

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 06/30/2016
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NAME OF PROVIDER OR SUPPLIER  HAMILTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: June 28, 29, 30, 2016</p> <p>Facility Number: 004686 Provider Number: 004686 AIM Number: N/A</p> <p>Census Bed Type: Residential: 36 Total: 36</p> <p>Census Payor Type: Other: 36 Total: 36</p> <p>Residential sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed on July 1, 2016 by 17934.</p>	R 0000		
R 0116  Bldg. 00	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the</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>screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p> <p>Based on interview and record review, the facility failed to ensure criminal background checks were performed prior to date of hire for 3 of 5 facility employees.</p> <p>QMA #27, Maintenance Supervisor, Care Service manager</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 6/29/16 at 10:30 a.m., the employee record of QMA (Qualified Medication Assistant) #27 was reviewed with a hire date of 5/12/16. Documentation was lacking of a criminal background check having ever been done.</li> <li>On 6/29/16 at 10:35 a.m., the employee record of the Maintenance Supervisor was reviewed, with a hire date of 7/28/15. Documentation was lacking of a criminal background check having ever been done.</li> <li>On 6/29/16 at 10:40 a.m., the employee record of the Care Service Manager was reviewed, with a hire date of 5/31/16. Documentation was lacking</li> </ol>	R 0116	<p>R 116- Personnel-Non compliance</p> <ol style="list-style-type: none"> <li>A criminal background check was completed for QMS #27 on 5/11/16. Employee remains eligible for employment</li> </ol> <p>A criminal background check was completed for the Maintenance Supervisor on 7/2/16. Employee remains eligible for employment.</p> <p>A criminal background check was completed for the Care Services Manager on 7/8/16. Employee remains eligible for employment.</p> <ol style="list-style-type: none"> <li>Current residents have the potential to be affected by the alleged deficient practice.</li> <li>Executive Director was educated by Amanda Palace, training Executive Director on 7/12/16 regarding employee background check requirements. Executive Director will be responsible for ongoing compliance.</li> <li>Executive Director will be responsible for sustained compliance. The Executive Director and/or designee will audit new</li> </ol>	08/30/2016

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R 0117 Bldg. 00	<p>of a criminal background check having ever been done.</p> <p>4. On 6/29/16 at 2:00 p.m., the Administrator was interviewed. He indicated he did not have criminal background checks for the Maintenance Supervisor, QMA #27, or the Care Service Manager.</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</p>		<p>employee files prior to start date to ensure background checks are completed and on file. Monitoring will be ongoing.</p> <p>5. Completion date: 8/30/16.</p>	

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	<p>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 interview and record review, the facility failed to ensure staff with current CPR (Cardiopulmonary Resuscitation) and First Aid certification were onsite at all times for 16 of 21 shifts in a 7 day schedule period.</p> <p>Findings include:</p> <p>On 6/29/16 at 11:00 a.m., the Administrator provide a nursing schedule for the time period of 6/1/16 - 6/7/16. The Administrator was interviewed at this time, and indicated the schedule was "as worked" and thus reflected the staff who were actually in the facility on the days and times as scheduled.</p> <p>On 6/29/16 at 12:00 p.m., the following employee records were reviewed with current CPR certifications observed: LPN (Licensed Practical Nurse) #20, CNA (Certified Nursing Assistant) #21, CDM (Certified Dietary Manager) #22, CNA #24, CNA #23 and Activity Staff #23. The following staff records were observed with current First Aid certifications: CDM #22, Activity Staff #23 and CNA #24.</p> <p>Upon review of the "as worked" nursing</p>	R 0117	<p>R117 – Personnel-Deficiency</p> <ol style="list-style-type: none"> <li>An initial CPR class for employees requiring CPR certification was completed on 7/19/16 by John Urso. A second CPR and First Aide class is in the process of being scheduled, to be completed by 8/30/16.</li> <li>Current residents have the potential to be affected by the alleged deficient practice.</li> <li>The Executive Director was re-trained on the CPR and First Aid requirement on August 11 by John Urso.</li> <li>The Care Services Manager is responsible for sustained compliance. The Executive Director and/or designee will review employee files to ensure compliance for scheduling staff, by reviewing 5 employee files weekly until current employees have been reviewed. Employee files will then be checked annually for updated CPR and First Aid Certification. Monitoring will be ongoing.</li> <li>Compliance Date 8/30/16.</li> </ol>	08/30/2016

