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 05/04/2012

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HEARTH AT WINDERMERE	9745 OLYMPIA DR FISHERS, IN 46038

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R0000	This visit was for a State Residential Licensure survey. Survey dates: May 1, 2, 3, and 4, 2012 Facility number: 002999 Provider number: 002999 AIM number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Heather Lay, R.N. (5/2 and 5/3) Melanie Strycker, R.N. Census bed type: Residential--96 Total--96 Census payor type: Other--96 Total--96 Sample: 10 These State findings are cited in accordance with 410 IAC 16.2. Quality review completed on May 9, 2012 by Bev Faulkner, R.N.	R0000	***DISCLAIMER:*** ***Preparation and implementation of this plan of correction does not constitute admission or agreement by (facility name) of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated May 4, 2012. The Hearth at Windermere specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider. The facility reserves the right to challenge the findings by way of independent review procedures established by the agency.***	

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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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to ensure that the lint filter screen for 1 of 1 dryers was cleaned before using it to dry laundry for residents of the Keepsake unit [the Alzheimer's unit]. This had the potential to impact 18 residents residing on the Keepsake unit, which is a separate building sharing a common wall with the main building and adjacent to the kitchen. Findings include: During the environment tour on 5-2-12, at 10:00 A.M., the dryer in the Keepsake unit was observed to contain a large sheet of lint that had fallen off the lint screen. There were clothes in the dryer and it was	R0148	1. The lint filter was cleaned. 2. All residents in the facility could be affected due to the safety issue. On May 17, 2012, the entire housekeeping, laundry and maintenance staff were provided a copy of the facility policy requiring the lint trap is cleaned after each load of laundry and were inserviced on the proper method of cleaning the lint trap. 3. Besides the inservice and review of the policy and procedure, the Housekeeping Supervisor will inspect the lint traps at various times thoughout each day to ensure the lint traps are being cleaned properly. 4. The Maintenance Supervisor and maintenance staff deep clean behind, inside and around the dryers and they will also monitor	05/17/2012

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	running. In an interview at that time, the Director of Housekeeping indicated the staff member washing laundry was expected to clean the lint filter screen after every load of laundry dried. In an interview on 5-3-12, at 3:30 P.M., the Director of Maintenance indicated the facility had a lint fire in that dryer in the past year. On 5-4-12, at 9:28 A.M., the Executive Director provided a copy of the facility's "Laundry Services Policy" [no date indicated]. The policy included, but was not limited to, the following: "... The Assistant managing the dryers will be responsible for cleaning the dryer lint filter screen by hand after every load...."		to determine if the lint traps are being cleaned per facility policy. The Housekeeping Supervisor will be responsible for ensuring the lint traps are cleaned after each load by monitoring the dryer(s) during operation and will training new staff on proper policy and procedure for cleaning the lint traps. Inservice was completed on May 17 and staff are fully compliant with this issue as of May 17, 2012.	

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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, interview and record review, the facility failed to ensure that the ice machine was clean for 1 of 1 ice machines in 1 of 1 kitchens. This had the potential to affect 96 residents who receive ice from the kitchen. Findings include: During the kitchen tour on 5/1/12 at 10:47 A.M., with Cook #1, the ice machine was noted to have brown liquid matter surrounding each of the brackets which open the ice machine door. During the tour on 5/2/12 at 11:15 A.M., the brown liquid looking material was pointed out to the Food Service Director (FSD). The Food Service Director was asked to provide any documentation and/or policies regarding the cleaning schedule of the ice machine. In an interview on 5/3/12 at 10 A.M., the Food Service Director (FSD) indicated a	R0154	The ice machine in question was cleaned and sanitized immediately after the conversation with the state inspector on 5/1/12. Director of Food Services contacted "VANCO" our refrigeration maintenance company who we are contracted to do preventative maintenance on the ice machine. Vanco came out 5/4/12 to do a professional cleaning and sanitizing of the ice machine. Vanco is contracted to clean and sanitize the machine twice a year, which is sufficient. However they missed the rotation due in February. Vanco assured me this will not happen again. To make certain of this Director of Food Services posted a laminated cleaning schedule to the front of the ice machine along with a sign off sheet to inspect the	05/04/2012

