

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 05/27/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 26 and 27, 2015</p> <p>Facility number: 013330 Provider number: 013330 AIM number: N/A</p> <p>Census bed type: Residential: 15 Total: 15</p> <p>Sample: 07</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>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. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors</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 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</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>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. Based on record review and interview, the facility failed to ensure 4 of 10 facility staff had CPR (Certified Pulmonary Resuscitation) and first aid certification (Employee #10, #15, #16 and #21) and 3 of 10 had first aid certification (Employee #4, #9, #20).</p> <p>Finding includes:</p> <p>On 5/27/15 at 4:00 P.M., review of the 10 employee files sampled indicated Employee # 4, #9 and #20 did not have first aid certification. Employee #10, #15, #16 and #21 did not have documentation of CPR or first aide certification.</p> <p>On 5/27/15 at 4:15 P.M., review of the May 2015 working schedule for the facility regarding staffing indicated from May 17 through May 31, 2015 twenty eight out of forty two shifts did not have at least one CPR/first aide certified staff</p>	R 0117	<p>1. Employee #4 and #9 will have first aide certification by date of correction. Employee #21 is currently off of the schedule. ISD gave no record to facility of employee # 10, 15, 162. Employee files were audited and no other staff were deficient in CPR or first aide certification³. Upon hiring staff will be required to provide proof of current CPR/first aide certification. This will include any staff utilized from a staffing agency.⁴ BOM will be responsible for monitoring new hire paperwork to ensure compliance. Audits will be completed for 7 months. The first 3 months audits will be conducted every 2 weeks. For the final 4 months, audits will be conducted monthly.</p>	07/12/2015

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R 0120 Bldg. 00	<p>working.</p> <p>During an interview on 5/27/15 at 4:30 P.M., the Director of Nursing (DON) indicated she has a current CPR and first aide certification and works during the day shift so the problem is on second and third shift. The DON further indicated her aides "might" have CPR/first aid certification but she doesn't know or receive it if they do.</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, 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</p>			

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	<p>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:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure the required dementia, abuse and residential rights inservicing was completed for 1 of 10 sampled employees. (Employee # 19) In addition, the facility failed to ensure the new employee orientation was completed for 3 of 10 sampled employees. (Employee #4, Employee #9 and Employee #19)</p> <p>Findings include:</p> <p>1. On 5/27/15 at 3:30 P.M., review of the 10 employee files sampled indicated Employee #19 was hired on 11/17/14 , there was no documentation in the file that Employee #19 had completed the new employee orientation which includes the resident rights, abuse and dementia training.</p> <p>During an interview on 5/27/15 at 3:40 P.M., the Director of Nursing indicated</p>	R 0120	<p>1. Employee # 19, 4, 9 have had the proper training and orientation completed and signed documentation.2. Residents and staff at the facility have the potential to be affected.3. Upon hiring staff will be given proper new employee orientation to include resident rights, abuse, and dementia training by the department managers prior to working on the floor.4. The BOM will be responsible for monitoring new hire paperwork to ensure compliance. Audits will be completed for 7 months. The first 3 months audits will be completed every 2 weeks. For the final 4 months, audits will be completed monthly.</p>	07/12/2015

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R 0121 Bldg. 00	<p>when Employee #19 was hired she started as an interim Administrator and once she accepted the Administrator position the new employee and job specific orientation either was not completed or was not placed in the employee file.</p> <p>2. A form titled " New Employee Orientation" indicated Employee #4's hire date was 3/5/15, the date orientation was completed was left blank and Employee #4 had not signed the form.</p> <p>A form titled "New Employee Orientation" indicated Employee #9's hire date was 4/23/15, the date orientation was completed was left blank and Employee #9 had not signed the form.</p> <p>During an interview on 5/27/15 at 3:45 P.M., the Director of Nursing indicated the new employee orientation forms should be signed and dated by the employee when the orientation is completed.</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</p>			

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	<p>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:</p> <p>(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 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 record reviews and interview, the facility failed to ensure facility staff was given a timely tuberculin skin test at the start of employment. (Employee # 7) In addition, the facility failed to ensure an</p>	R 0121	<p>1. Employee #7 was given as indicated. Employee #21 is currently off the schedule until TB is completed.2. Residents and staff of the facility have the potential to be affected.3. Staff</p>	07/12/2015

