

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 12/01/2015
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NAME OF PROVIDER OR SUPPLIER WALNUT CREEK ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 525 BENTEE WES COURT EVANSVILLE, IN 47715
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R 0000 Bldg. 00	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: November 30 and December 1, 2015</p> <p>Facility number: 013642 Provider number: N/A AIM number: N/A</p> <p>Residential Census: 8</p> <p>Sample: 6</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by #02748 on December 3, 2015.</p>	R 0000	<p>R-0000</p> <p>This Plan of Correction is submitted under State regulations applicable to licensed residential care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the Plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, constitute a deficiency or are correctly applied. Werequest this Plan of Correction serve as our credible allegation of compliance.</p>	
R 0117 Bldg. 00	<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</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>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 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.</p> <p>Based on record review and interview, the facility failed to ensure at least one staff member was on duty at all times who was certified in First Aid and CPR (cardiopulmonary resuscitation), in that, 11 (eleven) days lacked a First Aid certified staff member and 9 days lacked a CPR certified staff member. (11/17/15 - 11/30/15)</p> <p>Findings include:</p> <p>The staffing schedule was provided by the Business Office Manager (BOM) on 11/30/15 at 10:00 a.m.</p>	R 0117	<p>Corrective action includes having scheduled staff working in the facility being CPR/First Aid certified. To avoid the same deficient practice, personnel files will be audited to ensure scheduled staff are CPR/First Aid certified. Current staff will have educational opportunity to complete training for CPR/First Aid. To ensure the same deficient practice does not recur, the new hire checklist will have a section for CPR/First Aid added. The Business Office Manager will keep copies of said certification in the personnel files. The corrective actions will be monitored through an audit of the personnel files by the Business</p>	12/31/2015

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	<p>The CPR certifications for staff was provided by the BOM and reviewed on 11/30/15 at 3:05 p.m. The schedule indicated the facility lacked an employee with CPR certification on any shift on 11/21/15 and 11/22/15. The schedule indicated the facility did not have a CPR certified employee working from 6:30 a.m. - 3:00 p.m. on 11/19/15 and 11/29/15. The schedule indicated the facility did not have a CPR certified employee working from 2:30 p.m. - 11:00 p.m. on 11/17/15, 11/18/15, 11/23/15, 11/24/15, 11/25/15 and 11/30/15. The schedule further indicated the facility did not have a CPR certified employee working from 10:30 p.m. - 7:00 a.m. on 11/19/15 and 11/27/15. The schedule lacked an employee certified in First Aid for any shift from 11/17/15 through 11/30/15.</p> <p>During an interview on 11/30/15 at 4:15 p.m., the BOM indicated the employee files were complete and correct.</p> <p>During an interview with the Administrator (Adm) on 12/1/15 at 8:00 a.m., the Adm indicated she thought all nurses were trained on First Aid and was not aware of the need for the certification. The Adm indicated the facility did not have any employees with</p>		Office Manager monthly x3 months for compliance. The Health Services Director will coordinate with staffing schedule and monitor monthly x3 months for compliance with CPR/First Aid certification. Any issues/trends identified will be discussed in the QA committee and resolved accordingly. These systemic changes will be completed by 12/31/15.	

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R 0145 Bldg. 00	<p>First Aid certification.</p> <p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on interview and record review, the facility failed to maintain equipment and supplies in a safe and operational condition for 1 of 5 rooms reviewed. A room alarm call system was not functional. (Room 29)</p> <p>Findings include</p> <p>On 11/30/15 at 10:00 a.m., the record review for Resident #4 indicated the resident had a service plan which included a falls assessment dated 11/4/15. The service plan indicated the resident was a high risk for falls due to having a prior history of falls. A nurses note indicated the resident had a fall on 11/6/15 at 6:30 a.m. The note indicated the resident had been found laying on the</p>	R 0145	<p>Corrective action for Resident #4 that was affected by the deficient practice includes confirmation per testing by Maintenance Director that alarm in room 29 is fully functional as of 12/1/2015.</p> <p>Residents in the facility have the potential to be affected by same deficient practice. Maintenance Director tested all alarms to ensure they were in proper working order on 12/1/2015.</p> <p>The measure for ensuring that the deficient practice does not recur includes the Maintenance Director implementing a log for routine monitoring of the alarm board weekly x4wks, then monthly x3 months.</p> <p>The corrective actions will be monitored per the Administrator completing random checks of this log monthly x4 months. Any</p>	12/31/2015

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	<p>floor next to the bed. The nursing note also indicated there was suspicion the call light was faulty. Additional note on 11/8/15 at 4:00 a.m., the resident was found on the floor next to his bed. The nurses note indicated no alarms had sounded.</p> <p>On 11/30/15 at 11:30 a.m., an interview with RN #1 indicated that each room had a sensory alarm in the ceiling that would alarm when the resident moved. The RN #1 indicated there were different sensitivity modes according to the residents fall risk.</p> <p>On 11/30/15 at 2:13 p.m., an interview with the Administrator (Adm) indicated the facility had discovered after Resident #4's first fall, the nursing board alarm was not working. The Adm was unsure what had been done between the first and second fall.</p> <p>On 11/30/15 at 3:21 p.m., interview with RN #1 indicated interventions were provided after each fall for the resident, but the alarm board had not been checked. RN #1 indicated the sensor alarm had not sounded with each of the falls due to the awareness (sensitivity) of the alarm was not high enough. RN #1 indicated the facility staff were now checking the resident every 30-60</p>		<p>issues/trends noted will be discussed during monthly QA and followed up with accordingly. These systemic changes will be completed by 12/31/15.</p>	

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	<p>minutes.</p> <p>On 12/1/15 at 8:11 a.m., the CNA daily assignment sheets were received from the Administrator indicating the CNAs were to do hourly checks on the residents while in bed.</p> <p>A review on 11/30/15 at 3:34 p.m., a policy titled, "Acknowledgement of Risks in Assisted Living Communities Providing Dementia / Alzheimer's care." indicated the facility does not provide one on one care or continuous monitoring for each resident 24 hours per day. The policy indicated the risk of injury from falls and accidents were a reality. If a resident had sustained a fall prior to moving into our facility, or was considered at risk of falling for other reasons, it is likely that he/she would fall again at some point.</p> <p>During an interview on 12/1/15 at 9:30 a.m., the Maintenance person indicated the facility did not have a log for the alarm boards and the entire hall had not worked at the time of the resident's fall. The Maintenance person indicated the alarm board had been defective and had to be replaced.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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