

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2014
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1750 LINDBERG RD WEST LAFAYETTE, IN 47906
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 25, 26, 27, 28, and 29, 2014</p> <p>Facility number: 003673 Provider number: 155725 AIM number: 200450890</p> <p>Survey team: Bobette Messman, RN-TC Rita Mullen, RN (8/26, 27, 28, and 29/2014) Maria Pantaleo, RN (8/26, 27, 28, and 29/2014) Holly Duckworth, RN (8/26, 27, 28, and 29/2014)</p> <p>Census bed type: SNF: 16 NF: 1 SNF/NF: 6 Residential: 40 Total: 63</p> <p>Census Payor type: Medicare: 16 Medicaid: 1 Other: 46 Total: 63</p>	F000000		
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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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F000282 SS=D	<p>Residential sample: 9</p> <p>These deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was complete by Tammy Alley RN on September 8, 2014.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow the care plan regarding activities of daily living (ADL) assistance for a resident dependent on staff assistance for oral care for 1 of 1 residents reviewed for dental care and failed to follow physician orders regarding weekly weights for 1 of 6 residents reviewed for weights (Resident #24 and Resident #14).</p> <p>Findings include:</p>	F000282	<p>F282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care</p> <p>A. Corrective Action Resident #24 oral care was accomplished and verified by the Director of Nursing.</p> <p>B. Other resident's affected All Health Care residents' care plans, MDS and BIMS were reviewed for identification of same practice. No other residents were evidenced to</p>	09/17/2014

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	<p>1. The clinical record of Resident #24 was reviewed on 8/27/14 at 3:00 p.m. Diagnoses included, but were not limited to, debility, general osteoarthritis, general muscle weakness, and depressive disorder.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 8/01/14, indicated Resident #24 had a brief interview of mental status (BIMS) score of 8, indicating moderate cognitive impairment.</p> <p>A care plan, effective 8/08/14, indicated "...ADL deficit- requires extensive to total assistance from staff due to confusion/ weakness...staff to perform care which resident unable to do...."</p> <p>An ADL functional/restorative record, dated 5/8/14, indicated the resident needed assistance with oral care.</p> <p>An ADL functional/restorative record, dated 8/8/14, indicated the resident was totally dependent for oral care.</p> <p>During an interview on 8/27/14 at 10:00 a.m., Resident #24 indicated she was unable to brush her own teeth and rarely received assistance.</p>		<p>be affected.</p> <p>C. Guard against reoccurrence ADLs including oral care are identified by the care plan and prompted on the electronic charting mechanism. Nurses and C.N.A.s are instructed to electronically chart ADLs completed per self or with staff assistance.</p> <p>D. Monitoring for Compliance The Director of Nursing or designee will monitor ten percent of dependent residents identified and will log compliance in accordance to the Care Plan, MDS, and/or BIMS for four weeks. Following compliance in those four weeks the Director of Nursing or Designee will monitor five percent of dependent residents identified and will log compliance in accordance to Care Plan, MDS, and/or BIMS for four weeks. Continued compliance of these collective weeks will prompt the Director of nursing or designee to continue monitoring of compliance randomly and will take immediate action for any and all incidents of noncompliance. In each monitoring case, residents that are interviewable will be asked about oral care completion. Non-interviewable residents will be physically monitored for policy compliance. All noncompliance will be reported through the QIS process.</p> <p>E. Compliance date 9/17/2014</p>				

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	<p>During an observation on 8/27/14 at 10:03 a.m., the teeth of Resident #24 were observed to have food and particulates covering the top and bottom teeth and the areas in between the teeth.</p> <p>During an observation on 08/28/14 at 10:55 a.m., Resident #24's teeth were observed to have food and particulates on the upper and lower teeth and an odor was present. Resident #24's toothbrush was observed, dry, lying on the bathroom sink. Resident #24 indicated her teeth had not been brushed the evening of 8/27/14 or the morning of 8/28/14.</p> <p>During an interview on 8/28/14 at 10:50 a.m., the Director of Nursing (DON) indicated the certified nursing assistants (CNAs) mark in the kiosk every shift whether or not hygiene/oral care was completed.</p> <p>During an interview on 8/28/14 at 12:55 p.m., CNA #5 indicated Resident #24 needed total care. CNA #5 indicated day shift was responsible for brushing Resident #24's teeth before taking her to the dining room in the morning or after breakfast and documenting it on the ADL sheet in the kiosk. CNA #5 indicated Resident #24 was very cooperative with care.</p>				