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	<p>employee, with a history of a positive tuberculin skin test, completed a tuberculin risk assessment. (Employee #21) This affected 2 of 10 sampled employees.</p> <p>Findings include:</p> <p>1. On 5/27/15 at 12:05 P.M., ten employee records were reviewed which indicated Employee #7's start date at the facility was 2/26/15, and the 1st step TB (Tuberculin) skin test was administered on 5/4/15 and read on 5/6/15.</p> <p>During an interview on 5/27/15 at 2:30 P.M., the Director of Nursing indicated the day Employee #7 started she personally gave the employee a TB skin test and must have forgotten to write it down.</p> <p>2. On 5/27/15 at 1:55 P.M., Employee #21's record was reviewed which indicated her start date at the facility was 12/1/14. There was no indication Employee #21 received a TB skin test before the start of employment and there was no TB risk assessment in the employee's record.</p> <p>A form titled "Radiology Interpretation" dated 10/14/14, indicated a history of a positive PPD (purified protein</p>		<p>will be given 1st step TB at the start of employment and documented on the appropriate form. 2nd step TB will be given 2 weeks later and documented per protocol.4. BOM will be responsible for monitoring new hire paperwork to ensure timely compliance for TB tests. Monitoring will include audits of personnel files for 7 months. Audits will be conducted every 2 weeks for the first 3 months. For the final 4 months, audits will be conducted monthly.</p>	

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	<p>derivative). Procedure: Chest X-ray. Result: No acute finding.</p> <p>During an interview on 5/27/15 at 3:30 P.M., the Director of Nursing indicated she reviewed Employee #21's record and found a chest x-ray that indicated the employee had a history of testing positive to the TB skin test but could not find a risk assessment in the employees file.</p> <p>On 5/27/15 at 3:50 P.M., the Director of Nursing provided a policy titled, "Tuberculosis Screening," dated 12/2014, and indicated the policy was the one currently used by the facility. The policy indicated "...1. For each individual required to be screened for infectious tuberculosis, the facility obtains from the individual: a. At the time of employment or one (1) before the date the employee or volunteer begins providing services one the following will occur: i. Documentation of a negative Mantoux 2-step skin test or other tuberculosis screening test recommended by the U.S. Centers for Disease Control and Prevention (CDC) administered within twelve (12) months before the date the employee or volunteer begins providing services at the facility...2. The facility shall establish, document and implement a tuberculosis infection control program that complies with the Guidelines for</p>			

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R 0304 Bldg. 00	<p>Preventing the Transmission of ...tuberculosis in health-care settings, which includes: a. Conducting tuberculosis risk assessments, conducting tuberculosis screening testing...b. Maintaining documentation of any: i. Tuberculosis risk assessment. ii. Tuberculosis screening test of an individual who is employed by the facility...."</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or</p>			

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	<p>mobile drug storage unit.</p> <p>Based on observations, interview and record review, the facility failed to ensure medications were appropriately locked in the medication cart during 5 of 5 resident's medication administrations. (Resident #8, #9, #10, #11, and #12)</p> <p>Finding includes:</p> <p>On 5/26/15 at 12:00 P.M., LPN #1 was observed preparing Resident #8's noon medication in the hallway around the corner from the dining room. After she had removed a risperidone (an antipsychotic) 1 milligram (mg) tablet from the multi-dose pill punch card, LPN #1 laid the pill punch card that contained the remaining doses of risperidone on the top of the medication cart and walked away from the medication cart into the dining room to administer Resident #8's medication. LPN #1 returned to the medication cart and put the risperidone pill card inside the medication cart. LPN #1 then proceeded to remove another multi-dose punch card for Resident #9 which contained Levaquin (an antibiotic). She took one pill from the punch pack. LPN #1 was observed getting a large container of miralax powder out of the medication cart. She then mixed the miralax dose with water. LPN#1 left the container of miralax and Levaquin pill</p>	R 0304	<p>1. Resident # 8,9,10,11,12 did receive their medication appropriately.2. Residents in the facility did have the potential to be affected by this practice.3. LPN #1 was retrained on proper medication pass to include storage of medication and locking the medication cart. It is and has been the practice of LPN #1 to keep her medications locked and will continue to be the practice. Any person administering medication will be trained on the facilities medication Management Policy (see attachment # 1) for centrally stored and locked medications.4. Random monitoring will be conducted by the HSD to ensure medication security for all three shifts for 7 months. Monitoring will be conducted weekly for the first 3 months and monthly for the final 4 months.</p>	06/12/2015			

