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 09/06/2012

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STERLING HOUSE OF PORTAGE	3444 SWANSON RD PORTAGE, IN 46368

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: September 4, 5 & 6, 2012 Facility number: 010889 Provider number: 010889 AIM number: N/A Survey team: Kathleen (Kitty) Vargas, RN, TC Census bed type: Residential 39 Total 39 Census payor type: Other 39 Total 39 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2. Quality review 9/07/12 by Suzanne Williams, RN	R0000	**The following is the Plan of Correction for Sterling House of Portage in regards to the Statement of Deficiencies for the annual survey completed on 9-6-12 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, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.**	

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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R0144	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 maintain an environment that was clean and in a state of good repair related to mars and chipped paint on door frames, black caulking on shower stall, soiled carpet area and a soiled light fixture. This had the potential to affect 39 of the 39 residents residing in the facility. (Rooms #404 and #601, the laundry room and 100 hall near the beauty shop) Findings include: 1. During the Environmental tour on 9/6/12 at 1:45 p.m., with the Executive Director, the following was observed: a. The metal trim on the double doors located on 100 hall, near the beauty shop, had areas of chipped paint on the lower 3 feet of the trim. The door frame was in need of paint. b. The floor near the shower stall in Room #404 had areas of black caulking between the floor trim and the shower stall. One resident resided in Room #404. c. The light fixture in the laundry room	R0144	**R 144 410 IAC 16.2-5-1.5 (a)** **Sanitation and Safety - Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** The community makes every effort to provide its residents with a clean, orderly, environment that is in good repair, in order to provide reasonable comfort to our residents. · The metal trim on the double doors located near the 100 hall beauty shop had door trim repainted. · The shower stall floor in apartment #404 had repairs made to the black caulked area. · The light fixture in the laundry room was cleaned inside and out. · The wood door frame outside apartment #601 has been repainted. · The carpet in apartment #601 was cleaned using a professional carpet cleaner. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · The Maintenance Tech /Designee has made completed an environmental audit in order to determine where any additional touch-up painting, cleaning or repairs are needed. · The results of the audit have been reviewed with the Executive Director in order to implement a	10/05/2012

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	had soiled areas on both the outside and the inside of the light fixture. d. The wood door frame, outside of Room #601, had mars and gouges on the wood trim. One resident resided in Room #601. e. The carpet in Room #601 had a 2 foot area that was soiled and in need of cleaning. Interview with the Executive Director at the time, indicated the above areas were in need of cleaning and/or repair.		schedule for the completion of any repairs or touch-up painting that is need in addition to those noted above. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · The community will continue to adhere to the provisions noted in the residency agreement, and signed by all current residents and/or responsible parties, which addresses their responsibility and obligations with respect to the condition and maintenance of a suite. In this section of the residency agreement, the resident and/or responsible party affirms that their suite was received in satisfactory condition. It also provides that, subject to normal wear and tear, the Resident will maintain and surrender the suite in good condition. The Resident also agrees to pay for any damages to the suite or community property. The community may charge the resident and/ or the responsible party for cleaning. · The community will utilize a work –order system for associates/residents to document the need for any cleaning or repairs that is outside the scope of general housekeeping. · These work-order requests will be kept in a centralized location and will be available for review by the maintenance tech/designee. · The Maintenance Tech will review the repair/ cleaning schedule weekly, will check work order binder at each visit, and provide the Executive Director with documentation of all work completed each scheduled work day. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what**	

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			quality assurance programs will be put in place? · The Executive Director will review the repair / cleaning audit tool and Work Order binder weekly for completion. · Based on audit findings, the Executive Director will make additional recommendations for follow-up. ***By what date will these systemic changes be implemented?*** · 10-5-12	