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	<p>During an interview on 8/28/14 at 2:55 p.m., Registered Nurse (RN) #6 indicated oral care was "probably not" being completed. RN #6 indicated Resident #24's teeth "...never look brushed..."</p> <p>An oral care tracking sheet, dated 7/28/14 through 8/28/14, was reviewed on 8/29/14 at 9:00 a.m. The tracking sheet indicated no oral care was provided for Resident #24 on 8/1, 8/5, 8/10, 8/13, 8/15, 8/19, 8/22, or 8/24/14.</p> <p>2. The clinical record of Resident #14 was reviewed on 8/29/14 at 10:00 a.m. Diagnoses included, but were not limited to, hyponatremia (low sodium), high blood pressure and weakness.</p> <p>A Physician's order, dated 3/23/14, indicated weights were to be taken one time weekly for five weeks starting 3/23/14.</p> <p>A Nursing Admitting Assessment, dated 3/23/14, did not have an admission weight.</p> <p>A review of the weekly weights for the months of March and April 2014, indicated weekly weights for the weeks of 3/24/14 and 4/13/14 were not obtained.</p> <p>A Care Plan for a therapeutic diet for</p>						

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F000309 SS=D	<p>high blood pressure, heart health and a fluid restriction for hyponatremia, dated 3/24/14, indicated one of the interventions was to monitor weight.</p> <p>A Nutrition Assessment, dated 4/2/14, indicated Resident #14 had a hospital weight of 190 pounds (lbs) on 3/17/14, a weight of 205 lbs at the facility on 3/29/14 and her usual body weight was around 200 lbs.</p> <p>During an interview with the Registered Dietician, on 8/28/14 at 1:00 p.m., she indicated a baseline weight could not be found for Resident #14 and there were some weekly weights what were not done.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to monitor for weights for a resident on fluid restrictions for 1 of 6 residents reviewed for weight (Resident# 14).</p>	F000309	F309 Provide Care/Services for Highest Well Being A. Corrective Action Resident #14 had a weight completed and record was reviewed by the Director of Nursing and	09/17/2014			

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	<p>Findings include:</p> <p>The clinical record of Resident #14 was reviewed on 8/29/14 at 10:00 a.m. Diagnoses included, but were not limited to, hyponatremia (low sodium), high blood pressure and weakness. Resident was admitted on 3/23/14.</p> <p>A Physician's order, dated 3/29/14, indicated "...Fluid restriction 2000 cc [cubic centimeter] oral three times daily starting 03/29/2014."</p> <p>A Physician's order, dated 3/23/14, indicated weights were to be taken one time weekly for five weeks starting 3/23/14.</p> <p>A Physician's order, dated 3/23/14, indicated "Spironolactone [diuretic] 25 mg [milligrams] one time daily starting 3/24/14."</p> <p>A Nursing Admitting Assessment, dated 3/23/14, did not have an admission weight.</p> <p>A review of the weekly weights for the months of March and April 2014, indicated weekly weights for the week of 3/24/14 and 4/13/14 were not obtained.</p>		<p>Registered Dietician.</p> <p>B. Other residents affected Admission weights for 100% of other residents were reviewed and were in compliance</p> <p>C. Guard Against Reoccurrence 100% of admission documentation will be monitored for admission base weight per the admissions assessment data input process.</p> <p>D. Monitor for Compliance The Director of Nursing and/or MDS Manager, Registered dietician or Designee will view the admission weight of 100% of new admissions as part of the admissions assessment data input, electronic admission data input, and physical review. Any record not found will be corrected immediately and reported through the QIS process.</p>	