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	company comes and cleans the ice machine, but did not recall when the last cleaning was done. The FSD provided an invoice that indicated the last cleaning was performed on 9/23/11. The Food Service Director indicated the cleaning is scheduled to be performed two times a year. On 5/3/12 at 11 A.M., the Executive Director provided an undated policy titled "Dietary Services Policy. The policy indicated, " ...The Food Service Director shall see that all state and local health ordinances related to food service and sanitation are strictly observed in the storage, preparation and distribution of food, in the cleaning of dishes, equipment ... " "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following: Section 205(a) "Materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious (hazardous to health) substances or impart colors, odors, or tastes to food and under normal use ... "		ice machine the first of every month. Director of Food Services is responsible for this documentation.	

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. A. Based on interview and record review, the facility failed to ensure that 4 of 5 residents were evaluated prior to admission to the Keepsake secured/locked Alzheimer's unit to determine if their individual needs required placement on that unit; in a sample of 10 residents reviewed. [Residents #23, #25, #34, and #50] B. Based on interview and record review, the facility failed to ensure a semi-annual evaluation was completed for 1 of 1 residents; in a sample of 10 residents reviewed. [Resident #36] Findings include: A.1. In an interview during the initial orientation tour on 5/1/12 at 11:20 A.M., L.P.N. #5 indicated Resident #23 was able to walk only with assistance, was at risk for falls and utilized a bed alarm, and recently contracted with a Hospice agency for Hospice services.	R0214	The facility has implemented a new policy that will be used to determine when a resident will be admitted to Keepsake Village Unit. The current residents will re-assessed to make sure they all meet the appropriate policy for admission to Keepsake Village Unit. The residents will continue to be assessed for admission to the Hearth at Windermere for services needed and the level of care. During the assessment, along with family members the Assessment Nurse will assess cognitive ability, elopement risk and follow the Admission Criteria which includes, but is not limited to: “Keepsake Village Unit Admission Criteria · Resident has a diagnosis of dementia or dementia related diagnosis including but not limited to Alzheimer’s Disease or other cognitive impairments.	06/21/2012

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	The clinical record for Resident #23 was reviewed on 5/1/12 at 1:30 P.M. The resident was admitted directly to the Keepsake secured/locked Alzheimer's unit on 10/29/11. Diagnoses included, but were not limited to, dementia, depression, incontinence of bowel and bladder, chronic kidney disease, hypertension, and congestive heart disease. A four-page "Service Assessment" form, checked as "Pre-admit," was dated on 3 of the pages as "10/26/12" and signed by L.P.N. #5 on "10/26/12." The assessment indicated the resident had been admitted to a room on the secured/locked Alzheimer's unit. None of the information indicated the reason why Resident #23 required admission directly to the secured/locked Alzheimer's unit. During the daily conference on 5/2/12 at 2:45 P.M., the Executive Director was given the opportunity to submit any additional evidence that Resident #23 was evaluated for appropriate placement on the secured/locked Alzheimer's unit prior to admission to that unit. At the final exit on 5/4/12, no additional evidence/documentation of an evaluation was provided for review.		· Resident has disorientation to time and place and makes inappropriate decisions · Resident who has a psychosis/ mental illness diagnosis and/or acute/ chronic depression will be evaluated on a per case basis. · Resident must be medically stable · Resident must be free from communicable diseases that would require isolation from other residents. · If a resident has physically abusive/ combative behaviors, they must be manageable through therapeutic approaches of low to moderate medication. · Resident must be physically and mentally able to participate in the programming of the unit consistently everyday. · Physician must approve placement in the program and the physician's order must be received · Interdisciplinary team must complete pre-assessments including assessment of level of confusion, exit seeking behaviors, extent of wandering, danger to themselves/ others and personal safety and accept resident in to the program.	