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R 0119 Bldg. 00	<p>schedule in comparison the current CPR and First Aid certifications of the scheduled staff, the following was observed for the 21 shifts over a day period: 13 shifts had 1 CPR certified staff but no First Aid Certified staff; 5 shifts had 1 First Aid Certified staff but no CPR certified staff; 8 had neither CPR or First Aid Certified staff.</p> <p>On 6/30/16 at 11:00 a.m., the Administrator was interviewed. He indicated he was unaware of the requirement for the facility to have one staff member with current CPR (Cardiopulmonary Resuscitation) and First Aid certification onsite at all times.</p> <p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3)-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill;</p>						

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	<p>(D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure 5 of 5 employees were provided general and specific orientation to the facility and the facility further failed to ensure employees were provided abuse training. (QMA (Qualified Medication Aide) #31, Care Service Manager, LPN (Licensed Practical Nurse) #29, CNA (Certified Nursing Assistant) #30 and QMA #27)</p> <p>Findings include:</p> <p>On 6/29/16 at 10:00 a.m., the employee files were reviewed for the following</p>	R 0119	<p>R119 Personnel-Non-Compliance</p> <p>1. QMA # 31 completed general orientation, job specific orientation, and was in-serviced on Enlivant's Abuse and Neglect policy on 7/20/16 by Tricia Hasty</p> <p>Care Services Manager completed general orientation, job specific orientation, and was in-serviced on Enlivant's Abuse and Neglect policy on 7/6/16 by Mark Gephart, Executive Director</p>	08/30/2016			

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	<p>employees with the following hire dates for each : QMA #31 (4/8/15), Care Service Manager (5/31/16), LPN #29 (5/11/16), CNA #30 (5/10/16) and QMA #27 (5/12/16). Documentation was lacking in the employee files for job specific and general orientation in addition to abuse training.</p> <p>On 6/29/16 at 2:13 p.m., the Administrator was interviewed. He indicated the "Physical Plant Operations" checklist was what was used for orientation. The Administrator indicated new staff train with their counterpart but nothing was documented. He indicated he was not aware of any other orientation forms that were used.</p> <p>On 6/30/16 at 10:10 a.m., the Administrator was interviewed. He indicated he was unable to provide additional documentation of the above employees for general, job specific or abuse training. He also indicated the facility does not have a policy and procedure for abuse training and orientation. He indicated the nursing staff are required to work 2 weeks of each of the 3 different shifts so they are familiar with the residents and what goes on with the residents at various times of the day.</p>		<p>LPN #29 completed general orientation, job specific orientation, and was in-serviced on Enlivant's Abuse and Neglect policy on 7/20/16 by Tricia Hasty, Care Services Manager</p> <p>CNA #30 completed general orientation, job specific orientation, and was in-serviced on Enlivant's Abuse and Neglect policy on 7/20/16 by Tricia Hasty, Care Services Manager</p> <p>QMA #27 completed general orientation, job specific orientation, and was in-serviced on Enlivant's Abuse and Neglect policy on 7/20/16 by Tricia Hasty, Care Services Manager</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice.</p> <p>3. The Executive Director and Care Service Manager were educated on proper orientation, and Abuse and Neglect training for new employees, including the appropriate forms for documenting orientation and training on 6/29/16 by the Regional Director of care Services.</p> <p>4. The Executive Director is responsible for sustained compliance. The Executive Director and/or designee will audit new employee files within 14 days of hire</p>	

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R 0120 Bldg. 00	<p>On 6/30/16 at 10:20 a.m., a copy of the "Physical Plant Orientation" form was received from the Administrator. The form included the following: "I have received instructions and/or orientation on the following systems in my Residence: Electrical, plumbing, water and gas shut-off, fire sprinkler system, HVAC ( type of heating and cooling system), thermostat settings, fire alarm system, emergency call system, security system, irrigation system, elevator (if applicable) and standby generator (if applicable). There is an area for the employee and trainer to sign and date this form.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel,</p>		<p>to ensure general orientation, job specific orientation and training on Enlivant's Abuse and Neglect policy has been completed and documented on the appropriate forms. Monitoring will be ongoing.</p> <p>5. Completion Date 8/30/16</p>	

