

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 01/22/2014
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NAME OF PROVIDER OR SUPPLIER  MCKINNEY HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD LOGANSPORT, IN 46947
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R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: January 21 and 22, 2014</p> <p>Facility number: 004441 Provider number: 004441 AIM number: N/A</p> <p>Survey team: Bobette Messman RN TC Rita Mullin RN Maria Pantaleo RN</p> <p>Census bed type: Residential: 60 Total: 60</p> <p>Census payer type: Other: 60 Total: 60</p> <p>Sample: 9</p> <p>These state findings are cited in accordance with 410 IAC 16.2</p>	R000000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
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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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R000118	<p>410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.</p> <p>Based on record review and interview, the facility failed to ensure a certified nursing assistant (CNA) was currently licensed to work in their specific scope of practice for 1 of 25 employee files reviewed for licensure. (CNA #1)</p> <p>Findings include:</p> <p>During review of employee records on 1/22/2014 at 1:00 p.m., current licensure for CNA #1 was not found.</p> <p>During review of the staff schedule on 1/22/2014 at 3:00 p.m. and interview with the Administrator she indicated that CNA #1 did not renew CNA license which expired 10/09/2013 and she had worked 67 shifts, from 10/10/2013 to 1/22/2014.</p>	R000118	R118 The employee with the expired license referenced within the above violation was immediately removed from the schedule until such a time that a valid state mandated active license was provided to the community and placed within his/her employee file. The employee completed the licensure renewal process online and was able to provide the community with a valid active Certified Nurse Aid license within 24 hours of the initial finding. The Residence Director and/or Designee completed an employee file audit to ensure continued compliance with the above referenced regulation. No other employees were found to be affected.No residents were found to be affected.The Residence Director and/or Designee will be responsible to ensure potential employees prior to being hired have a current active valid license within their	01/23/2014			

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			file. The Residence Director and/or Designee will conduct a random monthly review of current employee files to ensure employees have a current valid license for a period of three months through the communities QA process. Audits will be reviewed after three months in order to determine the need for the ongoing frequency of the monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional team will also review the plan during community house visits no less than on a quarterly basis to also ensure continued compliance with Indiana state regulation R 118. Compliance Date: 1/23/2014.		

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R000121	<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 loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

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	<p>Based on record review and interview, the facility failed to ensure new personnel were given TB (tuberculin) skin test. This effected one of five employee records reviewed for pre-employment TB testing. (Cook #1)</p> <p>Findings include:</p> <p>Employee records were reviewed on 1/22/14 at 3:00 p.m. The following items were not found:</p> <p>The second step TB skin test for Cook #1 was not completed. Cook # 1 was hired on 10/8/13.</p> <p>During and interview on 1/22/2014 at 3:30 p.m., the Director of Health Services, indicated Cook #1 did not have the second step TB test completed.</p>	R000121	<p>R 121The employee referenced in the above violation received a two-step tuberculin skin test. The tuberculin skin test was read and indicated the employee was free from any communicable disease process. The Residence Director and/or Designee conducted an employee file audit with no other employees found to be affected.No residents were found to be affected. The Wellness Director implemented an employee tuberculin skin test administration spreadsheet and tuberculin skin test binder in order to ensure continued compliance. The spreadsheet and binder indicate the date the employee last received a tuberculin skin test that after administration is then filed under the designated month and recorded on the spreadsheet in order to track employees as to the month the tuberculin skin test are to be given. The Wellness Director and/or Designee will be responsible to review the employee tuberculin skin test binder monthly for a period of six months through the communities QA process in order to ensure continued compliance with the above referenced regulation. Audits will be reviewed after six months in effort to determine the need for the frequency of the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional team will also review the plan</p>	02/21/2014

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R000151	<p>410 IAC 16.2-5-1.5(h) Sanitation &amp; Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.</p> <p>Based on record review and interview the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian in 2 of 7 resident pets records reviewed. (Resident #3 and Resident # 6)</p> <p>Findings include:</p> <p>1. Resident #3's record was reviewed 1/21/2014 at 1:30 p.m.</p> <p>The record indicated the resident's pet vaccination had expired on 10/17/2011.</p> <p>2. Resident #6's record was reviewed 1/21/2014 at 1:45 p.m.</p> <p>The record indicated the resident's pet vaccine had not been done, since the resident was admitted on 1/10/2012.</p>	R000151	<p>during community house visits no less than on a quarterly basis to also ensure continued compliance with Indiana state regulation R 121. Compliance Date: 2/21/14</p> <p>R 151The above referenced pets found without updated vaccinations were immediately removed from the community by the families after providing education to the resident/family as to the state specific regulation until such a time they could arrange for the pet to receive updated vaccinations by an appropriately licensed individual. Families provided documentation of updated pet vaccination that was placed within the resident's administrative file prior to the pets return to the community.The Residence Director and/or Designee reviewed current employee administrative files with no other findings pertaining to outdated pet vaccinations. No other residents were found to be affected. The Residence Director and/or Designee will conduct a monthly audit of the resident's administrative file to ensure pets entering the community have up to date vaccinations for a period of twelve months through the communities QA process. The</p>	01/24/2014

