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 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00185296. Complaint IN00185296-Substantiated. State deficiency related to the allegations is cited at R0090. Survey dates: November 9 & 10, 2015 Facility number: 010890 Provider number: 010890 AIM number: N/A Residential Census: 102 Sample: 9 The following residential findings were cited in accordance with 410 IAC 16.2-5. Quality review completed by 26143, on November 15, 2015.	R 0000		
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted			

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	by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure the Administrative staff was immediately notified of an allegation of abuse for 1 of 3 allegations of abuse reviewed in the sample of 9. (Resident #D) Finding includes: The record for Resident #D was reviewed on 11/9/15 at 12:55 p.m. The resident's diagnosis included, but was not limited to, early stage dementia. An entry in the Nursing progress notes dated 9/2/15 at 1:30 p.m., indicated the writer was made aware of an alleged incident that occurred on 8/30/15 at 9:50 p.m. Resident unable to recall incident. Investigation started, Health Wellness Director, Executive Director, Power of Attorney, and Physician notified. The facility investigation was reviewed. Documentation indicated on 8/30/15 at 9:50 p.m., the resident was found crying in the hallway by staff members. The resident stated to staff that an agency nurse was being rough with her. Interview with the Executive Director on	R 0090	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. On or before November 27, 2015, the Administrator will ensure all corrective action in the following POC has been completed. _ · To ensure that no other residents, including resident D, were not further affected by this deficient practice, staff was in-serviced by Executive Director on 11/13/15, 11/24/15, and 11/25/15 about "Identification and reporting of resident abuse policy" and "ISDH Incident Reporting Policy." This included identifying potential abuse,reporting abuse, investigating alleged abuse, and preventing abuse. · Executive Director and designates audited all residents currently at the facility about quality of care or any other concerns that they may have. After reviewing the audits, there was no concerns regarding abuse or mistreatment. Any other concerns not relating to abuse were reviewed on the audits by the ED and then followed through with corrections. If resident was not able to communicate, a skin check was done by a C.N.A or LPN if agreeable by the resident.	12/08/2015

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	11/10/15 at 12:00 p.m., indicated a note was slipped under the Health and Wellness Director's door on 8/30/15 and the note was not found until the Health and Wellness Director returned to work on 9/2/15. The Executive Director indicated that either she or the Health and Wellness Director should have been notified immediately. Review of the facility policy titled "Mandatory Identification and Reporting of Resident Abuse" which was provided by the Executive Director on 11/10/15 at 12:00 p.m., indicated all abuse or suspected abuse must be reported to the community Administrator. In addition, you are required by law to follow the procedure below: The immediate report shall be made verbally to the community Administrator. This state deficiency is related to Complaint IN00185296.		Resident "D" immediately received a skin check. · The Executive Director will ensure all new staff will receive job specific orientation to include being in-serviced on identification and reporting of resident abuse policy. · The Executive Director or designee will continue with scheduled ongoing education on identifying and reporting suspected abuse at least annually and as needed. · Administrator, Director of Health Services, or designee will audit 5% of resident census daily for 30 days and monthly thereafter on an ongoing basis. This audit will consist of their responses on quality of care. If residents able to communicate, each resident will be interviewed to ascertain if they have ever been handled roughly, emotionally abused, or physically abused. If residents are not able to participate in the interview, if agreeable with the resident, resident's skin will be observed for any sign of suspicious bruising. · Executive Director, Health Services Director, or designee will audit 5% of employees daily for 30 days and monthly thereafter on an ongoing basis. This audit will consist of the steps for abuse reporting. · Quarterly, the Quality Assurance committee will review the audits to ensure ongoing compliance.	
R 0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance			

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Bldg. 00	(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, 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. (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. (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. Based on record review and interview, the facility failed to ensure three hours of dementia-specific training was completed annually for 4 of 8 employees who were	R 0120	· All current employees are in compliance with dementia training according to state regulations. · Employee records will be audited monthly for dementia	12/08/2015

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	reviewed for three hour annual dementia-specific training. (CNA #1, CNA #2, Receptionist #1, and Employee #1) Finding includes: 1. The employee file for CNA #1 was reviewed on 11/10/2015 at 10:00 a.m. The CNA was hired on 12/15/2006. The CNA had only completed 1 hour of the three hours required for annual dementia-specific training for the calendar year 2014. 2. The employee file for CNA #2 was reviewed on 11/10/2015 at 10:05 a.m. The CNA was hired on 2/16/2010. The CNA had only completed 1.5 hours of the three hours required for annual dementia-specific training for the calendar year 2014. 3. The employee file for Receptionist #1 was reviewed on 11/10/2015 at 10:10 a.m. The Receptionist was hired on 3/20/2010. The Receptionist had only completed 1.5 hours of the three hours required for annual dementia-specific training for the calendar year 2014. 4. The employee file for Employee #1 was reviewed on 11/10/2015 at 10:15 a.m. The Employee was hired on		training completion by Business Office Director or designee. · Business Office Director will report to Executive Director with audit findings. Based on findings, the ED will ensure all employees receive required dementia training to meet compliance per state regulations. · Resident rights,infection control, fire prevention and safety, accident prevention, special needs, and medication administration will also be included in the annual in-service requirements. · Quarterly, the Quality Assurance committee will review the audits to ensure ongoing compliance.	

