

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 07/08/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE ON OLD MERIDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 12130 OLD MERIDAN ST CARMEL, IN 46032
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 6, 7, and 8, 2015</p> <p>Facility Number: 012141 Provider Number: 012141 AIM Number: NA</p> <p>Census bed type: Residential: 79 Total: 79</p> <p>Census payor type: Private: 79 Total: 79</p> <p>Sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000		
R 0121 Bldg. 00	<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>			

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>(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 new personnel were screened for Tuberculosis (TB) using the two-step procedure skin test and failed to ensure present employee received annual assessment in lieu of TB testing for 2 of 10 employees reviewed for TB screening. (Employee #5 and Employee #6)</p>	R 0121	6/10/2015	08/15/2015

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	<p>Finding include:</p> <p>1. During a review of Employee # 5's health records on 7/7/15 at 3:30 p.m., the records indicated a hire date of 4/16/15, a first step skin test was completed. No second step skin test was completed.</p> <p>2. During a review of Employee # 6's health records on 7/8/15 at 10:00 a.m., the records indicated a chest x-ray was completed in 2013. No annual assessments were available for review.</p> <p>During an interview with The Business Office Coordinator on 07/08/15 at 10:30 a.m., she indicated she was not aware of the regulation regarding annual assessments.</p> <p>Policy review completed on 07/07/15 at 3:45 p.m., indicated "Tuberculosis Screening & Post-Exposure Protocols for Team Members" dated 06/09, "All Sunrise Senior Living Communities will provide tuberculosis screening and diagnostic measures as needed for all existing and potential team members...Section 1-TB testing... Process...2 Administration of the Mantoux Test (TST) for team members will be conducted in accordance with state regulations...."</p>		<p>7/14/2015</p> <p>August 15, 2015</p> <p>7/15/2015</p>				

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			<p>7/9/2015 and on going</p> <p>Employee #5 completed a 2 step skin test for tuberculosis on 06/10/2015 and is free of active tuberculosis disease.</p> <p>Employee #6 completed a chest x-ray test for tuberculosis on 07/14/2015 and is free of active tuberculosis disease.</p> <p>The Business Office Coordinator (BOC) and Executive Director (ED) will conduct an audit of team member files for evidence of required testing results that demonstrate they are free from active</p>	

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			<p>tuberculosis as required in 410 IAC 16.2-5-1.4(f)(1-4). The Business Office Coordinator (BOC) was retrained on the Tuberculosis testing requirements for new team members and for annual team members by the Executive Director (ED) The BOC is responsible to ensure that new team members receive a two-step Mantoux skin test, or chest x-ray, or provide documentation of a chest x-ray demonstrating they are free from active tuberculosis (TB) disease prior to the beginning of employment. The Executive Director will review all new team member candidates for compliance prior to hire date.</p> <p>Business Office Coordinator (BOC) audits compliance of team member TB testing monthly in order to ensure that all team member TB testing is done by the correct due date.</p> <p>Executive Director (ED)/designee is responsible for conducting a monthly QA compliance review of TB testing of new and current team members to ensure overall ongoing compliance. The ED will take immediate corrective action if deficiencies are noted.</p>	

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R 0246 Bldg. 00	<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 QMA (Qualified Medication Aide) obtained authorization from a licensed nurse prior to administering PRN (as needed) medications. The deficient practice affected 2 of 10 resident records reviewed for QMA prior authorization of PRN medications in a sample of 10. (Resident #6 and Resident #8).</p> <p>Findings include:</p> <p>1. Record review for Resident #6 was</p>	R 0246	07/09/2015	07/31/2015			

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	<p>completed on 07/06/15 at 3:30 p.m. The PRN medication tracking record indicated Resident #6 received Hydrocodone APAP 7.5/325 mg (a narcotic pain medication) orally. PRN medication tracking record indicated the medication was given by QMA #4 on 06/30/15 at 10:30 am. The PRN medication tracking sheet had no co-signature of a licensed nurse on the above date.</p> <p>2. Record review for Resident #8 was completed on 07/07/15 at 2:00 p.m., The PRN medication tracking record indicated Resident #8 received Hydrocodone APAP 5/325 mg orally. PRN medication tracking record indicated the medication was given by QMA #3 on 05/23/15 at 11:00 a.m., and was given by QMA #4 on 06/14/15 at 7:30 p.m., and 06/15/15 at 7:30 p.m. The medication tracking sheet had no co-signature of a licensed nurse on the above dates.</p> <p>During an interview with The Resident Care Director on 07/06/15 at 3:52 p.m., she indicated a QMA must get approval to administer a PRN and have a licensed nurse co-sign with the QMA. This should be documented on the PRN medication tracking sheet in the clinical record.</p>		<p>7/31/2015</p> <p>7/9/2015</p> <p>7/9/2015 and on going</p>				