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F000312 SS=D	<p>A Care Plan for a therapeutic diet for high blood pressure, heart health and a fluid restriction for hyponatremia, dated 3/24/14, indicated one of the interventions was to monitor weight.</p> <p>A Nutrition Assessment, dated 4/2/14, indicated Resident #14 had a hospital weight of 190 lbs on 3/17/14, a weight of 205 lbs at the facility on 3/29/14 and her usual body weight was around 200 lbs.</p> <p>During an interview with the Registered Dietician, on 8/28/14 at 1:00 p.m., she indicated a baseline weight could not be found for Resident #14 and there were some weekly weights what were not done.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary services to maintain oral hygiene for a resident dependent on staff assistance for oral care for 1 of 1 residents reviewed for dental care (Resident #24).</p>	F000312	<p>F312ADL Care Provided for Dependent Residents</p> <p>A. Corrective Action Resident #24 oral care was accomplished and verified by the Director of Nursing.</p> <p>B. Other resident's affected All Health Care residents' care plans,</p>	09/17/2014

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	<p>Findings include:</p> <p>The clinical record of Resident #24 was reviewed on 8/27/14 at 3:00 p.m. Diagnoses included, but were not limited to, debility, general osteoarthritis, general muscle weakness, and depressive disorder.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 8/01/14, indicated Resident #24 had a brief interview of mental status (BIMS) score of 8, indicating moderate cognitive impairment.</p> <p>A care plan, effective 8/08/14, indicated "...ADL [Activities of Daily Living] deficit- requires extensive to total assistance from staff due to confusion/ weakness...staff to perform care which resident unable to do...."</p> <p>An ADL functional/restorative record, dated 5/8/14, indicated the resident needed assistance with oral care.</p> <p>An ADL functional/restorative record, dated 8/8/14, indicated the resident was totally dependent for oral care.</p> <p>During an interview on 8/27/14 at 10:00 a.m., Resident #24 indicated she was</p>		<p>MDS and BIMS were reviewed for identification of same practice. No other residents were evidenced to be affected.</p> <p>C. Guard against reoccurrence ADLs including oral care are identified by the care plan and prompted on the electronic charting mechanism. Nurses and C.N.A.s are instructed to electronically chart ADLs completed per self or with staff assistance.</p> <p>D. Monitoring for Compliance The Director of Nursing or designee will monitor ten percent of dependent residents identified and will log compliance in accordance to the Care Plan, MDS, and/or BIMS for four weeks. Following compliance in those four weeks the Director of Nursing or Designee will monitor five percent of dependent residents identified and will log compliance in accordance to Care Plan, MDS, and/or BIMS for four weeks. Continued compliance of these collective weeks will prompt the Director of nursing or designee to continue monitoring of compliance randomly and will take immediate action for any and all incidents of noncompliance. In each monitoring case, residents that are interviewable will be asked about oral care completion. Non-interviewable residents will be physically monitored for policy compliance. All noncompliance will be reported through the QIS process.</p>				

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	<p>unable to brush her own teeth and rarely received assistance.</p> <p>During an observation on 8/27/14 at 10:03 a.m., the teeth of Resident #24 were observed to have food and particulates covering the top and bottom teeth and the areas in between the teeth.</p> <p>During an observation on 08/28/14 at 10:55 a.m., Resident #24's teeth were observed to have food and particulates on the upper and lower teeth and an odor was present. Resident #24's toothbrush was observed, dry, lying on the bathroom sink. Resident #24 indicated her teeth had not been brushed the evening of 8/27/14 or the morning of 8/28/14.</p> <p>During an interview on 8/28/14 at 10:50 a.m., the Director of Nursing (DON) indicated the certified nursing assistants (CNAs) mark in the kiosk every shift whether or not hygiene/oral care was completed.</p> <p>During an interview on 8/28/14 at 12:55 p.m., CNA #5 indicated Resident #24 needed total care. CNA #5 indicated day shift was responsible for brushing Resident #24's teeth before taking her to the dining room in the morning or after breakfast and documenting it on the ADL sheet in the kiosk. CNA #5 indicated</p>		E. Compliance Date 9/17/2014				

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F000371 SS=F	<p>Resident #24 was very cooperative with care.</p> <p>During an interview on 8/28/14 at 2:55 p.m., Registered Nurse (RN) #6 indicated oral care was "probably not" being completed. RN #6 indicated Resident #24's teeth "...never look brushed..."</p> <p>An oral care tracking sheet, dated 7/28/14 through 8/28/14, was reviewed on 8/29/14 at 9:00 a.m. The tracking sheet indicated no oral care was provided for Resident #24 on 8/1, 8/5, 8/10, 8/13, 8/15, 8/19, 8/22, or 8/24/14.</p> <p>3.1-38(a)(3)(C)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure employees involved in dining services wore hairnets and beard covers properly. This deficient practice involved 2 of 2</p>	F000371	F371 Food Procure, Store, Prepare, Serve A. Corrective Action Dietary staff was directly viewed for compliance to hairnet policy. Those with facial hair were provided beard	09/17/2014			