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	<p>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 interview and record review, the facility failed to ensure 1 of 5 employees hired within the last year, had dementia training. (Maintenance Supervisor)</p> <p>Findings include:</p> <p>On 6/29/16 at 10 a.m., the employee records were reviewed with the following hire dates observed: Maintenance Supervisor 7/28/15.</p> <p>On 6/29/16 at 2:26 p.m., the Administrator was interviewed. He</p>	R 0120	<p>R120 Personnel-Non-Compliance</p> <ol style="list-style-type: none"> <li>The Maintenance Director's Dementia Training was completed on 7/20/16 by Michelle Goodrich, SouthernCare Hospice.</li> <li>Current residents have the potential to be affected by the alleged deficient practice.</li> <li>The Executive Director was re-trained on the requirement for personnel to complete dementia training on by Amanda Palace, Training Executive on 7/12/16. Dementia-specific training will be</li> </ol>	08/30/2016			

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R 0121  Bldg. 00	<p>indicated the Dementia training was done yearly in July.</p> <p>On 6/30/16 at 10:00 a.m., the Administrator was interviewed. He indicated the Maintenance Supervisor was lacking documentation of having had dementia training during the last year. He indicated at this time, the facility did not have a policy and procedure to address the specifics of the dementia training for staff.</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: (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</p>				<p>completed with new employees within six months of hire and receive three hours annually thereafter.</p> <p>4. The Care Services Manager will be responsible for sustained compliance. The Executive Director and/or designee will review files for new employees within six months after start date to ensure compliance, and will review files annually to ensure compliance with annual training. Monitoring will be ongoing.</p> <p>5. Completion date 8/30/16</p>		

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	<p>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 interview and record review, the facility failed to ensure tuberculin skin testing was completed for 5 of 5 staff at hire.</p> <p>CSM (Care Service Manager), Maintenance Supervisor, LPN (Licensed Practical Nurse) #29, QMA (Qualified Medication Assistant) #27, CNA (Certified Nursing Assistant) #30</p> <p>Findings include:</p> <p>On 6/29/16 at 9:30 a.m., the CSM</p>	R 0121	<p>R121 Personnel-Non-Compliance</p> <p>1. The Care Services Manager received Step 1 PPD on 7/7/16 2nd step 7/21/16</p> <p>The Maintenance supervisor received Step 1 PPD on 8/1/16 2nd step 8/15/16</p> <p>LPN# 29 received Step 1 PPD on 7/8/16 2ndstep 7/20/16</p> <p>QMA#27 Is a reactor and provided x-ray results of 6/16/16 showing</p>	08/30/2016

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	<p>provided the current facility policy, titled TB Testing-Infection Control, with an effective date of 07/01/2014, which indicated, "...I. TB testing will be completed per state regulations for residents, staff and volunteers. See the chart of state-specific TB Testing Requirements in the Appendix of this guide....II. A chest x-ray will be obtained for any resident, staff and volunteer that has a positive TB skin test...III. State regulations will be followed for any required follow up for residents, staff members or volunteers who have had a positive skin test and a negative chest x-ray....IV. The Care Service Manager is responsible for conducting or arranging for Mantoux method TB tests...."</p> <p>On 6/30/16 at 11:05 a.m., the Administrator provided an undated Tuberculosis appendix which included, but was not limited to, the following: "Staff...Indiana...2-step: Step 1 on hire, step 2, 1-3 weeks after step 1. If TB test within past year prior to hire, then only 1-step on hire. Annual required..." 1. On 6/29/16 at 2:00 p.m., the employee record of QMA #27 was reviewed. QMA #27 had a date of 5/12/16 for her having started working at the facility. Documentation was lacking of a TB (tuberculosis) risk assessment having been completed. Documentation</p>		<p>clear of TB</p> <p>CNA#30 received Step 1 PPD on 6/29/16 2ndstep 7/13/16</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice.</p> <p>3. The Executive Director and Care Services Manager were re-trained on the requirement for tuberculin skin testing for new employees on 6/30/16 by Leigh Brown Regional Care Services Manager.</p> <p>4. The Care Services Manager will be responsible for sustained compliance. The Executive Director and/or designee will audit new employee files to ensure staff have received Step 1 of the PPD at the time of employment, or no later than one month prior to employment, or the required chest x-ray with previous positive result or documented allergy. Monitoring will be ongoing.</p> <p>5. Completion Date 8/30/16.</p>	

