: 155725 AIM number: 200450890</p> <p>Census bed type: SNF/NF: 2 SNF: 28 Residential: 29 Total: 59</p> <p>Census payor type: Medicare: 15 Medicaid: 2 Other: 13 Total: 30</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>This Plan of Correction is prepared and executed because it is required by provisions of the State and Federal Law, and not because University Place, Inc. agrees with the allegations contained therein. University Place maintains that each deficiency does not jeopardize the health and safety of its residents, nor is it of such character as to limit our capability to provide adequate care. University Place, Inc. respectfully requests that paper compliance be considered for this Plan of Correction.</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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F 0157 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on August 11, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p>			

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	<p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to notify the physician and the family of a change in skin condition for 1 of 2 resident reviewed for notification. (Resident #66).</p> <p>Findings include:</p> <p>The record for Resident #66 was reviewed on 8/4/16 at 9:36 a.m. Diagnoses included, but were not limited to, sepsis, urinary tract infection, enterocolitis due to Clostridium difficile.</p> <p>A clinical note dated 3/13/16 at 10:42 a.m., indicated Mepilex (foam dressing) was applied to the coccyx as a preventative measure. The skin was noted to be reddened and intact.</p> <p>A clinical note dated 3/16/16 at 10:22 a.m., indicated the dressing was applied to the reddened buttock and superficial skin loss was noted. Documentation did not indicate notifications were made to physician or family.</p>	F 0157	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The resident no longer resides at the facility. The physician is aware of the concern.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents with skin conditions have the potential to be affected. The wound nurse or designee will review documentation of residents with skin conditions and update physician and responsible parties when there is a decline in condition.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The wound nurse or designee is to provide skin log to the physician weekly for review. Education will be provided to nurses related to notification of skin condition changes to the physician and responsible parties by August 30, 2016.</p>	09/07/2016

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	<p>A clinical note dated 3/17/16 at 1:06 p.m., indicated Mepilex was applied to the coccyx, area which was reddened with superficial skin loss without drainage. Documentation did not indicate notifications were made to physician or family.</p> <p>A clinical note dated 3/18/16 at 8:17 a.m., indicated the coccyx appears red and raw with superficial skin loss. Documentation did not indicate notifications were made to physician or family.</p> <p>A clinical note dated 3/22/16 at 11:18 a.m., indicated Mepilex was applied to the buttocks with reddened skin and superficial skin loss. Documentation did not indicate notifications were made to physician or family.</p> <p>A current policy titled "Skin Integrity Policy" received from the Director of Nursing on 8/5/16 at 5:00 p.m., indicated "...All skin injuries will be documented weekly and reported to the physician for treatment, if necessary. Family and/or responsible party will be notified...."</p> <p>3.1-5(a)(2)</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will utilize a monitoring tool for submission (See Exhibit A) of weekly skin condition logs to the attending physician and responsible party notification when there is a decline in skin condition. This will be accomplished five (5) days per week by reviewing resident skin condition sheets for six (6) weeks, then two (2) times per week for four (4) weeks. This will be reported to the QAPI Committee monthly until compliance is met and then remain on ongoing observation for QAPI review.</p> <p>By what date will the systematic changes be completed: September 7, 2016</p>				

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and record review the facility failed to promote independence in dining and failed to ensure the resident could dine in a dignified manner for 1 of 4 residents observed in dining (Resident #10).</p> <p>Findings include:</p> <p>During dining observation on 8/02/16, the following observations were made:</p> <p>At 12:17 p.m. Resident #10 was sitting in a Broda chair. The chair alarm sounded as the resident moved his arms to reach for his drink.</p> <p>At 12:18 p.m. Resident #10 was attempting to eat on his own, the Broda chair would not fit under the table and Resident #10 was unable to reach his plate.</p> <p>At 12:19 p.m. Resident #10's chair alarm sounded as he tried to reach his drink.</p>	F 0241	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The resident no longer resides at the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents consuming meals in the health center dining room with specialty chairs have the potential to be affected. Therapy will screen residents in specialty chairs for appropriate positioning needs with the results provided to nursing to update individual resident plans of care.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>The DON or designee will conduct an in-service on August 30, 2016 stressing the importance of appropriate positioning of residents during meals to ensure dignity and</p>	09/07/2016	