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	<p>kitchens and 1 of 3 dining rooms.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 8/26/14 at 9:15 a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. Cook #1 was observed cooking breakfast with hairnet not completely covering hair. 2. Cook #2 was observed prepping food products without a beard cover. 3. During a dining observation on 8/26/14 at 12:00 p.m., CNA #3 and CNA #4 were observed serving residents and entering kitchen area with hairnet not completely covering hair. <p>During an interview on 8/26/14 at 11:05 a.m., the Dining Manager indicated the facility had an expectation that hair coverings, including beard covers, were to be worn during cooking and serving.</p> <p>The policy titled "Hair Restraints" dated 4/3/09 obtained from the Dining Manager on 8/26/14 at 11:05 a.m., indicated "Every associate of the Dining Services Department and any associate entering the food production area will wear an approved hair restraint. Male associates with beards must wear beard restraints if</p>		<p>guards for policy compliance</p> <p>B. Other Resident's affected All resident were potentially affected however hairnets are fully covering employee's hair and beards for those with beards.</p> <p>C. Guard against reoccurrence Dietary staff was provided a hair restraint in-service by the Registered Dietician on 8/29/2014. A post-test was also provided to ensure understanding and expectation of compliance.</p> <p>D. Monitoring for Compliance Dietary managers (4) will routinely view for hairnets each day and long compliance on the Hairnet Compliance Tool. Each chef and cook will monitor working staff for compliance. White hairnets have been placed for visibility ease and monitoring. Non-compliance will be immediately corrected and reported to the Dining Services manager and Infection control Manager or Designee.</p> <p>E. Compliance Date 9/17/2014</p>		

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F000431 SS=D	<p>facial hair is long enough to be combed. CNA and nurses delivering food and obtaining meal items from the kitchen must also abide by this policy."</p> <p>3.1-21(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except</p>			

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	<p>when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to insure an open vial of tuberculin skin testing solution was dated and initialed by the person opening the vial for 1 of 1 medication storage rooms.</p> <p>Findings include:</p> <p>During an observation of the Medication Storage room, on 8/29/14 at 9:00 a.m., with QMA (qualified medication assistant) #3, an open vial of Tuberculin skin testing solution (PPD) was found in the medication room refrigerator without an open date or the initials of the individual who opened the vial.</p> <p>During an interview with QMA #3, on 8/29/14 at 9:05 a.m., she indicated the open vial of PPD should have been dated when it was opened.</p> <p>A Policy received from the Director of Nursing, on 8/29/14 at 1:00 p.m., for "Storage of vials and Ampules, dated 1/2006, indicated "...2. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials...."</p> <p>3.1-25(o)</p>	F000431	F431 Drug Records, Label/Store Drugs & Biologicals A. Corrective Action TB vial was properly discarded. B. Other residents affected The box containing the vial was dated however the vial was not dated; therefore no other residents were affected. C. Guard against reoccurrence The auditing pharmacist will monitor that every medicine container has been correctly dated per policy. D. Monitoring for Compliance The Director of Nursing and/or designee will monitor compliance monthly for three months and quarterly for two quarters while maintaining 100% compliance. Any noncompliance will be immediately corrected and incident reported through the QIS process. E. Compliance Date 9/17/2014	09/17/2014			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 1 of 2 facility hallway ceilings and 3 of 21 resident bathrooms (Room #s, 1002, 1103, and 1104).</p> <p>Findings include;</p> <p>1. During the initial tour on 8/25/2014 at 4:15 p.m., the facility hallway ceiling lights on Hallway 1(H1), were observed to be dirty.</p> <p>2. During resident room observations on 8/26/2014, the following was observed:</p> <p>a.) Room 1002 at 3:05 p.m., the bathroom wallpaper was peeling from ceiling in bathroom, the shower floor was dirty and had debris in the shower and the wall near the shower area was marred and chipped.</p> <p>b.) Room 1103 at 2:46 p.m., the shower bumper/floor runner was dirty and debris</p>	F000465	<p>F465 Safe/Functional/ Sanitary/Comfortable Environment</p> <p>A. Corrective Action Hallway lights on (H1) were cleaned Room 1002 (1102) bathroom wallpaper was re-glued, the debris was removed from shower, and wall near the shower was repaired. Room #1103 shower bumper was cleaned and re-glued, debris on shower floor was removed, sink basin was ordered and contracted to be installed, wall near the shower repaired, and the bathroom wallpaper was re-glued. Room #1104 bathroom wall near the shower was repaired along with the walls near the toilet, bathroom wallpaper was partially removed and repaired.</p> <p>B. Other residents affected No other residents other than those rooms mentioned were found to be affected.</p> <p>C. Guard against reoccurrence The Environmental (housekeeping) manager will initiate inspections for 100% of Health Care rooms including bathrooms each month and keep a log sheet of inspections. Areas of wallpaper tears, wall damage, dirty lights along with debris found will be</p>	09/17/2014			