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R000272	<p>During an interview on 1/21/2014 at 2:30 p.m., the Administrator, indicated a resident with a pet must have a current vaccination record, and Resident #3 and Resident #6 did not have current vaccination records for their pets.</p> <p>Review of current facility policy on 1/21/2013 at 2:15 p.m., indicated "Pets must have current vaccinations as required by state law."</p> <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. Based on observation, record review, and interview, the facility failed to ensure food temperatures were palatable. This deficit practice had the potential to impact 57 of 60 residents who eat in the dining room. (Resident #5)</p> <p>Findings include:</p> <p>On 1/21/14 at 1:30 p.m., during an interview with Resident #5, he indicated the food was cold on numerous days and at different times.</p>	R000272	<p>audits will be reviewed after twelve months in order to determine the need for the ongoing frequency of the monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional team will also review the plan during community house visits no less than on a quarterly basis to also ensure continued compliance with Indiana state regulation R 151. Compliance Date: 1/24/2014.</p> <p>R 272The Residence Director contacted the Corporate Dietician for consultation regarding the above referenced concerns referenced within the regulation.The Corporate Dietician conducted an on-site training to the Dining Service Coordinator and cooking staff regarding the appropriate process for obtaining food temperatures as indicated within our policy and procedure and applicable state regulation. Going forward, the Dining Service Coordinator and/or cooking staff will obtain food temperatures prior to the meal service to ensure food is served at appropriate temperatures. No</p>	03/03/2014			

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R000273	<p>Record review of the resident council minutes indicated food was cold.</p> <p>During an observation on 1/22/14 at 1:00 p.m., a test tray was requested. the test tray consisted of Salisbury steak, mashed potatoes, mixed vegetables and chicken casserole. The temperature of the food on the test tray was below 100 degrees Fahrenheit.</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 and interview, the facility failed to maintain a clean</p>	R000273	<p>residents were found to be affected. The Dining Service Coordinator and cooking staff have been re-educated as to the appropriate process for obtaining food temperatures and will record food temperatures daily per our policy and procedure utilizing out Food Temp Log form that will be kept in a binder. The Residence Director and/or Designee will conduct a weekly audit of meal service and the Food Temp Log to ensure continued compliance with applicable food temperatures as indicated within our policy and procedure and state regulation for a period of six months through the communities QA process. Audits will be reviewed after six months in order to determine the need for an ongoing frequency of the monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional team will also review the plan during community house visits no less than on a quarterly basis to also ensure continued compliance with Indiana state regulation R 151. Compliance Date 3/3/2014</p> <p>R 273 The cook, cooking staff, and other applicable staff were</p>	01/23/2014

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	<p>and sanitary environment in the kitchen for 2 of 2 kitchen observations.</p> <p>1. During the kitchen tour on 1/21/14 at 11:10 a.m., the garbage can located at the dish washing station was uncovered.</p> <p>During an observation in the kitchen on 1/21/14 at 12:30 p.m., Cook #1 was observed in the kitchen without hairnet. She walked through the kitchen and placed personal items on a back desk. She then place a hairnet on to cover her hair. Kitchen staff were serving lunch at the time.</p> <p>During an observation on 1/22/14 at 1:00 p.m., the garbage can located in the dishwashing area was seen to be uncovered.</p>		<p>provided re-education as to our policy and procedures regarding Food Safety and Sanitation regarding donning of hairnets, and covering of trash receptacles when not in use. Upon discovery of the cook being in the kitchen without a hairnet to place personal belongings, the cook was asked to put on a hairnet and re-educated about hair nets on 1/23/2014. Upon discovery of the trash can lid being off of the trash can in the dish washing area the cooks and the dish washing aides were re-educated on 1/23/14 ensuring that all garbage cans are clean and covered at all times. No other employees entered the kitchen without a hairnet, nor were any other garbage receptacles left uncovered after the initial finding. No residents were found to be affected. The Dining service Coordinator and/or Designee will be responsible for continued compliance with the above referenced regulation regarding kitchen safety and sanitation requirements referencing donning of hairnets and ensuring garbage receptacles are kept covered when not in use. The Residence Director and/or Designee will conduct weekly random walking rounds of the kitchen to ensure continued compliance for a period of three six months through our QA process. Audits will be reviewed at the end of six months in order to determine the</p>				

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			frequency for the ongoing monitoring plan at that time. Findings suggestive of compliance will result in cessation of the monitoring plan. Compliance Date: 1/23/2014		