

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155676	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/28/2015
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NAME OF PROVIDER OR SUPPLIER  MILNER COMMUNITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 370 E MAIN ST ROSSVILLE, IN 46065
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey date: April 20, 21, 22, 23, 24, 27 and 28, 2015</p> <p>Facility number: 000299 Provider number: 155676 AIM number: 100286940</p> <p>Census bed type: SNF/NF: 60 Residential: 16 Total: 76</p> <p>Census payor type: Medicare: 5 Medicaid: 54 Other: 1 Total: 60</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on May 1, 2015.</p>	F 000	<p>Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc. that the allegations contained in this survey report are a true and accurate portrayal of the provisions of nursing care at this health care facility. Milner Community Health Care, Inc., as a licensed and certified provider recognizes its obligation to provide legally and medically required care and services in an economical and efficient fashion. We respectfully request that a desk review be completed. All Plan of Corrections have been completed as stated. Please accept this Plan of Correction as the Credible Allegation of Compliance.</p>	
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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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F 273 SS=D Bldg. 00	<p>483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)</p> <p>Based on record review, and interview, the facility failed to correctly identify and accurately assess the residents status regarding Hospice for 2 out of 2 residents reviewed for Hospice. (Resident # 35 and # 68 )</p> <p>Findings include:</p> <p>1. The Clinical record for Resident # 35 was reviewed on 4/23/2015 at 10:30 a.m. Diagnoses included but were not limited to dementia, altered mental status, Alzheimer disease, anxiety, depression, disorders of the joints, chronic pain and</p>	F 273	<p>1. Section J, question 1400 on the MDS assessment were modified to correct coding for both cited residents(#35 and #68). 2. All Hospice residents were cross referenced with Hospice charts and MDS assessments to assure section J question 1400 were coded correctly. 3. All Hospice companies will turn over resident admission form to both DON and MDS. DON or designee will audit new Hospice residents MDS assessments to assure proper coding, following completion of admission assessment. 4. DON will report any continuing concerns to Administrator and will reviewed by QAA committee for 6</p>	05/28/2015

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	<p>dehydration.</p> <p>A Physician's order, dated 1/20/2015, indicated, admission to Hospice with diagnosis of Alzheimer's disease and "...resident has life expectancy of six months or less if the terminal illness runs its normal course..."</p> <p>A significant change Minimum Data Set Assessment (MDS), dated 1/23/2015, indicated Resident #35 was on hospice and did not have a prognosis of less than six months.</p> <p>2. The Clinical record for Resident # 68 was reviewed on 4/23/2015 at 10:10 a.m. Diagnoses included but were not limited to heart failure, hypertension, difficulty walking, pain, and insomnia.</p> <p>A Physician's order, dated 10/20/2014, indicated, admission to Hospice with diagnosis of Cardiac disease and "...resident has life expectancy of six months or less if the terminal illness runs its normal course..."</p> <p>A significant change Minimum Data Set Assessment (MDS), dated 10/27/2014, indicated Resident # 68 was on hospice and did not have a prognosis of less than six months.</p>		months.		

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F 371 SS=F Bldg. 00	<p>A quarterly assessment MDS, dated 1/16/2015, indicated Resident #68 was on Hospice and did not have a prognosis of less than six months.</p> <p>During an interview with the MDS coordinator on 4/23/20145 at 11:30 a.m., regarding the hospice status of Residents # 35 and # 68, she indicated that hospice was indicated on the MDS, but Residents # 35 and #68 did not have a prognosis of less than six months indicated on the MDS.</p> <p>3.1-31(a) 3.1-31(d)(3)</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</p> <p>Based on observation and interview, the facility failed to ensure that food was labeled, dated in the dry storage and freezer areas, and prepared in a sanitary environment in one of one kitchens in the facility. This deficiency had the potential to affect 59 residents out of 60 residents who received meals from the kitchen.</p>	F 371	<p>1. All unlabeled food was immediately removed and destroyed and entire kitchen was cleaned during survey period. New containers were ordered to replace cracked units. 2. All residents have the ability to be affected by this deficient practice. 3. All Dietary staff will be inserviced by facility consultant</p>	05/28/2015