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	During an interview with QMA #2 on 07/08/15 at 8:10 a.m., she indicated she must call a nurse for permission to administer a PRN medication. She then monitors for effectiveness of the medication, reports to the nurse, and the nurse should co-sign with the QMA on the medication tracking sheet.		7/9/2015 and ongoing	

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			<p>The Health Care Coordinator (HCC) conducted an audit of current resident medication administration record documentation to determine if others were potentially affected. There were no additional residents potentially affected by similar documentation process incidents. No actual medication errors occurred.</p> <p>HCC conducted in services on 7/6/201. QMA's Qualified Medication Aides (QMAs) have been instructed to call nurse to receive permission for a PRN medication. The QMA will then flag the MAR as a reminder for nurse to sign off on permission.</p> <p>The Health Care Coordinator (HCC) retrained Qualified Medication Aides (QMAs) and Wellness Nurses on proper documentation of the administration of PRN medication including authorization as well as required signatures.</p> <p>The Health Care Coordinator (HCC) counseled QMA and Nurse in question on proper documentation of PRN medication including authorization as well as signatures.</p> <p>The Health Care Coordinator (HCC) will audit PRN Medication signatures weekly to ensure</p>		

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R 0272 Bldg. 00	<p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation and record review, the facility failed to monitor temperatures in refrigerators and dish machines in 2 of 4 serving kitchens. This deficient practice affected 27 residents on the Reminiscence Unit and 27 residents on the Terrace Club Unit.</p> <p>Findings include:</p> <p>During a tour of the facility on 7/6/15 at 10:15 a.m., with the Resident Care Director, the following were found:</p>			R 0272	<p>compliance. HCC is responsible to immediately take action to correct any performance deficiencies noted.</p> <p>The Executive Director (ED)/designee will monitor ongoing compliance during the monthly QA meeting by reviewing the results of the HCC audits and completing monthly random spot checks of Medication Administration Record PRN Medication documentation. The ED is responsible to ensure immediate corrective actions are taken if compliance deficiencies are noted.</p> <p style="text-align: center;">7/31/2015</p>		07/31/2015

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	<p>1. The temperature log dated July 2015, for Terrace Club area was reviewed and found to be incomplete for the homestyle refrigerator/freezer, the commercial refrigerator/freezer, and the dish machine temperatures.</p> <p>2. The temperature log dated July 2015, for the Reminiscence dishwasher was found to be incomplete.</p> <p>During an interview with Executive Director and Dietary Manager on 7/8/15 at 10:45 a.m., the Executive Director indicated the Dietary Manager has ultimate responsibility for the kitchens on the unit but the day to day operation is monitored and assigned by the unit managers and lead care managers.</p> <p>During an interview with the lead care manager on Terrace Club on 7/8/15 at 12:35 p.m., she indicated the assignment sheet designated 2 different assignments, one assignment was dish machine temperatures and the other assignment for refrigerator temperatures.</p> <p>During an interview with lead care manager on the Reminiscence unit on 7/8/15 at 12:45 p.m., she indicated she was aware of the log books but did not know the logging of temperatures was part of her assignment.</p>		<p>7/31/2015</p> <p>7/9/2015 and on going</p> <p>7/9/2015 and on going</p>				