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NAME OF PROVIDER OR SUPPLIER  HAMILTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUTLER RD FORT WAYNE, IN 46815
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	<p>indicated QMA #27 was allergic to the TB testing serum. The file indicated the employee had a CXR (chest X ray) 3 months after hire, 6/16/16.</p> <p>2. On 6/29/16 at 2:05 p.m. the employee record of LPN #29 was reviewed, with a date of beginning work at the facility on 5/11/16. Documentation was lacking of a TB skin test having been done at all.</p> <p>3. On 6/29/16 at 2:10 p.m. the employee record of the Maintenance Supervisor was reviewed, with a date of hire of 6/28/15. Documentation was lacking of TB skin test being performed at hire.</p> <p>4. On 6/29/16 at 2:15 p.m. the employee record of the Care Service Manager was reviewed, with a hire date of 5/31/16. Documentation was lacking of a TB skin test being performed at hire.</p> <p>5. On 6/29/16 at 2:20 p.m., the employee record of CNA #30 was reviewed, with a hire date of 5/10/16. The only TB test performed was dated 6/29/16. Documentation was lacking of a TB skin test having been performed at hire and also a two step TB test having been performed.</p>			

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R 0153 Bldg. 00	<p>410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.</p> <p>Based on observation, interview and record review the facility failed to ensure portable oxygen tanks were stored in a safe and secure manner for 2 of 3 residents with portable oxygen tanks stored in their rooms. (Resident # 5 and Resident #9)</p> <p>Findings include:</p> <p>1. On 6/28/16, the following observations were made in Resident #5's room:</p> <p>At 1:00 p.m., the room was entered with the LPN #5 to administer a nebulizer treatment (a breathing treatment). Resident #5 was observed to have her oxygen on per nasal cannula. The oxygen tubing was attached to the portable oxygen tank which was stored in an oxygen storage bag for a wheelchair, hanging from and between the two wheelchair handles. An observation of 6 metal, torpedo shaped cylinders of</p>	R 0153	<p>R153 Sanitation and Safety Standards - Deficiency</p> <ol style="list-style-type: none"> <li>Resident #5 received a proper storage rack for oxygen on 7/1/16</li> <li>Resident #9 received a proper storage rack for oxygen on 7/1/16</li> <li>Current residents on oxygen have the potential to be affected by the alleged deficient practice</li> <li>Proper storage education has been provided to staff on 7/20/16 by Tricia Hasty Care Services Manager.</li> <li>The Care Services Manager is responsible for sustained compliance. The Executive Director and/or designee will check apartments for residents who are on oxygen, to check for proper storage, weekly during routine rounds. Monitoring will be ongoing.</li> <li>Completion 08/30/16</li> </ol>	08/30/2016

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	<p>portable oxygen (oxygen tanks) were observed in her room. One oxygen tank was observed to be standing upright, un-secured on the carpeted floor, next to the metal oxygen rack where the 5 additional oxygen tanks were stored. It was also observed the metal oxygen rack had 1 vacant (empty) space to one oxygen tank. There was also an empty portable oxygen tank cart observed beside the oxygen rack, which would have been available to store 1 oxygen tank securely.</p> <p>During the administration of the nebulizer treatment from 1:00 p.m. to 1:20 p.m., LPN #5 was observed to walk around the unsecured oxygen tank and did not secure the oxygen tank in the oxygen rack.</p> <p>An interview with LPN #5 on 1/28/16 at 1:20 p.m., indicated the oxygen equipment was provided by Hospice. She indicated Resident #5 used the oxygen concentrator when she is in the room and the oxygen tanks were used when she was out of her room.</p> <p>Review of the clinical record for Resident #5 on 6/28/16 at 2:20 p.m., indicated the following: diagnoses included, but were not limited to CHF (Congestive Heart Failure), diabetes mellitus, atrial</p>			