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	A.2. In an interview during the initial orientation tour on 5/1/12 at 11:30 A.M., L.P.N. #5 indicated Resident #25 was able to walk using a walker, and occasionally became verbally aggressive with staff and other residents but was able to be re-directed. The clinical record for Resident #25 was reviewed on 5/3/12 at 10:50 A.M. The resident was admitted directly to the secured/locked Alzheimer's unit on 2/20/12 with diagnoses which included, but were not limited to, senile dementia--Alzheimer's type, chronic low back pain, hypertension, history of migraines, and osteoarthritis. A "Service Assessment" form, checked as a "Pre-Admit" assessment and dated 2/1/12, indicated the resident required cueing, supervision, and/or assistance with daily care [bathing, toileting, dressing, etc.] and only "minimal intervention" with behaviors. None of the information indicated the reason why Resident #23 required admission directly to the secured/locked Alzheimer's unit. During the daily conference on 5/3/12 at 3:15 P.M., the Executive Director was		· Family/ responsible party is willing to have the resident participate in the program. " The current residents on the Keepsake Unit will have a cognitive screen by the Keepsake Village Unit Manager (as per the Vigilan Assessment Software) and Elopement Risk Assessment (per Vigilan Software) within the last calendar quarter or a new one will be performed within the next 30 days to ensure that they are appropriately placed on the Secured Memory Care Unit. New residents wishing to enter the Keepsake Village Unit will have the Assessments, meet the criteria, have an MD order stating that placement on secured unit is appropriate for the resident and family/ POA approval will be obtained for all future residents on the Keepsake Village Unit. The above measures will be used systematically for all new move-ins for the Keepsake Village Unit. The Assessments will be collected and placed in the chart upon admission to the Keepsake Unit. The Unit Manager or a nurse designee will assess, and collect the information, consents, MD order and the Director of Nursing and/or Executive Director will review prior to all move-ins on	

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	given the opportunity to submit any additional evidence that Resident #25 was evaluated for appropriate placement on the secured/locked Alzheimer's unit prior to admission to that unit. At the final exit on 5/4/12, no additional evidence/documentation of an evaluation was provided for review. A.3. The clinical record of Resident #34 was reviewed on 5-3-12 at 1:25 P.M. The resident was originally admitted to the facility general population of the facility		the Keepsake Village Unit. The changes will be in place and Keepsake Unit Manager and the nurses will be in-serviced by the Director of Nursing by June 21, 2012.	

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	on 6-13-05, with diagnoses that included, but were not limited to, hypertension and dementia. During the daily conference on 5-3-12, at 3:30 P.M., the Executive Director was given the opportunity to submit documentation/evidence of resident's actual admission date to the Keepsake unit and any evaluation of the resident indicating appropriateness for admission to the secured unit. In an interview during the daily conference on 5-4-12, at 11:25 A.M., the Executive Director indicated they transferred the resident to the Keepsake unit on 12-8-11, the day they found her in her wheelchair in the vestibule between the external and internal doors of the facility. At the final exit on 5-4-12, at 2:00 P.M., no additional evaluation documentation was provided for review. A.4. In an interview during the initial orientation tour on 5/1/12 at 11:40 A.M., L.P.N. #5 indicated Resident #50 was admitted directly to the Keepsake unit about 2 months ago. The clinical record for Resident #50 was reviewed on 5/2/12 at 10:15 A.M. The resident was admitted on 4/4/12 with			

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	diagnoses that included, but were not limited to, dementia, depression, hyponatremia, osteoporosis, history of falls with head trauma [prior to admission], and potential deep vein thromboses. A "Service Assessment," dated 4/2/12, indicated "Orientation, Behavior, Safety: Need assistance with management of behaviors at least weekly..." A "Nurse's Notes," dated 4/4/12 at 9:00 P.M., indicated "[Resident #50] Admitted... son transported... very confused and disoriented, nervous...." A "Fall Risk" assessment, dated 4/4/12, indicated Resident #50 scored an 18 [a score greater than 10 equals a high fall risk]. There were no other assessments located in Resident #50's clinical record regarding evaluation for the locked unit. During the daily conference on 5/2/12 at 3:00 P.M., the Executive Director and Director of Nursing were given the opportunity to provide a pre-admission evaluation demonstrating her placement on the secured/locked Alzheimer's unit was appropriate.			

