

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 07/14/2015
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NAME OF PROVIDER OR SUPPLIER BROOKDALE EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 6521 GREENDALE DR EVANSVILLE, IN 47711
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 13 and 14, 2015</p> <p>Facility number: 010681 Provider number: 010681 AIM number: NA</p> <p>Census bed type: Residential: 31 Total: 31</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</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 0120 Bldg. 00	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance</p> <p>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice</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>education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure education and inservice training was provided for 2 (two) of 5 (five) employees reviewed for dementia training and 3 (three) of 5 (five) employees reviewed for abuse training; the dementia training and abuse training inservices were not completed. (HWD (Health Wellness Director), RN #1, CNA #1, CNA #2, CNA #3)</p> <p>Findings include:</p>	R 0120	<p>#R120</p> <p>1. Corrective Action for Affected Personnel:</p> <p>There have been no apparent negative outcomes because of delayed dementia and abuse training for 5 personnel. The 5 cited associates will complete the required training on or before August 10, 2015. This training will</p>	08/03/2015

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	<p>1. During record review on 7/13/15 at 10:45 a.m., the employee files indicated the HWD was hired on 2/14/14. The employee file indicated the HWD had not completed the yearly Dementia training.</p> <p>2. During record review on 7/13/15 at 10:45 a.m., the employee files indicated RN #1 was hired on 5/9/12. The employee file indicated RN #1 had not completed the yearly Dementia training.</p> <p>3. During record review on 7/13/15 at 10:45 a.m., the employees files indicated CNA #1 had not completed the Abuse training. The file indicated CNA #1 had been hired on 2/9/15.</p> <p>4. During record review on 7/13/15 at 10:45 a.m., the employees files indicated CNA #2 had not completed the Abuse training. The file indicated CNA #2 had been hired on 4/23/15.</p> <p>5. During record review on 7/13/15 at 10:45 a.m., the employees files indicated CNA #3 had not completed the Abuse training. The file indicated CNA #3 had been hired on 10/10/14.</p> <p>During an interview on 7/13/15 at 3:58 p.m., the Adm (Administrator) indicated training should have been completed.</p>		<p>be provided by the Health and Wellness Director (HWD), Nurse Designee, or other appropriately trained associates.</p> <p>2. How to identify other personnel with potential for similar events: Personnel files will be audited by the Executive Director /Business Office Manager or other designee to verify required training has been completed to meet regulatory standards.</p> <p>3. Systemic Changes: The Business Office Manager has been re-educated by the Executive Director (E.D.) on the training requirements and the log that will be used for tracking purposes. Each employee will receive a sign in log with date, time, location, name of instructor, title of instructor, names of participants, program content and will be signed by each employee when each program is completed. The Business Office Manager/Designee will be responsible for verification that training has been completed within the appropriate time frame, and that the appropriate documentation has been completed. This change</p>	

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R 0121 Bldg. 00	<p>A form titled, "Indiana Associate Training Requirements" dated 1/2014 and obtained from the Adm on 7/14/15 at 9:57 a.m., indicated direct care associates were required to have 3 (three) hours of dementia care annually beginning the year following the employee's date of hire.</p> <p>A form titled, "Indiana Associate Training Requirements" dated 1/2014 and obtained from the Adm on 7/14/15 at 9:57 a.m., indicated the employee should have abuse training prior to working independently at the facility</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>will be immediate and ongoing to verify that regulatory standards are met.</p> <p>4. Monitoring Q.A. plan: The Business Office Manager (BOM)/Designee will be responsible for weekly updates of the training log for associates. The BOM will complete monthly audits of personnel files to verify compliance with regulatory training. A report will be provided to the E.D. who will be responsible for directing additional actions, based on QA findings.</p> <p>5. Date of compliance: 8-3-15</p>				

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	<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 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 tuberculin (TB) skin tests were completed for 2 (two) of 5 (five) staff members reviewed for TB skin tests, 2 employees had not received the second step skin test. (CNA #1, CNA #2)</p> <p>Findings include:</p>	R 0121	<p>#R121</p> <p>1. Corrective Action: Personnel C.N.A. #1 and C.N.A. #2 received completed tuberculin skin tests and no negative outcomes are noted. TB Surveillance form completed by the Health and Wellness Director/Licensed nurse designee reveals both to be asymptomatic.</p> <p>2. How to identify other personnel with the potential for</p>	08/03/2015