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	<p>Findings include:</p> <p>During the tour of the kitchen on 4/20/2015 at 8:50 a.m., the following observations were made:</p> <ol style="list-style-type: none"> <li>1. The main kitchen area was observed to have plastic containers of flour and sugar opened and not dated.</li> <li>2. The dry storage area was observed to have a cracked plastic container with no lid and packages of pudding inside.</li> <li>3. The dry storage area was observed to have individual plastic containers of cornmeal, bread crumbs, macaroni noodles, corn starch and rice opened and not dated.</li> <li>4. The dry storage area was observed to have a package of Oreo cookies opened and not dated.</li> <li>5. The cook's freezer was observed to contain a frozen package of bread buns, opened and not labeled or dated.</li> <li>6. The kitchen floor, and the back wall next to stove were dirty with debris and splatters.</li> </ol> <p>During observation of kitchen area on</p>		<p>RD on cleaning schedule and food storage and labeling policy.</p> <p>4. RD and Administrator will monitor compliance with facility policies through weekly kitchen rounds on various days and at various times Any issues or concerns will be noted and presented to QAA committee for continued action for 6 months.</p>		

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	<p>4/27/2015 at 3:00 p.m., the following was noted :</p> <ol style="list-style-type: none"> <li>1. The kitchen floor, the back wall next to the stove, the clean dishwasher area and the wall next to the steamer all had debris and and splatters.</li> <li>2. The kitchen floor next to the steamer had an old rust covered pipe lying on the floor.</li> </ol> <p>During an interview on 4/20/2015 at 9:35 a.m., with the Dietary Manager, he indicated the opened food should have been dated.</p> <p>During an interview on 4/20/2015 at 1:55 p.m. with the Dietary Manager , he indicated the kitchen area did not have any written procedures for dating food in the kitchen.</p> <p>During an interview on 4/27/2015 at 3:10 p.m., with the Dietary Manager, he indicated the areas should be cleaned and the pipe removed.</p> <p>During an interview with the Director of Nursing on 4/22/2015 at 3:00 p.m., she indicated there were no written polices and procedures for kitchen operations, but they followed the State of Indiana guidelines for kitchen operations.</p>			

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F 431 SS=E Bldg. 00	<p>3.1-21(i)(2)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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 when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing</p>			

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	<p>dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure expired medications were removed from medication storage area. This affected 1 of 1 medication storage area reviewed for expired medications. (Residents #53, #3, #30)</p> <p>Findings include:</p> <p>During a medication storage review with Director of Nursing (DON) on 4/22/15 at 3:00 p.m., the following were observed:</p> <ol style="list-style-type: none"> <li>1. A bottle of Mary's Magic Mouthwash (prescribed compound) ordered for Resident #53 on 3/10/15, discontinued on 3/15/15 was observed with expiration date on bottle of 3/19/15.</li> <li>2. A bottle of cephalexin (an antibiotic) 250 milligrams/milliliters (mg/ml) ordered 2/26/15 for Resident #3 on 2/26/15 had an expiration date of 3/13/15.</li> <li>3. A bottle of lorazepam (an anxiolytic) 2 mg/ml ordered for Resident #30 on 4/3/14 was observed with expiration date of 4/3/15.</li> <li>4. 5 vials of cefazolin (an antibiotic) 1 gm per vial for PRN (as needed)</li> </ol>	F 431	<p>1 All expired medicines were immediately removed from refrigerator and destroyed per facility policy. 2. All residents have the ability to be affected by this deficient practice. 3. Facility drug destruction policy and procedure was updated for Q.A. approval, to add facility's only med. room refrigerator to weekly expiration check area. New form will be kept on refrigerator to be initialed by staff nurse auditing for expired drugs every Wednesday night DON, or designee, will initial their review each Thursday. 4 DON will report any issues or concerns to Administrator and review policy adherence to QAA committee for 6 months.</p>	05/28/2015

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R 000  Bldg. 00	<p>intraperitoneal use was observed with expiration date of 3/2015.</p> <p>During an interview with the DON on 4/22/15 at 3:00 p.m., she indicated night shift nurses were assigned and responsible for checking for expired medications.</p> <p>3.1-25(o)</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc. that the allegations contained in this survey report are a true and accurate portrayal of the provisions of nursing care at this health care facility. Milner Community Health Care, Inc., as a licensed and certified provider recognizes its obligation to provide legally and medically required care and services in an	