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	In an interview on 5/3/12 at 9:30 A.M., the Director of Nursing indicated the facility did not have any other pre-admission evaluation for Resident #50. A.5. Following the survey entrance conference on 5/1/12, the Executive Director provided copies of the "Residential Care Residency and Service Agreement with Attachments" for "The Hearth at Windermere" and "Keepsake Village of Windermere" [the secured/locked Alzheimer's unit]. Both service agreements contained the same information. During the daily conference on 5/2/12 at 2:45 P.M., the Executive Director was given the opportunity to identify and clarify the criteria used to determine the specific needs of a resident that would qualify them to be admitted to the Keepsake unit. On 5/3/12, the Executive Director provided a two-page policy, dated 7/13/01 and titled "Pre-Admission Assessment Policy." The Policy included, but was not limited to, the following information: "PURPOSE: To establish guidelines for the acceptance of individuals for residency and to ensure that only those			

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	individuals whose needs can be met by the facility staff and services are admitted to the assistive living or the residential living area(s).... POLICY: It is the policy of Keepsake Village at The Hearth of Windermere to conduct a pre-admission assessment for each prospective resident prior to residency. The assessment shall be used to assure appropriate accommodations are provided.... STANDARDS: 1. The admission team reviews all prerequisite information relating to a prospective resident's qualifications for residency and to approve applicants for residency. 2. The team shall function in accordance with established admission criteria, policies and procedures...." The Executive Director also provided a 1-page paper, dated as revised September 2011, and titled "Keepsake Admission Policy." The policy included, but was not limited to, the following information: "... The determination of who may be appropriate for the unit is based on the resident's needs, the family's reiteration of the history and the attending Physician's recommendations. In determining whether the correct placement for a			

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	resident in a secured unit or nonsecured unit the following criteria will be considered: 1. Does the prospective resident have a legal guardian? If so then the features of the Keepsake unit will be explained to the legal guardian so they may determine whether the unit is a good fit for the resident's needs. Once the legal guardian and the attending physician determine the unit is appropriate for the resident then the community may consider admitting the resident. Other criteria for admission are the resident must be appropriate for admission based on assessments done by community nursing staff, other community policies and procedures for admission and state regulation concerning admission to assisted living communities...." The remainder of the policy addressed who would make medical decisions if a resident was or was not competent, and had or did not have legal guardianship. The actual specific baseline criteria used to determine if a resident would be appropriate for a secured/locked unit was not listed. In an interview on 5/3/12 at 9:30 A.M., the Executive Director indicated the facility used the two policies as the criteria to determine residency on the secured/locked unit.			

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	B.1. The clinical record for Resident #36 was reviewed on 5/2/12 at 11:00 A.M. Diagnoses included, but were not limited to, dementia, diabetes, and depression. A "Service Assessment," dated 4/21/11, was the most current service plan located in the resident's clinical record. During the daily conference on 5/2/12 at 3:00 P.M., the Executive Director and the Director of Nursing were given the opportunity to submit a completed semi-annual evaluation that would have been due on or about October, 2011. On 5/3/12 at 9:30 A.M., the Director of Nursing indicated the 4/21/11 "Service Assessment" was the only one she could locate.			

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R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to identify services provided to a resident [Resident #50] with a recent fall; and failed to have the service plans signed by the resident/legal representative [Residents #36 and #101]. The deficient practice impacted 1 of 1 resident reviewed with a history of falls, and 2 of 2	R0217	The Unit Manager and Director of Nursing schedule semi- annual care conferences with family members and residents. They are scheduled for the year by the Director of Nursing or a designee. The family is sent an invitation via United States Postal Service and the residents are	06/21/2012