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	<p>punch card on the medication cart as she walked toward Resident #9 who was in the dining room. The medication was unattended on the cart. The LPN returned to the cart and placed the medications that were on top of the cart inside the cart.</p> <p>On 5/26/15 at 12:11 P.M., LPN #1 was observed preparing a dose of oxybutynin 5 mg from a multi-dose punch card for Resident #10. LPN #1 walked away from the medication cart leaving and entering the dining room leaving the oxybutynin (medication for overactive bladder) on top of the medication cart. The LPN administered the medication to Resident #10. She then checked on another resident before returning to the medication cart. LPN #1 prepared levothyroxine (thyroid medication) 100 mcg (micrograms) and celexa (antidepressant) 20 mg for Resident #11. The LPN left the multi-dose punch cards on top of the cart and walked into the dining room to administer the resident's medications.</p> <p>On 5/26/15 at 12:16 P.M., LPN #1 was observed preparing Resident #12's noon medications. She pulled 3 multi-dose pill punch cards containing quetiapine (an antipsychotic) 25 mg., ferrous sulfate (iron) 325 mg. and vitamin C 250 mg.</p>			

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R 0410 Bldg. 00	<p>LPN #1 left the multi-dose pill punch cards on top of the medication cart as she administered Resident #12's medication in the dining room.</p> <p>During an interview on 5/26/15 at 12:20 P.M., LPN #1 indicated she meant to put the multi-dose pill punch cards inside the cart before entering the dining room. She further indicated she normally did not leave medications on top of the cart unattended.</p> <p>On 5/26/15 at 3:25 P.M., the Director of Nursing indicated the facility had no policy regarding medication storage.</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 record review and interview, the facility failed to ensure residents newly admitted to the facility were given a timely tuberculin skin test for 2 of 7 residents reviewed for tuberculin skin tests. (Resident # 3 and Resident #8)</p> <p>Findings include:</p> <p>1. On 5/27/15 at 9:15 A.M., the clinical record for Resident #3 was reviewed. Resident #3 was admitted on 8/7/14 with diagnoses included, but not limited to: "...Alzheimer's disease, hypertension and congestive heart failure...."</p> <p>A form titled, "TB (Tuberculin) Documentation Form," dated 8/13/14, indicated, the date the test was administered was 8/13/14 at 2:45 P.M., and the date the test was read was 8/15/14 at 3:00 P.M.</p> <p>During an interview on 5/27/15 at 9:45 A.M., the Director of Nursing indicated the TB test was not given to Resident #3 on admission because the nurse on duty that day thought she needed a doctors</p>	R 0410	<p>1. Resident #3 and 8 did receive TB test.2. Residents in the community have the potential to be affected.3. Nurses admitting residents into the facility have been retrained on the protocol for admission on obtaining orders and giving the TB tests.4. The HSD will monitor new admitted residents by check the nursing admission check list (se attachment #2) for 7 months. The audits will be conducted every 2 weeks for the first 3 months. For the final 4 months, audits will be conducted monthly</p>	07/12/2015

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 05/27/2015
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NAME OF PROVIDER OR SUPPLIER HERITAGE POINT ALZHEIMER'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 TRINITY PLACE MISHAWAKA, IN 46545
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	<p>order before she could administer the skin test.</p> <p>2. On 5/27/15 at 10:00 A.M., the clinical record for Resident #8 was reviewed. Resident #8 was admitted on 4/18/15 with diagnoses included, but not limited to: "...Alzheimer's disease, hypertension and hyperlipidemia...."</p> <p>A form titled, "TB Test Documentation Form," dated 4/26/15, indicated, the date the test was administered was 4/26/15 at 11:00 A.M., and the date the test was read was 4/28/15 at 2:20 P.M.</p> <p>During an interview on 5/27/15 at 11:00 A.M., the Director of Nursing indicated Resident #8 came to them from an out of state facility. She further indicated when she called the facility to see if the resident had received a TB skin test at their facility and they informed her he had not because in that state they do not require a TB skin test prior to entering a facility.</p> <p>On 5/27/15 at 1:50 P.M., the Director of Nursing provided a policy titled, "Tuberculosis Screening," dated 12/2014, and indicated the policy was the one currently used by the facility. The policy indicated "...b. Prior to admission each resident will be required to: "...ii.</p>			

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	Documentation of a negative Mantoux 1-step skin test or other tuberculosis screening test recommended by the U.S. Centers for Disease Control and prevention (CDC) administered within three (3) months before the date the resident is admitted to the facility or upon admission...."			