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	<p>fibrillation, hypertension, dementia, anxiety, muscle weakness and history of falls. The clinical records also indicated the resident was receiving hospice services for her CHF.</p> <p>On 6/28/16 at 11:45 a.m., the Executive Director provided a list of resident identified as interviewable (alert, oriented and reliable) by the facility. Resident #5's name was not on the list.</p> <p>A second observation of Resident #5's room on 2/28/16 at 4:15 p.m., indicated the single oxygen tank was still unsecured, standing upright on carpeted floor next to the oxygen rack. The Resident was sitting in her recliner chair watching TV and had her oxygen on per nasal cannula and the oxygen tubing was attached to the oxygen concentrator. While in resident's room, CNA #6 entered the room and indicated she was making rounds to check on the residents.</p> <p>An interview with CNA #6 on 4:17 p.m., indicated Resident #5 used the oxygen continuously and indicated the portable oxygen tanks were used when she was out of the room. She indicated she checked the oxygen gage for the amount of oxygen left in the tank. She indicated the tall oxygen tanks would last 4-6 hours. She also indicated when the</p>						

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	<p>needle on the oxygen gage would gets close to the red area, she changed to a new oxygen tank. She also indicated she did not let the oxygen run out before she changed the oxygen tank. It was observed, CNA #6 did not put the unsecured oxygen tank in the oxygen rack.</p> <p>2. On 6/28/16, the following observations were made in Resident #9's room:</p> <p>At 4:05 p.m., the room was entered and Resident #9 was observed sitting in her chair watching TV with her oxygen on per nasal cannula. The oxygen tubing was connected to the oxygen concentrator. There were 4 large oxygen tanks standing unsecured and upright on the carpeted floor between the back of the resident's chair and the wall. There was 1 additional oxygen tank stored in the secure oxygen tank holder on the wheelchair. An interview with Resident #9 indicated she did not know who brought the oxygen to her, she indicated the oxygen was in the room when she came.</p> <p>On 6/28/16 at 11:45 a.m., the Executive Director provided a list of residents identified as interviewable (alert, oriented and reliable) by the facility. Resident</p>			

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	<p>#9's name was not on the list.</p> <p>An interview with the Executive Director and the CSM (Care Service Manager) on 6/28/16 at 4:20 p.m., indicated the facility did not store oxygen or oxygen tanks for residents. The Executive Director indicated the Oxygen Companies delivered oxygen directly to the resident's room. The Executive Director also indicated he did not believe the facility had a policy for oxygen storage. The CSM indicated the oxygen tanks should be stored securely in the racks in a resident's room.</p> <p>An interview with the Executive Director and the CSM on 6/28/16 at 4:30 p.m., after they observed the storage of the oxygen tanks in Resident #5's and Resident #9's rooms, indicated they were not aware the oxygen tanks were not being stored in racks and indicated the Oxygen Company would be contacted to bring a storage rack immediately to store the oxygen tanks securely.</p> <p>An interview with LPN #5 on 6/28/16 at 4:40 p.m., indicated they found a cardboard oxygen storage rack in Resident #9's room and indicated the oxygen tanks were now stored securely in the oxygen racks.</p>						

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R 0216 Bldg. 00	<p>An interview with the CSM on 6/29/16 at 10:44 a.m., indicated the facility did not have a policy for oxygen storage and further indicated the facility followed Indiana State Regulations for oxygen storage.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interviews and record review, the facility failed to evaluate a resident for safe self-administration of medications for 1 of 3 residents reviewed who self-administered their medications. (Resident #4)</p> <p>Findings include:</p>	R 0216	R216 Evaluation-Noncompliance 1. Resident #4 had a self-medication assessment completed on 7/15/16. 2. Current residents who self-medicate have the potential to be affected by the alleged deficient practice. 3. The Care Services Manager was educated on the requirement to complete the Self-Medication	08/30/2016

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	<p>During an interview with Resident #4 on 6/29/16 at 9:15 a.m., she indicated that her medications were set up into a daily medication container by a family member for her to self administer due to having "poor vision".</p> <p>The record for Resident #4 was reviewed on 6/29/16 at 10:00 a.m. Diagnoses included, but were not limited to, diabetes and macular degeneration (eye disease that causes vision loss). Resident #4's record did not indicate a self-medication assessment had been completed since admission to the facility.</p> <p>An interview with the Care Service Manager (CSM) on 6/29/16 at 11:15 a.m., indicated Resident #4 should have had a self-medication assessment on admission but the resident did not have a self-medication assessment completed.</p> <p>Review of a policy provided by the CSM on 6/29/16 at 11:25 a.m., titled "Self-Medication Assessment", current version 7/1/14 noted, "...I. At the time of move-in residents will be evaluated by the Care Services Manager or designee regarding their ability to self-administer medications...II. Residents who desire to self-administer their medications without staff assistance will be evaluated by the</p>		<p>Administration checklist on admission, on 6/30/16 by Leigh Brown Regional Care Services Manager. 4. The Care Services Manager is responsible for sustained compliance. The Care Services Manager and/or designee will audit the resident record for residents who self-medicate, within 72 hours after move in to ensure the Self-Medication Administration checklist has been completed. Audit results will be discussed at monthly QI Meetings The QI Committee will determine if continued auditing is necessary after six consecutive months of full compliance. 5. Completion 8/30/16</p>	