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	residents in a sample of 10 residents reviewed. Findings include: 1. In an interview during the initial orientation tour on 5/1/12 at 11:40 A.M., L.P.N. #5 indicated Resident #50 had been in the facility for about 2 months, was ambulatory with a walker, was at risk for falls because she tired easily, and had fallen while on an outing. The clinical record for Resident #50 was reviewed on 5/2/12 at 10:15 A.M. The resident was admitted on 4/4/12 with diagnoses that included, but were not limited to, dementia, depression, hyponatremia, osteoporosis, history of falls with head trauma [prior to admission], and potential deep vein thromboses. A "Service Assessment," dated 4/2/12, indicated "Pre-Admit... Mobility, Transfers, Escort: Assistance required with mobility. Transport to and from all meals per walker.... Every 2 hour checks for safety and toileting and every 4 hour [safety checks] during the night...." A "Fall Risk" assessment, dated 4/4/12, indicated Resident #50 scored an "18" [a score greater than 10 equals a high fall		sent one (delivered to their apt). A copy of the invitation is placed in the Medical Chart under "Care Plan" tab. The family members are given several ways to contact the attendees for the care conferences to rsvp to the meeting or set up alternate times, request to have the care plan mailed, email, telephone conference or fax the care plan to them, etc. They are reviewed and signed during those meetings. The Director of Nursing and Keepsake Village Unit Manager will review all charts to ensure that the Care Plans have been signed by the resident or their designee. The Keepsake Unit Manager and the Director of Nursing will ensure that all residents or designees that fail to respond to the care conferences are sent a copy via United States Postal Service or any other way that they wish to receive the Care Plan. They will then be able to review the Care Plan, sign it and return it. A note will be placed on the Medical chart with the information of when it was sent and the route of which it was sent to the resident and/or designee. An audit will be completed of all medical charts to ensure that each resident and/ or designee have had the opportunity to review and sign their care plan. A new meeting time will be scheduled as needed. For non-compliant residents and	

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	risk]. A Nurse's Note, dated 4/11/12 [no time listed], indicated Resident #50 had fallen while on an outing, with no injury noted at that time. A Physical Therapy progress note, dated 4/20/12, indicated Resident #50 was evaluated on 4/20/12 and was scheduled to receive physical therapy services through 5/25/12 for transfers. During the daily conference on 5/2/12 at 3:00 P.M., the Executive Director and Director of Nursing were given the opportunity to submit all service plans formulated since the resident's admission. On 5/3/12 at 9:30 A.M., the Executive Director provided a "Capital Senior Living Assessment" for Resident #50 that was dated 5/2/12. She indicated this was the Service Plan for the resident. In an interview at that time, the Director of Nursing indicated the facility did not have any other Service Plans for Resident #50. A Service Plan from admission addressing the resident's history and risks of falls was not provided for review. A Service Plan, revised after the fall on 4/11/12 and addressing services to be		designees, the Executive Director will be notified for assistance in obtaining the signature. The Keepsake Unit Manager and Director of Nursing will follow up with any absent residents and designees at the end of the care conference days. A review of the daily Care Conference Schedule will be the tool for attendance and follow up. A note will also be placed in the medical chart . The Director of Nursing will in-service the Keepsake Unit Manager on the procedure. The in-service and audit will be completed by June 21, 2012	

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	provided was not provided for review. 2. On 5/2/12 at 11:00 A.M., Resident #36's record was reviewed. Diagnoses included, but were not limited to, dementia, diabetes, and depression. A "Service Assessment," dated 4/21/11, did not have signatures for the resident or authorized family member. A signature was present for the staff member completing the evaluation On 5/2/12 at 3:00 P.M., the signature page was requested from the Executive Director and the Director of Nursing. On 5/3/12 at 9:30 A.M., in an interview, the Director of Nursing indicated there was no further information to provide on Resident #36's 4/21/11 service plan. 3. Record review for Resident #101 was completed on 5/3/12 at 10:45 A.M. Diagnoses included, but were not limited to, anxiety, overactive bladder, vertigo and history of pelvic fracture. Resident #101 was admitted on 11/20/10. She had hospitalizations and the most recent readmission was on 12/27/11. The chart indicated the resident fell on 10/21/11, went to hospital and returned. The resident then went to rehabilitation 10/25/11 and returned 12/27/11. The			

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	resident fell again on 4/11/12 and was sent to the hospital and then to rehabilitation. The service plans found in the chart were dated: 10/22/11 and 4/11/12. Both of these service plans had no resident or family member signature. During an interview with the DoN on 5/4/12 at 10 A.M., she indicated the resident had gone out for rehabilitation and didn't get a chance to sign it, and that she had contacted the son by phone and he indicated he planned to sign the most recent service plan after the resident returned from rehabilitation. She indicated the service plan from 10/25/11 was not signed for the same reason.			

