

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 03/04/2016
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NAME OF PROVIDER OR SUPPLIER  TRADITIONS AT REAGAN PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 1176 KINGWOOD DRIVE AVON, IN 46123
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dated: March 4, 2016</p> <p>Facility number: 013264 Provider number: 013264 AIM number: N/A</p> <p>Census bed type: Residential: 77 Total: 77</p> <p>Census payor type: Other: 77 Total: 77</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 3/7/16 by 29479.</p>	R 0000	This plan of correction is neither an agreement of wrong doing by this facility or it's staff members, rather it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of March 31, 2016 and request paper compliance on this issue	
R 0120  Bldg. 00	<p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance</p> <p>(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,</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>safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(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.</p> <p>(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.</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 employees received annual inservices on resident rights, abuse, and dementia for 3 of 5 employees reviewed for annual inservices (Housekeeper #1, Maintenance Director, Licensed Practical Nurse #3).</p> <p>Findings include:</p>	R 0120	<p>R120- Personnel- Noncompliance</p> <p>-What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?</p> <p>All employees to be reviewed for inservice compliance priorto March 31, 2016.</p>	03/31/2016

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	<p>1. On 3/4/16 at 2:15 p.m., Housekeeper #1's employee record was reviewed. Housekeeper #1's record indicated the employee started employment on 10/23/14. Housekeeper #1's record lacked documentation of an annual inservice for resident rights in 2015.</p> <p>2. On 3/4/16 at 2:30 p.m., Maintenance Director's employee record was reviewed. The Maintenance Director's record indicated the employee started employment on 6/30/14. The Maintenance Director's record lacked documentation of annual inservices in 2015 for resident rights, abuse, or dementia.</p> <p>3. On 3/4/16 at 3:00 p.m., Licensed Practical Nurse (LPN) #3's employee record was reviewed. LPN #3's record indicated the employee started employment on 12/10/14. LPN #3's record lacked documentation of annual inservices in 2015 for resident rights, abuse, or dementia.</p> <p>During an interview on 3/4/16 at 3:26 p.m., the Executive Director (ED) indicated they currently did not have a good tracking system for the annual inservices: resident rights, abuse, and dementia. The ED indicated the</p>		<p>-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All employees to be reviewed for inservice compliance prior to March 31, 2016.</p> <p>-What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur?</p> <p>Annual orientation workday will be held prior to day of compliance to ensure all employees receive required annual inservices. Attendance and sign off sheets will be monitored by the Executive Director and/or designee. (Attachment A)</p> <p>-How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place?</p> <p>Inservices given during new hire orientation will be monitored by Executive and/or designee monthly x 12 months to ensure compliance. Annual inservices will be monitored during the annual</p>	

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R 0410 Bldg. 00	<p>documentation of inservices was missing for Housekeeper #1, Maintenance Director, and Licensed Practical Nurse #3. The ED indicated there was no policy for annual employee re-education or inservices.</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 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.</p> <p>Based on record review and interview, the facility failed to ensure Tuberculin Test were administered on or prior to admission for 2 of 7 residents reviewed for infection control (Residents #5 and #8).</p>	R 0410	<p>orientation workday to ensure compliance. (Attachment B and C)</p> <p>-By what date the systemic changes will be completed?  March 31, 2016</p> <p>R410- Infection Control- Noncompliance</p> <p>-What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?</p>	03/31/2016

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	<p>Finding includes:</p> <p>1. Resident #5's record was reviewed on 3/4/16 at 12:15 p.m. Resident #5 was admitted to the facility on 11/14/15. The record lacked indication a Tuberculin Test was administered on or prior to admission.</p>		<p>The second step mantoux will be repeated on Residents #5 and#8.</p> <p>-How the facility will identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <p>All new admits as of 2016 have been audited to ensure thesecond step has been done. The 2 stepmethod of TB testing is to be done on all new admits. If the first step hasbeen done prior to being admitted the 2nd step will be done within 7to 21 days. When the resident is beingadmitted without starting the 1st step, the 2nd stepmethod, the initial mantoux will be started the day of admission.</p> <p>-What measures will be put into place or what systemicchanges the facility will make to ensure the deficient practice does not recur?</p> <p>The test will be signed off on their MAR and vaccinationrecord under history and physical. Allnew admits as of 2016 have been audited to ensure the second step has beendone. All nurses will be educated prior to 3/31/16 on the mantoux process. (AttachmentD)</p> <p>-How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e,</p>	

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			<p>what quality assurance program will be put into place?</p> <p>All new admits will be audited within 3 weeks of admission to ensure the 2nd step has been done properly. (Attachment E). The Wellness Director and/or his designee will monitor within 3 weeks of admission x 1 year.</p> <p>-By what date the systemic changes will be completed?</p> <p>March 31, 2016</p>		