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	<p>At 12:20 p.m. Resident #10 reached forward to take a bite of food, then leaned back in chair. His chair was in a reclined position.</p> <p>At 12:23 p.m. Resident #10 leaned forward to get a bite of food, then leaned back while he chewed his food. Resident #10 was unable to reach the dining table without leaning forward and staff did not assist to reposition the resident's chair.</p> <p>At 12:24 p.m. Resident #10 leaned forward to grab his drink, then leaned back in the chair.</p> <p>At 12:25 p.m. Resident #10 leaned forward to pick up his cup, leaned back and took a drink then leaned forward to put his cup back on the table.</p> <p>The record for Resident #10 was reviewed on 8/03/16 at 9:41 a.m. Diagnoses included but were not limited to, dementia without behavioral disturbance and dysphagia.</p> <p>A current policy titled "Resident Dining Assistance" received from the Director of Nursing on 8/5/16 at 5:00 p.m., indicated "...Assistance will be provided to residents as needed to promote independence and adequate nutrition. Approaches may include the</p>		<p>promotion of independence while dining.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DON or designee will monitor compliance utilizing a tool (See Exhibit B) for resident positioning during meal consumption in the dining room for five (5) meals per week for four (4) weeks, and then three (3) meals per week for four (4) weeks. This will be reported to the QAPI Committee monthly until compliance is met and then remain on ongoing observation for QAPI review.</p> <p>By what date will the systematic changes be completed: September 7, 2016</p>				

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F 0309 SS=E Bldg. 00	<p>following:...Resident will be positioned properly in chair...."</p> <p>3.1-3(t)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview the facility failed to ensure residents with dementia were assisted at meal time to promote a meaningful and helpful meal experience for 4 of 30 residents eating in the main dining area. (Residents #10, #15, #22 and #33)</p> <p>Findings include:</p> <p>During an observation of the Main Dining Area on 08/01/16 at 11:34 a.m., the following were observed:</p> <p>Residents #22 and #33 were sitting at the same table. Residents #10 and #15 were sitting at the next table. CNA (certified</p>	F 0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents #10, #15, #22 & #33 were reviewed for appropriate dining interventions and their plans of care were updated to indicate so. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with dementia have the potential to be affected while assistance is provided in the health center dining room. What measures will be put into place or what systemic changes will be made to</p>	09/07/2016	

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	<p>nursing assistant) #2 was observed to be assisting these four residents with dining.</p> <p>CNA #2 was observed to be assisting all four residents to eat and was moving back and forth between the two tables and no individual attention was observed during dining. CNA #2 continued to assist all four residents in this manner throughout the dining observation. .</p> <p>The record for Resident #10 was reviewed on 8/03/16 at 9:41 a.m. Diagnoses included but were not limited to, dementia without behavioral disturbance and dysphagia. (swallowing difficulty)</p> <p>The record for Resident #15 was reviewed on 8/03/16 at 2:33 p.m. Diagnoses included but were not limited to, dementia without behavioral disturbance.</p> <p>The record for Resident # 22 was reviewed on 8/05/16 at 2:28 p.m. Diagnoses included but were not limited to, dementia without behavioral disturbance and dysphagia.</p> <p>The record for Resident #33 was reviewed on 8/03/16 at 11:10 a.m. Diagnoses included but were not limited to dementia without behavioral</p>		<p>ensure that the deficient practice does not recur: The DON or designee will conduct an in-service by August 30, 2016 stressing the importance of dignity during mealtime and provision of individual assistance with resident meal consumption. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will monitor compliance using a tool (See Exhibit B) for resident meal assistance and employee engagement with residents in the health center dining room for five (5) meals per week for four (4) weeks, and then for three (3) meals per week for four (4) weeks. This will be reported to the QAPI Committee monthly until compliance is met and then remain on ongoing observation for QAPI review. By what date will the systematic changes be completed: September 7, 2016.</p>		