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	10/25/2011. The Employee had only completed 1.5 hours of the three hours required for annual dementia-specific training for the calendar year 2014. Interview with the Executive Director on 11/10/2015 at 11:30 a.m., indicated the above employees had not completed their required annual three hours of dementia-specific training.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the facility was clean and in a state of good repair related to stained carpet and tile, marred walls and doors as well as marred chairs on 4 of 4 units throughout the facility. (First, Second, Third, and Memory Care Unit) Findings include: 1. During the Environmental Tour on 11/10/15 at 10:35 a.m., with the Maintenance Supervisor, the following was observed on the First unit: a. The bathroom floor tile in Room 107	R 0144	· Maintenance Director will immediately complete the stated environmental findings for rooms 107, 132, 228, 308, and 428. · Maintenance Director immediately replaced 15 marred and scratched chairs in the dining room and lounge area in Memory Care Unit. Maintenance Director will order more chairs for lounge and dining area until all chairs are replaced. · 5% of facility census resident rooms will be audited for wear and tear daily for 30 days by maintenance director or designee and monthly thereafter on an ongoing basis. · A total house round including common areas will be checked monthly by	12/08/2015

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	was discolored along the edges. b. The bathroom wall in Room 132 was scratched and marred. The bathroom door as well as the door to the resident's room was scratched and marred. The floor tile in the bathroom was discolored along the edges. 2. The Second unit a. The bathroom carpet in Room 228 was stained. The bathroom wall was gouged and marred. The wall by the resident's refrigerator was also scratched and marred. 3. The Third unit a. The carpet in Room 308 was stained in sections near the entry way as well as by the kitchen sink. There were also marred walls and doors near the entrance to the room as well as in the bathroom. 4. Memory Care unit a. The bathroom door was scratched and marred at the base in Room 428. b. There were fifteen chairs in the dining and lounge area that had scratched and marred arms and legs.		maintenance director or designee. · Maintenance Director or designee will report to Executive Director with audit findings according to the time frame. · Quarterly, the Quality Assurance committee will review the audits to ensure ongoing compliance.	

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	Interview with the Maintenance Director at the time, indicated all of the above were in need of cleaning and/or repair.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure sliding scale insulin was administered as ordered for 1 of 9 sampled residents. (Resident #4) Finding includes: The record for Resident #4 was reviewed on 11/9/15 at 1:20 p.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus. The November 2015 Physician's Order Summary (POS), indicated the resident was to receive Novolog insulin based on the following sliding scale:	R 0241	· To determine if any other residents in the facility were affected by the deficient practice, the Director of Health Services immediately audited all sliding scale blood sugars dated back to November 1, 2015. No deficiencies were found. · Director of Health Services or designee will audit all sliding scale blood sugars daily for 30 days and then monthly thereafter on an ongoing basis. · Director of Health Services or designee will meet with the Executive Director after each audit to review and ensure compliance. · Director of Health Services or designee will in-service licensed personnel within 30 days on following physicians orders to include sliding scale insulin	12/08/2015

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	125-150=6 units 151-200=8 units 201-250=10 units 251-300=12 units 301-350=14 units 351-400=16 units Greater than 400 call Physician The September 2015 Medication Administration Record (MAR) was reviewed. The resident received the incorrect dose of insulin on the following dates and times: 9/12/15 Before breakfast blood sugar was 167. The resident received 6 units of insulin rather than 8 units. 9/22/15 Before breakfast blood sugar was 166. The resident received 6 units of insulin rather than 8 units. 9/23/15 Before breakfast blood sugar was 165. The resident received 6 units of insulin rather than 8 units. 9/16/15 Before lunch blood sugar was 254. The resident received 10 units of insulin rather than 12 units. 9/21/15 Before dinner blood sugar was 291. The resident received 14 units of insulin rather than 12 units.		administration. · All staff responsible for assisting/administering medications will be in serviced within 30 days on standards of medication administration. Incidents of medications not being administered as ordered will be investigated and corrective action implemented to avoid a re-occurrence. ·Notified MD and POA on 11/23/15 of incorrect sliding scale dosage for resident #4 for the following dates and times: 9/12/15 before breakfast, and 9/30/15 before dinner, 9/22/25 before breakfast, 9/23/15 before breakfast, 9/16/15 before lunch, and 9/21/15 before dinner. ·Quarterly, the Quality Assurance committee will review the audits to ensure ongoing compliance.	

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	9/30/15 Before dinner blood sugar was 215. There was no documentation of insulin coverage. Interview with LPN #1 on 11/10/15 at 11:15 a.m., indicated the resident did not receive the correct dose of insulin on the above dates.			