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R 0328 Bldg. 00	<p>Care Services Manager to ascertain if the resident is capable of self-administration, maintaining security of medications...."</p> <p>410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.</p> <p>Based on interview and record review, the facility failed to ensure the Activity Director had completed an approved Activity Director course within 1 year of hire for 1 of 1 Activity staff reviewed. Activity Staff #1</p> <p>Findings include:</p> <p>On 6/29/16 at 11:30 a.m. the employee file of Activity Staff #1 was reviewed. The employee file lacked documentation of Activity Staff #1 having ever attended an approved Activity Director course.</p> <p>On 6/30/16 at 12:00 p.m. the</p>	R 0328	<p>R328 Activities Program-Noncompliance</p> <ol style="list-style-type: none"> <li>Activity staff #1 will attend training in an activities director course approved by the division beginning 8/12/16.</li> <li>Current residents have the potential to be affected by this alleged deficient practice.</li> <li>The Executive Director was re-educated on the requirement for the activities director training on 6/30/16 by Alex Germain Regional Director.</li> <li>The Executive Director is</li> </ol>	08/30/2016

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R 0356 Bldg. 00	<p>Administrator was interviewed. He indicated there was no Activity Certificate for Activity Staff #1 having ever attended an approved course. He also indicated the company who manages the facility does not require the Activity Director to have such a certificate. He indicated he is now aware of the requirement for the Activity Director to have a certificate of attendance at an approved course.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. A. Based on observation, interview and record review, the facility failed to maintain an accurate and complete</p>	R 0356	<p>responsible for sustained compliance. The Executive Director and/or designee will review credentials for future applicants to ensure the qualifications meet the minimum requirements for the activities director position. Monitoring will be ongoing.</p> <p>5. Completion date 8/30/16</p> <p>R356 Clinical Records- Noncompliance</p>	08/30/2016			

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	<p>emergency information file containing a photograph of each resident for the 2 different emergency files as identified by the facility. This deficiency could potentially affect 11 of 36 residents and 14 of 36 residents who resided in the facility depending on the emergency file the facility chose to use.</p> <p>B. Based on interview and record review the facility failed to ensure a photograph of each Resident was in the MAR (Medication Administration Record) to properly identify Residents during medication administration. This deficient practice had the potential to affect 12 of 36 resident residing in the facility. (Resident (R) #2, R #4, R #6, R #9, R #10, R #11, R #12, R #13, R #14, R #15, R #16, R #23)</p> <p>Findings include:</p> <p>A. The facility emergency information file in the Community Crisis Plan was reviewed on 6-28-2016 at 11:30 a.m. During the review, photographs of 11 residents were missing of the 36 residents currently residing in the facility.</p> <p>The Executive Director was interviewed on 6-28-2016 at 2:44 p.m. During the interview, he indicated photographs of residents should be in the emergency file.</p>		<ol style="list-style-type: none"> <li>1. Resident #2, #4,#6,#9,#10,#11,#12,#13,#14,#15,#16,#23 had appropriate pictures in place for emergency binder and MAR on 7/1/16</li> <li>2. Current residents have the potential to be affected by the alleged deficient practice.</li> <li>3. The Executive Director and Care Services Manager were re-trained on the requirement for photographs in the emergency binder and MAR on 6/30/16 Leigh Brown, Regional Care Services Manager.</li> <li>4. The Care Services Manager is responsible for sustained compliance. The Executive Director and/or Designee will audit the MAR and emergency binder to ensure compliance, on a monthly basis. Monitoring will be ongoing.</li> <li>5. Compliance date 8/30/16.</li> </ol>				