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F 0371 SS=F Bldg. 00	<p>disturbance.</p> <p>During an interview on 8/04/16 at 12:59 p.m. with a resident's family member, the family member indicated dining was a problem and has voiced this concern with administration. The concern was there is not enough staff to assist with dining. The family member stated some family would like to have meals in the dining room with their relatives but there is not enough room. The family member stated meals are very important and it is not just space, there is a shortage of personnel. Usually only two CNA's assist with dining and with all the residents that need help there should be more staff in the dining room.</p> <p>A current policy titled "Resident Dining Assistance" received from the DON on 8/5/16 at 5:00 p.m., indicated "...It is the policy of the community to provide assistance to residents that need assistance with consuming meals..."</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>			

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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to ensure foods were dated when opened in 1 of 1 kitchens. This deficient practice had the potential to affect 30 out of 30 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 8/01/16 at 9:12 a.m., with the General Manager of Dining, the following observation was made.</p> <p>The dry storage area was observed to have three bags of dry pasta opened and not dated.</p> <p>During an interview on 8//01/16 at 9:30 a.m. The General Manager of Dining indicated all foods should be dated when opened.</p> <p>A current policy titled "Food Storage and Handling" received from the General Manager of Dining on 8/2/16 at 9:15 a.m., indicated "...Procedure: Dating System For Open Foods...Using a LABEL, complete the following: Write</p>	F 0371	<p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The unlabeled items were discarded by the DiningServices Manager during the survey. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. TheDining Services Manager or designee will conduct an in-service for all diningservices staff at the facility regarding the labeling and dating policy. Inaddition, as part of the daily stand-up meeting before meals at least once perweek the Executive Chef or designee will discuss the labeling and datingpolicy. The policy will also be covered during dining service employeeorientation.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: The Dining Services Manager or designee will conductan in-service for all dining services staff at the facility regarding</p>	09/07/2016

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F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease		the labeling and dating policy by August 30, 2016. In addition, as part of the daily stand-up meeting before meals at least once per week the Executive Chef or designee will discuss the labeling and dating policy. The policy will also be covered during dining service employee orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Chef or designee will check the food storage areas daily to ensure that all the items are dated appropriately. The Dining Services Manager or designee will monitor compliance utilizing a tool (See Exhibit C) for accurate date placement. This will be accomplished five (5) days per week for six (6) weeks and then two times per week for four (4) weeks. This will be reported to the QAPI Committee monthly until compliance is met and then remain on ongoing observation for QAPI review. By what date will the systematic changes be completed: September 7, 2016	

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	<p>and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to ensure staff washed their hands and used gloves during dining for 1 of 1 dining observation. (Resident #10, #15, #22, and #33)</p> <p>Findings include:</p>	F 0441	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: C.N.A. #2 will be provided individual education related to handwashing and appropriate glove use. How other residents having the potential to be affected by the</p>	09/07/2016

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	<p>During an observation of the Main Dining Area on 08/01/16 at 11:34 a.m., the following were observed:</p> <p>Residents #22 and #33 were sitting at the same table. Residents #10 and #15 were sitting at the next table. CNA#2 was observed to be assisting with dining.</p> <p>CNA #2 was observed giving Resident #10 one half of his sandwich with her bare hands and no handwashing observed.</p> <p>CNA #2 gave Resident #33 a bite of food, then gave Resident # 22 a bite of food and no handwashing observed.</p> <p>CNA#2 wiped Resident #22's mouth with a cloth napkin and then gave Resident #33 a bite of food without using handgel or washing her hands.</p> <p>During an interview on 8/03/16 at 11:09 a.m., the Director of Nursing indicated all staff are trained on handwashing policy/procedure during onboarding. She also indicated staff assisting multiple residents in the dining room should sanitize their hands and staff should use gloves to touch a sandwich.</p> <p>A current policy titled " Standard</p>		<p>same deficientpractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected whenassistance is provided while they are consuming meals in the main dining roomof the health center.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: The DON or designee will conduct in-service byAugust 30, 2016 stressing the importance of hand washing, sanitizing, and gloveusage while assisting residents with meal consumption.</p> <p>Howthe corrective action(s) will be monitored top ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: The DON or designee will monitor compliance using atool (See Exhibit B) for handwashing/sanitizing and resident meal assistancewith residents in the health center dining room for five (5) meals per week forfour (4) weeks, and then three (3) meals per week for four (4) weeks. Therresults will be reported to the QAPI Committee monthly until compliance is metand then remain on ongoing observation for QAPI review.</p> <p>Bywhat date will the systematic changes be completed: September 7, 2016</p>	