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R 273 Bldg. 00	<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.</p> <p>Based on observation and interview, the facility failed to ensure that food was labeled, dated in the dry storage and freezer areas, and prepared in a sanitary environment in one of one kitchens in the facility. This deficiency had the potential to affect 16 residents out of 16 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 4/20/2015 at 8:50 a.m., the following observations were made:</p> <ol style="list-style-type: none"> <li>1. The main kitchen area was observed to have plastic containers of flour and sugar opened and not dated.</li> <li>2. The dry storage area was observed to have a cracked plastic container with no</li> </ol>	R 273	<p>economical and efficient fashion. We respectfully request that a desk review be completed. All Plan of Corrections have been completed as stated. Please accept this Plan of Correction as the Credible Allegation of Compliance.</p> <ol style="list-style-type: none"> <li>1. All unlabeled food was immediately removed and destroyed and entire kitchen was cleaned during survey period. New containers were ordered to replace cracked units.</li> <li>2. All residents have the ability to be affected by this deficient practice.</li> <li>3. All Dietary staff will be inserviced by facility consultant RD on cleaning schedule and food storage and labeling policy on 5/20/15.</li> <li>4. RD and Administrator will monitor compliance with facility policies through weekly kitchen rounds on various days and at various times Any issues or concerns will be noted and presented to QAA committee for continued action for 6 months.</li> </ol>	05/28/2015

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	<p>lid and packages of pudding inside.</p> <p>3. The dry storage area was observed to have individual plastic containers of cornmeal, bread crumbs, macaroni noodles, corn starch and rice opened and not dated.</p> <p>4. The dry storage area was observed to have a package of Oreo cookies opened and not dated.</p> <p>5. The cook's freezer was observed to contain a frozen package of bread buns, opened and not labeled or dated.</p> <p>6. The kitchen floor, and the back wall next to stove were dirty with debris and splatters.</p> <p>During observation of kitchen area on 4/27/2015 at 3:00 p.m., the following was noted :</p> <p>1. The kitchen floor, the back wall next to the stove, the clean dishwasher area and the wall next to the steamer all had debris and and splatters</p> <p>2. The kitchen floor next to the steamer had an old rust covered pipe lying on the floor.</p> <p>During an interview on 4/20/2015 at 9:35</p>			

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R 300 Bldg. 00	<p>a.m., with the Dietary Manager, he indicated the opened food should have been dated.</p> <p>During an interview on 4/20/2015 at 1:55 p.m. with the Dietary Manager , he indicated the kitchen area did not have any written procedures for dating food in the kitchen.</p> <p>During an interview on 4/27/2015 at 3:10 p.m., with the Dietary Manager, he indicated the areas should be cleaned and the pipe removed.</p> <p>During an interview with the Director of Nursing on 4/22/2015 at 3:00 p.m., she indicated there were no written polices and procedures for kitchen operations, but they followed the State of Indiana guidelines for kitchen operations.</p> <p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation and interview, the facility failed to ensure expired medications were removed from</p>	R 300	1 All expired medicines were immediately removed from refrigerator and destroyed per facility policy. 2. All residents	05/28/2015

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	<p>medication storage area. This affected 1 of 1 medication storage area reviewed for expired medications. (Resident # 34)</p> <p>Findings include:</p> <p>During a medication storage review with Director of Nursing (DON) on 4/22/15 at 3:00 p.m., the following were observed:</p> <p>A bottle of cefazolin (an antibiotic) 1 gram (gm) intravenous solution ordered for Resident #34 on 2/5/15 was observed with expiration date was 2/13/15. This medication stored in the main refrigerator of the facility.</p> <p>During an interview with the DON on 4/22/15 at 3:00 p.m., she indicated night shift nurses were assigned and responsible for checking medication refrigerator temperatures and expired medications.</p>		<p>have the ability to be affected by this deficient practice. 3. Facility drug destruction policy and procedure was updated for Q.A. approval, to add facility's only med. room refrigerator to weekly expiration check area. New form will be kept on refrigerator to be initialed by staff nurse auditing for expired drugs every Wednesday night DON, or designee, will initial their review each Thursday. 4 DON will report any issues or concerns to Administrator and review policy adherence to QAA committee for 6 months.</p>	