

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155727	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2016
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NAME OF PROVIDER OR SUPPLIER  STONEBRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 20, 21, 22, 23, 24, 27, 28 and 29, 2016</p> <p>Facility number: 003924 Provider number: 155727 AIM number: 200472040</p> <p>Census bed type: SNF: 9 SNF/NF: 40 Residential: 30 Total: 79</p> <p>Census payor type: Medicare: 7 Medicaid: 38 Other: 4 Total: 49</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed on July 06, 2016.</p>	F 0000		

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 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 25 residents reviewed for accuracy of the MDS. (Resident #113)</p>	F 0278	The facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 of 25 residents reviewed for accuracy of the MDS. Immediate Interventions:	07/29/2016

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	<p>Findings include:</p> <p>Resident #113's clinical record was reviewed on 6/24/2016 at 11:20 a.m. Diagnoses included, but were not limited to right femur fracture.</p> <p>Resident #113's Admission Minimum Data Set (MDS) assessment dated 5/27/2016, indicated, " ... Functional Status ... ADL Self-Performance ... Bed Mobility ... Limited assistance with two plus persons physical assist ..."</p> <p>Resident #113's 14 day MDS assessment dated 6/3/2016, indicated, " ... Functional Status ... ADL Self-Performance ... Bed Mobility ... Extensive assistance with two plus persons physical assist ..." The 14 day MDS indicated Resident #113 had declined in bed mobility since the Admission MDS dated 5/27/16.</p> <p>On 6/24/2016 at 12:05 p.m., the MDS coordinator indicated the Admission MDS dated 5/27/2016, for Bed Mobility was coded in error and should have been coded as Extensive assistance with two plus persons physical assist.</p> <p>On 6/25/2016 at 9:35 a.m., the DON indicated the facility did not have a policy related to accuracy in coding of the MDS. They use the Resident Assessment</p>		<ul style="list-style-type: none"> <li>· Resident #113 as immediately corrected.</li> <li>· All residents have the potential to be affected To prevent future deficiencies of accuracy with MDS the facility will: <ul style="list-style-type: none"> <li>· MDS Nurse will audit the last MDS completed on all current resident's for accuracy and make necessary modifications if indicated by 7/29/16.</li> <li>· MDS Nurse will print the ADL assessment for each MDS completed and review x 6 months.</li> <li>· Director of Health Services/Designee will monitor compliance of MDS Coordinator's compliance with plan of correction weekly x 6 months by reviewing 5 residents, ADL assessments with MDS.</li> <li>· The results of audits will be reported, reviewed and trended for compliance through the campus QA monthly x 6 months.</li> </ul> </li> </ul>	

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F 0280 SS=D Bldg. 00	<p>Instrument (RAI) Version 3.0 Manual.</p> <p>3.1-31(d)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure care plans were revised to address severe weight loss for 2 of 4 residents reviewed during stage II for revision of care plans. (Resident #113 and Resident #70)</p>	F 0280	<p>The facility failed to ensure care plans were revised to address severe weight loss of 2 of 4 residents reviewed during stage II for revision of care plans.</p> <p>Immediate Interventions: Residents #113 and</p>	07/29/2016

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	<p>Findings include:</p> <p>1.) On 6/23/16 at 1:38 P.M., the clinical record for Resident #113 was reviewed. Diagnoses included, but were not limited to fracture of right femur, muscle weakness, cardiomegaly, hypertension (htn), atrial fibrillation (afib), and hypothyroidism.</p> <p>The Minimum Data Set Assessment (MDS) dated 5/27/16, indicated a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident to be cognitively able to be interviewed. The MDS indicated the resident had no dental abnormalities or swallowing difficulties and required meal set up only. Diet orders with a start date of 5/22/16 and current through 6/28/16, were for regular diet.</p> <p>The admission weight for Resident #113 was recorded on 5/23/16, as 175 pounds. The recorded weight for 6/15/16, was 163 pounds. The recorded weight for 6/22/16, was recorded as 163 pounds. This indicated a weight loss of 6.85%. Weight loss greater than 5% in 30 days is severe.</p> <p>The 6/22/16, Monthly Nutrition Note indicated, "....significant weight loss with normal BMI of 26.3, no new</p>		<p>#70 have both been discharged from the facility to home.</p> <ul style="list-style-type: none"> <li>· All resident have the potential to be affected.</li> <li>· All current residents will be reviewed for any significant weight loss by 7/11/16.</li> <li>· Director of Health, MDS nurse or designee will review and update plan of care, with appropriate interventions for all residents identified with significant weight loss by 7/11/16.</li> <li>· To prevent future deficiencies with revision of care plans for weight loss identified the facility will: <ul style="list-style-type: none"> <li>· Director of Health Services, Unit Manager, Medical Records, MDS or Designee will review care plans of all significant weight changes in Clinical Meeting and immediately update with appropriate interventions.</li> <li>· The results of audits will be reported, reviewed and trended for compliance through the campus QA monthly x 6 months.</li> </ul> </li> </ul>	