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R 0000 Bldg. 00	<p>Precautions" received from the Director of Nurses on 8/5/16 at 5:00 p.m., indicated "... Handwashing...2. Wash hands immediately after gloves are removed, between resident contacts and when otherwise indicated to avoid transfer of microorganisms to other residents or environments...."</p> <p>A current policy titled "Safety and Sanitation" received from the Director of Nursing on 8/5/16 at 5:00 p.m., indicated "...Glove Usage Description: disposable gloves shall be utilized as necessary during food service operations when handling ready to eat foods and when preparing food for use...."</p> <p>3.1-18(l)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 29</p> <p>Sample: 8</p>	R 0000	<p>This Plan of Correction is prepared and executed because it is required by provisions of the State and Federal Law, and not because University Place, Inc. agrees with the allegations contained therein. University Place maintains that each deficiency</p>	

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R 0117 Bldg. 00	<p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by 21662 on August 11, 2016.</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 (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 met</p>	R 0117	<p>does not jeopardize the health and safety of its residents, nor is it of such character as to limit our capability to provide adequate care. UniversityPlace, Inc. respectfully requests that paper compliance be considered for thisPlan of Correction.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen</p>	09/07/2016	

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	<p>requirements of First Aid training and certification. This deficient practice affected 2 of 15 shifts reviewed and had the potential to affect 29 of 29 residents residing in the facility.</p> <p>Findings include:</p> <p>During a review of staff schedules on 8/8/16 at 9:45 a.m., with the Director of Resident Services, CPR and First Aid certification was assessed for the week of 8/1/16 through 8/5/16. On Thursday, 8/4/16, no staff member with First Aid certification was located on the campus during the shift of 6 p.m. to 7 a.m. On Friday, 8/5/16, no staff member with First Aid certification was located on the campus during the shift of 6 p.m. to 7 a.m.</p> <p>During an interview with the director of Resident Services on 8/8/16 at 1:00 p.m., she indicated she was not aware that First Aid certification was required for the Assisted Living area.</p>		<p>affected by the deficient practice: Nurses, who are not currently certified in first aidtraining, will receive training to achieve certification. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: Certified First Aid Training will be held andcompleted by August 26, 2016 to include a sufficient number of nursing staff toachieve 24-hour first aid certificate daily coverage in the building. As a partof the onboarding process, all new nurses will be required to be certified inCPR/First Aid or take a certification course upon being hired. Current nurseswill either receive a CPR/First Aid certification or a renewal of their currentcertification when as required. The daily staffing sheets will note theCPR/First Aid certifications. Howthe corrective action(s) will be monitored top ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place: The DON or designee will monitor compliance with a tool (See Exhibit D) byreviewing the daily staffing</p>		

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R 0273 Bldg. 00	<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, record review and interview, the facility failed to dispose of expired food in 1 of 1 kitchens. This deficient practice had the potential to affect 29 of 29 residents who receive food from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 8/01/16 at 10:14 a.m., with the General Manager of Dining the following observation was made:</p> <p>The refrigerator had 10 containers of yogurt with prepared date of 7/28/16 and use by date of 7/31/16.</p> <p>During an interview on 8/01/1/6 at 10:15</p>	R 0273	<p>sheets for CPR/First Aid certified staff weeklyfor four (4) weeks and then monthly for four (4) months. The results will bereported to the QAPI Committee monthly until compliance is met and then remainon ongoing observation for QAPI review. Bywhat date will the systematic changes be completed: September 7, 2016</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The expired items were discarded by the DiningServices Manager during the survey. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. TheDining Services Manager or designee will conduct an in-service for all diningservices staff at the facility regarding the labeling, dating and disposal ofexpired food items policy. In addition, as part of the daily stand-up meetingbefore meals at least once per week the Executive Chef or designee will discussthe labeling, dating and</p>	09/07/2016	