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	<p>was on the shower floor, the wash basin sink was cracked near the water drain area, the wall near the shower area was chipped and cracked, and the bathroom wall paper was peeling.</p> <p>c.) Room 1104 at 3:19 p.m., the bathroom wall near the shower area was chipped and cracked and a hole, the size of a fifty cent piece, was in the wall, the walls near the toilet seat were marred and dirty, and the bathroom wallpaper was ripped and peeling.</p> <p>d.) On 8/26/2014 at 10:00 a.m., and 3:00 p.m., the facility hallway ceiling lights on Hallway 1 were observed to be dirty.</p> <p>On 8/28/2014 at 9:15 a.m., during the environmental tour with the Director of Plant Maintenance and the Supervisor of Environmental Services, they indicated they were not aware of the resident rooms and hallway H1 light issues.</p> <p>3.1-19(f)</p>		<p>immediately corrected including making proper work orders for correction.</p> <p>D. The MOD (Manager On Duty) will randomly audit resident rooms including bathrooms to ensure areas are safe, functional, sanitary, and comfortable. Any noncompliance will be logged in the daily MOD report and reported in the morning stand-up meeting and QIS process.</p> <p>E. Compliance Date 9/17/2014</p>				

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R000000	These state findings are cited in accordance with 410 IAC 16.2-5.	R000000		
R000151	<p>410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.</p> <p>Based on record review and interview the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian in 1 of 1 resident pets records reviewed. (Resident #96)</p> <p>Findings include:</p> <p>Resident #96's record was reviewed on 08/29/14 at 10:00 a.m.</p> <p>The resident's pet vaccination and examination record was not in the clinical record.</p> <p>The resident was admitted to the facility on 8/16/2014.</p> <p>During an interview on 08/29/14 at 1:15 p.m., the Director of Assisted Living indicated resident # 96 had a pet and there was no current examination or</p>	R000151	<p>R151 Sanitation and Safety Standards, (h) Any pet housed in a facility shall have a periodic veterinary examinations and required immunizations.</p> <p>A. Corrective Action Resident #96 pet veterinary records have been obtained and are now on file.</p> <p>B. Other residents affected No other pets reside in this area.</p> <p>C. Guard against reoccurrence All pets to reside in the Residential area will have veterinary records obtained upon or before admission. The information is a part of the resident health service plan and is reviewed every six months minimally. Upon the second service plan renewal or before the twelfth month a new veterinary record will be obtained for the process of renewal.</p> <p>D. Monitoring for compliance The Residential Care Manager or designee will be a part of the service plan and will ascertain if a pet</p>	09/17/2014

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R000216	<p>vaccination record.</p> <p>On 8/29/2014 at 11:00 a.m., the Director of Assisted Living, provided the Pet Policy, undated and currently used by the facility. The policy indicated: "... 6. ...Any pet housed in the facility shall have periodic veterinary examinations and all required immunizations."</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to evaluate the</p>	R000216	<p>continues to reside in the residential area. All (100%) pets in that area will have a veterinary record present in the chart or the record will be obtained through the Residential Care Manager. Any pet to be introduced to permanent placement will first require the owner to sign the pet addendum on the lease agreement obligating the owner to produce a current veterinary care and vaccination records. One hundred percent of pets residing in the facility will be reported and listed on file with the Resident Care Manager or Designee for ongoing and routine audit.</p> <p>E. Compliance Date 09/17/2014</p> <p>R216 Evaluation Noncompliance A. Corrective Action All residents self-administering</p>	09/17/2014			