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	<p>1. During record review on 7/13/15 at 1:10 p.m., CNA #1 had a hire date of 2/9/15. The employee file for CNA #1 did not have a second step for the tuberculin test completed upon employment.</p> <p>2. During record review on 7/13/15 at 1:10 p.m., CNA #2 had a hire date of 4/23/15. The employee file indicated CNA #2 did not have a second step tuberculin skin test completed upon employment.</p> <p>During an interview on 7/13/15 at 1:55 p.m., the Adm (Administrator) indicated the facility overlooked the second step for the tuberculosis skin tests for both employees,</p> <p>A policy titled, "Tuberculosis Exposure Control Plan Policy - Associates" effective 4/1/1997 and obtained from the Adm indicated the initial screening should be completed using the two-step tuberculin skin test.</p>		<p>similar events: The Business Office Manager (BOM) will audit personnel records to verify other associates have completed a tuberculin skin test as per regulations; other associates audited were found to be up to date with documentation present and recorded. New hires will be reviewed for TB testing needs prior to their start dates, and will be assigned for the appropriate two step schedule and annual testing by the BOM. BOM will notify the appropriate department head when additional testing is required.</p> <p>3. The Business Office Manager/Designee will be re-educated on the TB testing requirements and the use of a tickler file for tracking Mantoux tests for new and existing associates. This tool will indicate monthly due dates for tuberculin skin tests. This audit tool will be monitored monthly by the BOM/Designee to verify compliance with regulatory standards.</p> <p>4. The Business Office Manager/Designee will provide with a list of department associates requiring annual TB testing to each department manager <i>a month prior</i> to the due date, so that appropriate notice may be given to the associate to obtain the required testing at the assigned date, time and location. In the event the associate fails to</p>	

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R 0217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p>		<p>report for the required testing prior to the due date, they will be taken off the schedule until they are back in compliance. The BOM will provide audit results to the ED on a monthly basis, and the ED will be responsible for determining additional corrective actions, based on QA findings.</p> <p>5. Date of compliance: 8-3-15</p>	

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	<p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure 1 (one) of 7 (seven) residents had a signed service plan, the service plan was developed but never signed by the resident or responsible party. (Resident #1)</p> <p>Findings include:</p> <p>During the initial tour of the facility on 7/13/15 at 8:15 a.m., the SMM (Sales/Marketing Manager) indicated Resident #1 was interviewable.</p> <p>During a interview on 7/13/15 at 9:25 a.m., Resident #1 indicated he had not participated in his service plan agreement.</p> <p>The clinical record for Resident #1 was reviewed on 7/13/15 at 10:30 a.m. The clinical record indicated Resident #1 was admitted to the facility on 3/28/15. Resident #1 had clinical diagnoses including, but not limited to, diabetes mellitus type 2 (two), hypertension, hyperlipidemia, arteriosclerotic cardiovascular disease, diabetic neuropathy, and reactive depression.</p>	R 0217	<p>R217</p> <p>1. Corrective Action: Resident Service Plan:</p> <p>The Personal Service Plan for Resident #1 was reviewed with the resident by the HWD/ED and presented for signature. No harm or lack of service was noted to have occurred.</p> <p>2. How to identify other Residents with potential for similar events:</p> <p>Current resident files will be audited by the HWD/Licensed Nurse Designee to check for the presence of signatures for all Personal Service Plans completed in the last 30 days . The Health/Wellness Director will follow up with families that have not responded to the requests for signatures and reviews of Personal Service Plans.</p>	08/10/2015

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	<p>Resident #1 had signed the following admission documents on 3/20/15, which included, but was not limited to, "Personal Belongings Form, "Resident Rights, "Undercooked Foods," "Authorization For Release of Brookdale Health Care Records," " Resident Orientation Move-In Checklist," "Resident/Associate Photographic/Media/Written Statement Authorization and Release," and a statement indicating the resident had received a copy of the "Indiana Law Concerning Advance Directives".</p> <p>A service plan agreement, dated 4/2/15, for Resident #1 was observed in the resident's clinical record. The service plan had not been signed by the resident or responsible party of the resident.</p> <p>During an interview on 7/13/15 at 11:10 a.m., the HWD (Health Wellness Director) indicated the resident had not signed the service plan agreement. The HWD indicated he had sent a copy of the service agreement to the resident's POA (Power of Attorney) on 4/2/15, but the POA had never returned the signed agreement. The HWD indicated he had not followed up with the resident or the POA regarding having the service plan agreement signed. Upon query, the HWD indicated the resident had not had</p>		<p>3. Systemic Changes:</p> <p>The Health/Wellness Director and Executive Director will create a tickler system that will serve as a reminder to follow and check for signatures within thirty days of completion of personal service plan. If resident or responsible party is unable to sign, then this conversation will be documented on the Personal Service Plan signature area by the HWD to indicate the care plan meeting has been offered. A letter will be sent to those responsible parties with a self-addressed stamped envelope provided for their return of signed document. A copy of this letter will be kept with each Personal Service Plan for those residents/ responsible parties who have not signed. Signed PSP's will be placed in the resident record in the same tab as the Personal Service Plan.</p> <p>4. Monitoring Q.A. Plan:</p> <p>The Executive Director/Designee will be responsible for monitoring Resident Personal Service Plan audit tool on a monthly basis to verify compliance. Additional corrective action will be determined by the E.D., based on audit findings.</p>	

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	<p>a cognitive change. Upon further query, the HWD indicated the resident could have signed the service plan agreement.</p> <p>A policy titled, "Personal Service Plan" effective 6/1/1997 and obtained from the Adm on 7/14/15 at 9:57 a.m., indicated the resident or legally responsible party should sign the Personal Service Plan.</p>		5. Date of compliance: 8-10-15		