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	A policy titled "Kitchen Equipment" dated 7/9/13 obtained from the Executive Director on 7/8/15 at 12:45 p.m., indicated "... D. Equipment Temperature Log...3. the equipment temperature log must be completed daily...."		<p>The Dining Services Director (DSD) completed an audit of the temperature logs for refrigerators and dish machines to ensure that all food is being served and stored at an appropriate temperature and logs that were not in place after the audit. Any logs not compliant during the audit the team members were immediately addressed and training provided.</p> <p>Team members will be retrained by the Dining Services Director (DSD) to ensure they understand their responsibility and requirement to document temperatures of both dishwasher and refrigerators during or at each meal.</p> <p>The Reminiscence Coordinator (RC) and the Terrace Club Coordinator (TC) monitor the temperature logs weekly for 6 weeks and then monthly to ensure temperatures are being documented during each meal for all dishwashers and refrigerators.</p> <p>The Executive Director (ED) completes a random monthly spot check on the temperature logs for refrigerators and dishwashers. The ED is responsible to ensure that immediate corrective action is taken if deficiencies are noted.</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. Based on observation and interview, the facility failed to ensure that food was labeled, dated and removed when expired in the dry storage area and in the refrigerator in 1 of 4 kitchens in the facility. The facility failed to ensure the recommended concentrations of sanitizing solution in the three compartment sink as well as the sanitizing buckets were maintained. This deficient practice had the potential to affect 79 of 79 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>1. During a tour of the main kitchen dry storage area and the refrigerator on 7/6/15 at 9:15 a.m., with the Dietary Manager, the following was observed: a container of peaches with a use by date of 6/31/15 was still in the refrigerator. Containers of yogurt, cottage cheese, and dressing were in the refrigerator with no open date marked. In the dry storage area, a bag of almonds, pecans, coconut, sunflower seeds, and peanuts were found</p>	R 0273	<p>7/31/2015 08/15/2015 7/9/2015 7/9/2015 and on going 7/23/2015 7/9/2015 and on going 7/9/2015 and on going The Dining Service Director (DSD) completed a team member training on proper dating, labeling, proper storage and disposal of food items in all kitchens The Dietician will train team members on proper labeling and dating and storage of food to reinforce comprehension of all dietary regulations to meet the Rule 410 IAC 16-2-5-5.1(f). The Dining Services Director audits each kitchen area weekly for 6 weeks and then monthly on going to ensure opened food is labeled and dated correctly and properly stored. The Reminiscence Coordinator(RC), The Terrace Club Coordinator (TCC) and the Assisted Living Coordinator (ALC) will complete monthly random spot checks in all 3 kitchen areas to ensure opened food dating labeling is in place, expired food items have been removed, and proper food storage requirements</p>	08/15/2015			

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	<p>with no opened date.</p> <p>During an interview with the Dietary Manager on 7/6/15 at 10:15 a.m., he indicated he needed clarity as to dating and labeling regulations. He indicated he was not aware of the regulations.</p> <p>During a review of the Policies and Procedures from Crandall Corporate Dieticians, dated 5/14, received from the Dietary Manager on 7/6/15 at 4:11 p.m., "...Section 3, Receiving, inventory and Storage...8. All foodstuffs are to be dated... Procedure: All products should be dated upon receipt and when they are prepared. Use [use-by-dates] on all food stored in refrigerators... Dry Storage:...</p> <p>7. Any opened products should be placed in seamless plastic or glass containers with tight fitting lids and labeled and dated...."</p> <p>2. During a tour of the main kitchen on 7/6/15 at 9:45 a.m., the lead cook was asked to test the sanitizing bucket, the test strip read 100 parts per million (ppm), the sanitizing section of the three compartment sink was tested and the reading was 100 ppm.</p> <p>During the interview with the lead cook on 7/6/15 at 9:45 a.m., the lead cook</p>		<p>are in compliance The Executive Director (ED)/designee completes random monthly spot checks of dating and labeling of opened foods, disposal of all expired food items, and food being properly stored in all 3 kitchen areas. The ED/designee is responsible to immediately correct any deficiencies noted. The Dining Services Director (DSD) retrained the dietary team members on the proper sanitation process of 3 compartment sink and sanitation buckets. The Dining Services Director (DSD)/designee audits compliance of the sanitation process of the buckets and 3 compartment sink daily for 10 days and then 3 times weekly ongoing. The DSD/designee is responsible to immediately correct any deficiencies noted. The Executive Director (ED)/or designee complete random spot checks of the sanitation bucket and 3 compartment sink weekly for 6 weeks and then monthly thereafter. The Executive Director (ED) is responsible to ensure that immediate corrective action is taken if deficiencies are noted.</p>				

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	<p>indicated the corrected concentration for the sanitizing solution was 200 ppm.</p> <p>A review of the policy titled "Kitchen Sanitation" dated 7/16/13 received from the Executive Director on 7/8/15 at 12:45 p.m., indicated "... d. an acceptable sanitizing product is Quaternary ammonium compound product, a concentration of 200 ppm...."</p>				