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	<p>He indicated he was not aware that the pictures were not with each resident's emergency information. The Executive Director indicated the face sheet with the resident's name and room number, POA (Power of Attorney) contact information, medications, funeral home and picture should be included in the file. He indicated the Concierge #1 and Activities #2 were responsible for getting the pictures.</p> <p>An interview with Concierge #1 on 6-28-2016 at 2:45 p.m., indicated he received the information from the nurse to place in the emergency file and the pictures were taken by Activities #2.</p> <p>An interview with the Executive Director on 6-28-2016 at 3:06 p.m., indicated he talked to the Corporate office and was informed there was not a policy for the Emergency file. He indicated in the event of an emergency, the staff would get the residents out and would get the Community Crisis Plan gray binder. The Executive Director indicated the staff would go back into the nurse office and get the 3 red binders, as they have the residents' pictures, orders, POA information and nursing notes.</p> <p>During a review of the 3 red binders (also used as an emergency file per the</p>						

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	<p>Executive Director) on 6-28-2016 at 3:20 p.m., there were 14 records of 36 without photographs to identify the residents.</p> <p>An interview with Activities on 6-28-2016 at 3:08 p.m., indicated she did not take the pictures of residents for the emergency file.</p> <p>An interview with the CSM (Care Service Manager) on 6-28-2016 at 3:10 p.m., indicated the 3 red binders should have the residents pictures in them.</p> <p>An observation with the CSM of the red binders indicated the 2nd resident information reviewed in one of the red binders, did not have a picture. The DoN(Director of Nursing) indicated she reviewed the 3 red binders last week and made a list of the residents from the red binders that did not have pictures and gave the list to Concierge #1. Further interview with the CSM #3 while the Executive Director was present, indicated Concierge #1 had indicated he did not take the residents' pictures. Concierge #1 indicated Activities #2 took the pictures and when Activities #2 person was interviewed, she indicated she did not take the residents' pictures for the emergency file.</p> <p>B. On 6/29/16 at 10:00 a.m., a review of the facility's MAR indicated the</p>			

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	<p>following:</p> <p>The residents' photographs, in the MAR, were to be displayed on the front side of the plastic tabbed divider, in a clear plastic photo holder. The tabs of the divider were labeled with room numbers. The photographs were not present in the MAR for 12 of 36 residents.</p> <p>During the review of the MAR, the records indicated the following Residents did not have a photograph to identify them during medication administration in the MAR binder: Resident (R) #2, R #4, R #6, R #9, R #10, R #11, R #12, R #13, R #14, R #15, R #16, R #23.</p> <p>An interview with the CSM (Care Service Manager) on 6/29/16 at 10:20 a.m., indicated the MAR should have a photograph of each of the residents. The photograph was used to correctly identify a Resident during medication administration. She also indicated she had been made aware of the missing photographs in the MAR, earlier that morning. She also indicated there were no reported medication errors in the facility since she had began working at the facility 3 weeks ago.</p> <p>An interview with LPN #5 on 6/29/16 at 10:22 a.m., indicated the facility had not</p>			

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R 0410 Bldg. 00	<p>had any reported medication errors for over a year.</p> <p>On 1/29/16 at 10:49 a.m., the CSM provided the current facility policy, titled, Medication Management, with an effective date on 07/01/2014, indicated, "...the six "rights" of medication and treatments administration are observed-right resident, right medications, right dose, right form and route, right time, right documentation. In addition to these six rights, the resident always has the right to refuse medication...."</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) 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</p>			

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	<p>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 all residents were tested for TB (tuberculosis) using the Mantoux (tuberculin skin test) 2 step method prior to or on day of admission for 4 of 7 Residents reviewed for 2 step TB testing. (Resident #1, #2, #4, #6.) This deficient practice had the potential to affect all 36 residents residing in the facility.</p> <p>Findings include:</p> <p>1. A review of the clinical record for Resident #2 on 6/28/16 at 3:11 p.m., indicated the following: diagnoses included, but were not limited to lumbar stenosis, hypertension, chronic kidney disease, history of falls, depression, gastroesophageal reflux disease, anxiety, weakness, cognitive communication deficit. The clinical record also indicated the resident moved into the facility on 11/14/15. There was no documentation of the TB testing being completed.</p> <p>An interview with the CSM (Care Service Manager) on 6/28/16 at 3:15</p>	R 0410	<p>R410 IAC 16.2-5-12 (e) (f) (g) infection control-noncompliance</p> <p>1. The Care Services Manager received Step 1 PPD on 6/29/16 Second step 7/14/16 The Maintenance supervisor received Step 1 PPD on 7/7/16 LPN# 29 received Step 1 PPD on 7/6/16 second step on 7/20/16 QMA#27 received Step provided chest x-ray 6/29/16 CNA#30 received Step 1 PPD on 6/29/16 second step on 7/13/16 2. Current residents have the potential to be affected by the alleged deficient practice 3. The Executive Director and Care Services Manager were re-trained on the requirement for tuberculin skin testing for new employees on 6/29/30by Leigh Brown, Regional Care Services Manager. 4. The Care Services Manager will be responsible for sustained compliance. The Executive Director and/or designee will audit new employee files to ensure staff have received Step 1 of the PPD at the time of employment, or no later than one month prior to employment, or the required chest x-ray with previous positive result or documented allergy. Monitoring will be ongoing. 5. Completion Date 8/30/16.</p>	08/30/2016			