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	<p>a.m., the General Manager of Dining indicated the yogurt containers should have been thrown away.</p> <p>A current policy titled "Food Storage and Handling " received from the General Manager of Dining on 8/2/16 at 9:15 a.m., indicated "...Check labels daily and discard out-dated food!...."</p>		<p>disposal of expired food items policy. The policy will also be covered during dining service employee orientation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Dining Services Manager or designee will conduct an in-service for all dining services staff at the facility regarding the labeling, dating and disposal of food items policy by August 30, 2016. In addition, as part of the daily stand-up meeting before meals at least once per week the Executive Chef or designee will discuss the labeling, dating and disposal of expired food items policy. The policy will also be covered during dining service employee orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Chef or designee will check the food storage areas daily to ensure that all the items are dated and disposed of whenever appropriate. The Dining Services Manager or designee will monitor compliance utilizing a tool (See Exhibit C) for accurate date placement. This will be accomplished five (5) days per week for six (6) weeks and then two times per week for four (4) weeks. This will be reported to</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: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on observation,interview and record review, the facility failed to dispose of expired medications within the recommended pharmaceutical guidelines in 1 of 2 medication carts reviewed. (Resident #110)</p> <p>Finding include:</p> <p>During a medication storage review with LPN #1 on 8/8/16 at 9:30 a.m., in the medication cart on the Assisted Living</p>	R 0306	<p>the QAPI Committeemonthly until compliance is met and then remain on ongoing observation for QAPIreview. Bywhat date will the systematic changes be completed: September 7, 2016.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The expired medications were destroyed on the dateof discovery per facility protocol. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: A review of medications in residential medicationstorage areas</p>	09/07/2016

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	<p>area, a Humalog (insulin) pen was found to be opened on 7/9/16, according to guidelines the pen had expired on 7/23/16.</p> <p>A vial of Lantus (insulin) was found in the cart with an opened date of 7/10/16, the expiration date on the vial was 8/6/16.</p> <p>A review of physician orders on 8/8/16 at 10:30 a.m. for Resident #110 indicated the Resident had an order for Humalog to be given subcutaneously based on blood sugar results four times daily. The order was written on 3/19/16. Resident #110 also had an order for Lantus insulin 18 units subcutaneously every morning, written on 7/13/16.</p> <p>A review of the Medication Administration Record (MAR) and the Glucose Monitoring Sheet on 8/8/16 obtained from LPN#1, the Resident received the following doses of Humalog and Lantus:</p> <p>8/5/16: 2 units of Humalog at bedtime. 8/6/16: 2 units of Humalog at bedtime. 8/7/16: 4 units of Humalog at 11:00 a.m. and 2 units of Humalog at bedtime. 8/7/16: 18 units of Lantus at 6:00 a.m.</p> <p>During an interview with the Director of Resident Services on 8/8/16 at 1:00 p.m.,</p>		<p>inspected showed no additional findings. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DON or designee will conduct an in-service related to discovery and disposal of expired medications along with the discussion of medication storage recommendations. Upon opening insulin or any other medication with an expiration date, a "destroy by" date will be noted on the container. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will monitor compliance utilizing a tool (See Exhibit E) for review of medication expiration and timely destruction of medications three (3) times weekly for four (4) weeks, and then two (2) times weekly for four (4) weeks, and then weekly for four (4) weeks. This will be reported to the QAPI Committee monthly until compliance is met and then remain on ongoing observation for QAPI review. By what date will the systematic changes be completed: September 7, 2016.</p>		

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	<p>she indicated all expired medications should be disposed according to community policy.</p> <p>A review of Insulin Storage Recommendations with a revision date of 5/7/13, received from Director of Resident Services on 8/8/16 at 12:45 p.m., indicated Humalog has an expiration date of 28 days when opened and at room temperature. An opened vial of Lantus at room temperature expired after 28 days.</p> <p>The current policy for "Expiration Dating", received from the Director of Resident Services on 8/8/16 at 12:45 p.m., indicated "...Purpose: To insure the community strictly adheres to the expiration dating established by the pharmacy committee. Procedure...4. It is the responsibility of all nurses who administer medications to monitor the expiration dates of the medications. Expired medications will not be administered in the community. All expired medications will be disposed per community policy...."</p>			