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure 3 of 4 employees for 1 of 1 the kitchens had their hair fully secured under a hair restraint. This deficiency had the potential to affect 96 of 96 residents living in the facility who received food from the kitchen. [Cook #1, Server #2, and Server #3] Findings include: During the kitchen tour on 5/1/12 at 10:47 A.M., Cook #1 was noted to have her bangs and several strands of hair hanging out from under her hair net. On 5/2/12 at 11:15 A.M., during the kitchen tour, Cook #1, Server #2 and Server #3 were noted to have hairs that were not secured underneath the hair net. The cook was preparing food and getting ready to serve the residents' lunch at this time.	R0273	All kitchen staff members were wearing hair nets. However, there were strands of hair sticking out of some of the hair nets. The Director of Food Service immediately conducted an informal in-service with all employees demonstrating the proper way to wear a hair net so hair is restrained. Director of Food Services will conduct a formal in-service and have all documentation in personnel files by 5/31/12 Director of Food Services and Cooks will monitor to ensure all staff have thier hair nets on properly.	05/31/2012

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	In an interview with the Kitchen Manager on 5/2/12 at 11:17 A.M., he indicated the employees should have all of their hair restrained. On 5/3/12 at 11 A.M., the Executive Director provided an undated policy titled " Dietary Services Policy. The policy indicated, " ...B. Hair must be restrained. This may be accomplished by wearing a cap with long hair placed under cap or pulled back and secured through hole in cap or by wearing a hairnet ... " "Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following: Section 138(a) " ...food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens and (3) unwrapped and single-service and single-use articles ... "			

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R0410	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 repeat testing will depend on the risk of infection with tuberculosis. (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. Based on record review and interview, the facility failed to complete a first step tuberculin skin test for tuberculosis on or prior to admission; or a second step tuberculin skin test within 3 weeks of the first tuberculin skin test; for 2 of 2 residents in a sample of 10 residents reviewed. [Residents #23 and #50] Findings include: 1. The clinical record for Resident #50 was reviewed on 5/2/12 at 10:15 A.M. The resident was admitted to the facility	R0410	Residents admitting to the Hearth at Windermere will receive a Tuberculin skin test within three months prior to admission or upon admission. The Licensed Nurses will be in-serviced on collecting the PPD documentation prior to admission or giving a PPD upon admission. Resident #50 and Resident #23 were both given PPDs upon discovery (on May 2, 2012) that they not been administered the 2 nd step. The Director of Nursing will conduct and audit of all PPD records for all residents. The schedule for each PPD	06/21/2012

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	on 4/4/12 with diagnoses which included, but were not limited to, dementia, depression, osteoporosis, and potential deep vein thromboses. A "Resident TB/Immunization Record" indicated the first step tuberculin test was placed on the day of admission of 4/4/12, and read on 4/6/12. A second step test was recorded as placed on 5/2/12 with no date of the results. The time frame between the first step and the second step was 4 weeks. On 5/2/12 at 3:00 P.M., any other tuberculin skin tests were requested from the Executive Director and Director of Nursing. On 5/3/12 at 9:30 A.M., the Director of Nursing indicated she did not have any other documentation for Resident #50's tuberculin skin testing. 2. The clinical record for Resident #23 was reviewed on 5/1/12 at 1:30 P.M. The resident was admitted on 10/29/11 with diagnoses that included, but were not limited to, dementia, anemia, history of colon cancer, and congestive heart failure. A "Resident T.B./Immunization Record" form indicated the resident had a first-step tuberculin skin test for tuberculosis		due is on the Director of Nursing's calendar and each of the two nurse's station daily calendars. The date the PPD is due is on the Medication Administration Record (MAR) and will also be maintained on the Physician's orders provided by the pharmacy. Each nurse will also review the PPD record with the re-writes every month. The nursing staff will be in-serviced on the PPD audit, schedule and procedure. The Director of Nursing and Keepsake Village Unit Manager will spot check the PPD records after the audit is complete to ensure compliance and timely TB skin testing is completed. The completion date for the audit is June 21, 2012.	

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	placed on 11/1/11, the day after she was admitted to the facility. A second step tuberculin test was not documented. During the daily conference on 5/2/12 at 2:45 P.M., the Director of Nursing was given the opportunity to provide any additional documentation of a second-step tuberculin skin test, or information that the resident did not require a second-step because a tuberculin skin test had been done in the previous 12 months prior to admission. In an interview on 5/3/12 at 3:15 P.M., the Director of Nursing indicated she was unable to find any information that the resident had a second-step tuberculin test, or that a test had been done in the 12 months prior to admission.			