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	<p>p.m., indicated she could not locate Resident #2's TB record.</p> <p>2. A review of the clinical record for Resident #6 on 6/28/16 at 2:00 p.m., indicated the following: diagnoses included, but were not limited to diabetes mellitus, depression, hypothyroidism, Hyperlipidemia, pacemaker implant, amputation of lower extremity. The clinical record also indicated the resident moved into the facility on 1/30/16. There was no documentation of the TB testing being completed.</p> <p>An interview with the CSM on 6/28/16 at 3:15 p.m., indicated she could not locate Resident #6's TB record.</p> <p>3. A review of the clinical record for Resident #4 on 6/29/16 at 9:00 a.m., indicated the following: diagnoses included, but were not limited to atrial fibrillation, anxiety, hypothyroidism, diabetes mellitus, hypertension, peripheral vascular disease. The clinical record also indicated the resident moved into the facility on 4/27/16.</p> <p>A review of Resident #4's Immunization and Health History, from another Long Term Care facility, was provided by the CSM on 6/29/16 at 11:05 a.m. The</p>						

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	<p>document indicated Resident #4 was given the 2 step Mantoux test in February and March 2015 and an annual Mantoux test was given on 2/17/16. The CSM indicated no documentation was found to indicate the resident was re-tested for TB with the Mantoux skin test upon admission to this facility.</p> <p>An interview with the CSM on 6/29/16 at 11:05 a.m., indicated she could not located Resident #4's TB record. She further indicated there was no documentation on the MAR (Medication Administration Record) that Resident #4 was given the Mantoux skin test on admission to the facility.</p> <p>An interview with the CSM on 6/29/16 at 2:40 p.m., indicated she could not find any documentation related to TB skin testing for Resident #2, Resident # 6 or Resident #4. She indicated she received a physician's order to do the first step of the Mantoux skin test for Resident #2 and Resident #4 and she further indicated the Step 1 Mantoux was given yesterday to Resident # 2 and Resident # 6.</p> <p>On 6/29/16 at 9:30 a.m., the CSM provided the current facility policy, titled TB Testing-Infection Control, with an effective date of 07/01/2014, which indicated, "...I. TB testing will be</p>			

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	<p>completed per state regulations for residents, staff and volunteers. See the chart of state-specific TB Testing Requirements in the Appendix of this guide....II. A chest x-ray will be obtained for any resident, staff and volunteer that has a positive TB skin test....III. State regulations will be followed for any required follow up for residents, staff members or volunteers who have had a positive skin test and a negative chest x-ray....IV. The Care Service Manager is responsible for conducting or arranging for Mantoux method TB tests...."</p> <p>On 6/30/16 at 11:05 a.m., the Administrator provided an undated Tuberculosis appendix which included, but was not limited to, the following: "Resident...Indiana...2-step: Step 1 on admission, step 2, 1-3 weeks after step 1. If TB test within past year prior to admission, then only 1-step on admission. Annual required..."</p> <p>4. On 6/28/16 at 2:00 p.m., the clinical record of Resident #1 was reviewed. Diagnoses included, but were not limited to: seizures and anemia. The resident was admitted to the facility on 10/26/15. The "Tuberculosis Testing and Vaccine Consents and Records" were reviewed and indicated the following: A Mantoux (TB skin test) step 1 was given 10/26/15</p>			

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	and was read 10/28/15 with documentation lacking for results of the testing. The testing was signed by RN #4. The Mantoux step 2 was given on 11/9/15 and was read on 11/11/15 with documentation lacking for results of the testing. The testing was signed by RN #4.			