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	<p>resident's ability to self administer medications for 2 of 5 residents reviewed for self administration of medication. (Resident# 91, Resident# 92).</p> <p>Findings include:</p> <p>During the initial tour of the Assisted Living Center on 8/29/14 at 10:00 a.m., staff identified residents that are currently self administrating medications. She indicated Resident # 91 and # 92 self administered their medications.</p> <p>1. During a review of Resident #91's clinical record done on 8/29/14 at 11:15 a.m., the evaluation for self administration of medications was not located.</p> <p>2. During a review of Resident#92's clinical record done on 8/29/14 at 11:20 a.m., the evaluation for self administration of medications was not located.</p> <p>During an interview with the Director of Assisted Living on 8/29/14 at 1:30 p.m., she indicated evaluation of self administration of medications should have been done but were not for these residents.</p>		<p>medications were identified through "life steps" portion titled Assessment For Self-Administration of Medications that were reviewed for accuracy of current status.</p> <p>B. Other residents affected Based on life step review, no other residents were affected.</p> <p>C. Guard against reoccurrence Life step evaluation tools are used to measure independence of ADLs including medication administration. The life steps are completed every six months and with any significant physical or cognitive decline. Life steps will be monitored for compliance for medication self-administration. The Mediset medication placement system will be used to monitor for accuracy of use over the past 30-day cycle. Any concerns regarding the accuracy of medications self-administered will be directed to the nurse and Residential Care Manager for review and intervention.</p> <p>D. Monitoring for compliance The Residential Care Manager or Designee will review semi-annual life steps evaluation tools including Assessment For Self-Administration of Medications form for those residents practicing self-administration selecting 5% per month to audit for two months. The audit will ensure accuracy of the use and interpretation of the tools for resident safety. With continued compliance during the two months</p>				

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R000273	<p>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, interview and record review, the facility failed to ensure employees involved in dining services wore hairnets and beard covers appropriately. This deficient practices involved 2 of 2 kitchens.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 8/26/14 at 9:15 a.m., the following was observed.</p> <p>Cook #1 was observed cooking breakfast with hairnet not completely covering hair. Cook #2 was observed prepping food products without a beard cover.</p> <p>During an interview with Dining Manager on 8/26/14 at 11:05 a.m., he indicated the facility had an expectation that hair coverings including beard covers</p>	R000273	<p>the audit will be 1% for two months then random. Any noncompliance will result in continued auditing at 5% and reporting through the QISW process as well as the Director of Nursing and Executive Director. E. Compliance Date 9/17/2014</p> <p>R273 Food and Nutritional Services-Dietary, All food preparation and serving areas are maintained in according to state and local sanitation and safe handling standards. A. Corrective Action Dietary staff was directly viewed for compliance to hairnet policy. Those with facial hair were provided beard guards for policy compliance B. Other Resident's affected All resident were potentially affected however hairnets are fully covering employee's hair and beards for those with beards. C. Guard against reoccurrence Dietary staff was provided a hair restraint in-service by the Registered Dietician on 8/29/2014. A post-test was also provided to ensure understanding and expectation of compliance. D. Monitoring for Compliance</p>	09/17/2014

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	were to be worn during cooking and serving. A policy titled "Hair Restraints" obtained from the Dining Manager on 8/26/14 at 11:05 a.m., stated " Every associate of the Dining Services Department and any associate entering the food production area will wear an approved hair restraint . Male associates with beards must wear beard restraints if facial hair is long enough to be combed. CNA and nurses delivering food and obtaining meal items from the kitchen must also abide by this policy."		Dietary managers (4) will routinely view for hairnets each day and log compliance on the Hairnet Compliance Tool. Each chef and cook will monitor working staff for compliance each meal service for twenty days then each day for 30 days. Audits will be documented during each of these two periods then randomly to maintain compliance. White hairnets have been placed for visibility ease and monitoring. Non-compliance will be immediately corrected and reported to the Dining Services manager and Infection control Manager or Designee for follow-up through the QIS process. E. Compliance Date 9/17/2014		