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was prepared under sanitary conditions related to soiled areas on the oven, on the hood above the oven, on the front plate of the stove and on the stove and oven knobs. This had the potential to affect 39 of the 39 residents who consumed food prepared in the facility kitchen. Findings include: 1. During the Kitchen Tour on 9/5/12 at 10:45 a.m., with the Dietary Service Manager, the following was observed: a. The inside walls, doors and bottoms of 2 of 2 ovens were observed with an accumulation of burnt-on food splatter. b. The outside surfaces of 2 of 2 oven doors were observed with burnt-on food spillage. c. The hood edge above the oven had an accumulation of grease stains. d. The front plate of the stove had an	R0154	**R 154 410 IAC 16.2-5-1.5 (k) Sanitation and Safety Standards (deficiency)** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · The inside walls, doors and bottoms of the 2 ovens were cleaned. · The outside surfaces of the 2 oven doors were cleaned. · The range hood was professionally cleaned on 9-14-12. · The front plate of the oven was cleaned using a degreasing agent. · The knobs on the stoves and ovens were cleaned. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · An existing kitchen audit/cleaning schedule tool was utilized by the Dietary Manager and Executive Director to inspect the kitchen for any other areas in need of improvement. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · The dietary staff was	10/05/2012

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	accumulation of burnt-on food and grease. e. The knobs on the stove and on the ovens were sticky with food spillage. Interview with the Dietary Service at the time of the tour, indicated all of the above areas were in need of cleaning.		re-educated by the Executive Director /Designee on the use of the existing cleaning schedule. · A schedule was developed for professional cleaning of the range hood at regular intervals and as needed. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Executive Director / Designee will review the cleaning schedule documentation weekly and will complete weekly visual audits of the kitchen to review compliance with expectations. · The Executive Director will then make additional recommendations, if needed, in order to provide additional support to the dietary team. ***By what date will these systemic changes be implemented?*** · 10-5-12	

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain accurate clinical records related to the lack of a physician's order for laboratory tests for 1 of 7 records reviewed in a sample of 8. (Resident #40) Findings include: The closed record for Resident #40 was reviewed on 9/4/12 at 12:30 p.m. The resident was admitted to the facility on 6/2/12. He had diagnoses that included, but were not limited to, hypertension, degenerative joint disease and memory loss. Review of the resident's laboratory tests indicated the resident had a prothrombin test result (a blood test to assess blood clotting) that was dated 6/19/12. Review of the Physician's Orders, dated 6/2/12 through 6/19/12, indicated there was no physician's order to obtain the blood test	R0349	**R 349 410 IAC 16.2-5-8.1 (a) (1-4) Clinical Records (Non-compliance)** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident #40 had already been discharged from the community at the time of this finding, so no additional action could be taken on behalf of this resident. · Based on the existing third-party provider policy, as well as the Personal Service Plan for this resident, the Home Health agency was responsible for obtaining any lab orders for this resident. · In the event new orders were obtained, the third party provider was responsible for coordinating completion of these orders and providing the community with copies of their orders. At no time were labs obtained without a physician order.· Rather the home Health Provider failed to provide the community with the appropriate documentation of the	10/05/2012

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	on 6/19/12. There was a laboratory test result, dated 7/19/12, for a basic metabolic profile, (BMP). Review of the Physician's Orders, dated 6/2/12 through 7/19/12, indicated there was no order to obtain a BMP on 7/19/12. Interview with the Health and Wellness Director on 9/5/12 at 9:05 a.m., indicated the record was lacking clarification orders from the Physician to obtain the prothrombin test on 6/19/12 and the BMP on 7/19/12. She indicated there should have been a written physician's order for both of the lab tests.		orders they received. · A conference was held with this Home Health Provider to review the community's expectations regarding provision of documentation going forward. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents utilizing third-party providers for Home Health or Hospice have the potential to be affected by the alleged non-compliant practice. · To that end, the Executive Director/Health and Wellness Director/Designee will schedule meetings with current outside agencies providing care in our community. · The Third – Party provider expectations will be reviewed with their representatives, and a copy of the document will be provided. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Third-party providers will be required to sign-in and out of the community, at which time the third party provider is to give a verbal report to one of the community's nurses on duty. · At this time, they are to communicate any new orders received as a result of their visit as well as communication with	

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			the attending physician. · Such orders, if applicable, will be documented by the nurse prior to leaving each day. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Health and Wellness Director /Designee will audit Home Health and Hospice orders weekly, and will make recommendations for additional corrective actions and QA based on audit findings, reporting all findings to the Executive Director on a monthly basis. ***By what date will these systemic changes be implemented?*** · 10-5-12	