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	<p>recommendations, will followup per protocol...".</p> <p>The care plan for the category of Nutrition with a problem start date of 5/26/16 and current through 6/28/16, indicated a long term goal of, "Maintain my weight at a healthy range for me without any unwarranted significant weight changes..." The care plan included no revisions to address the severe weight change experienced by Resident #113.</p> <p>On 6/27/16 at 10:11 A.M., an interview with the Director of Nursing (DON) was conducted. The DON indicated tracking weights is important for ensuring the maintenance of optimal nutritional status. The DON indicated significant weight losses and gains are immediately reported to the DON. The dietician reviews the information on a weekly basis and makes recommendations to the physician. Care plan interventions are made as soon as possible, usually by the MDS coordinator and are also addressed in the daily clinical care meetings. The DON indicated there is no written facility policy regarding weight changes.</p> <p>2.) On 6/24/16 at 10:18 A.M., the closed clinical record for Resident #70 was reviewed. Diagnoses included, but were</p>			

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	<p>not limited to nondisplaced fracture of right lower leg, muscle weakness, and hypertension (htn).</p> <p>The Minimum Data Set Assessment (MDS) dated 1/8/16, indicated a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident to be cognitively able to be interviewed. The MDS indicated the resident had no dental abnormalities or swallowing difficulties and required meal set up only. Diet order with a start date of 1/2/16 and current through the discharge date of 2/25/16, were for controlled carbohydrate diet (CCHO).</p> <p>The admission weight for Resident #70 was recorded on 1/1/16, as 185 pounds. The recorded weight for 1/18/16 was 175 pounds. This is a weight loss of 5.4%. Weight loss of greater than 5% in 30 days is severe.</p> <p>No nutritional notations are indicated in the progress notes.</p> <p>The care plan for the category of Nutrition with a problem start date of 1/7/16 and current through the long term goal target date of 4/8/16, indicated a long term goal of, "Maintain my weight at a healthy range for me without any unwarranted significant weight</p>			

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F 0281 SS=D Bldg. 00	<p>changes...". The care plan included no revisions to address the significant weight change experienced by Resident #70.</p> <p>On 6/27/16 at 10:11 A.M., an interview with the Director of Nursing (DON) was conducted. The DON indicated tracking weights is important for ensuring the maintenance of optimal nutritional status. The DON indicated significant weight losses and gains are immediately reported to the DON. The dietician reviews the information on a weekly basis and makes recommendations to the physician. Care plan interventions are made as soon as possible, usually by the MDS coordinator and are also addressed in the daily clinical care meetings. The DON indicated there is no written facility policy regarding weight changes.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the</p>			

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	<p>facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident rinsed their mouth and spit after administration of a steroid inhaler for 2 of 2 residents observed for inhaled medication administration in a sample of 41 residents reviewed for medication administration. (Resident #76, Resident #5)</p> <p>Findings include:</p> <p>1. Resident #76's clinical record was reviewed on 6/27/2016 at 11:50 a.m. Diagnosis included but, were not limited to: asthma.</p> <p>Current Physician's order dated June 2016, indicated Resident #76's medications included, but were not limited to Breo Ellipta (a corticosteroid) blister with device 100-25 mcq (micrograms) dose, 2 puffs once a day. Special instructions: After inhalation rinse mouth with water without swallowing.</p> <p>On 6/27/2016 at 8:22 a.m., Licensed Practical Nurse #1 (LPN) was observed to administer Breo Ellipta inhaler to Resident #76. Resident #76 was observed to take 2 puffs as ordered and to</p>	F 0281	<p>The facility failed to ensure a resident rinsed their mouth and spit after administration of a steroid inhaler for 2 of 2 residents observed for inhaled medication administration in a sample of 41 residents reviewed for medication administration.</p> <p>Immediate Interventions</p> <ul style="list-style-type: none"> <li>Nurse #1 received immediate (6/27/2016) education.</li> <li>Residents #76 and #5 had their orders immediately (6/27/2016) reviewed and "rinse mouth after inhalation" was added to special instructions by DHS/Designee. To prevent future deficiencies of incorrect administration the facility will: <ul style="list-style-type: none"> <li>Director of Health Services, MDS, Medical Records/ Designee will review all resident orders for like orders (steroid inhalers) and update with special instructions to "rinse mouth after inhalation" by 7/29/2016.</li> </ul> </li> </ul>	07/29/2016

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	<p>immediately swallow her oral medications with water after the inhaler. LPN #1 was not observed to have Resident #76 rinse and spit after using the inhaler.</p> <p>On 6/27/2016 at 9:04 a.m., LPN #1 indicated she looked up the inhaler and it is a corticoid steroid so she should have had Resident #76 rinse her mouth after administration.</p> <p>On 6/27/2016 at 1:41 p.m., the Director of Nursing (DON) provided the policy "Specific Medication Administration Procedures" dated 9/1/2013, and indicated the policy was the one currently being used by the facility. The policy indicated, " ... O. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back in cup ..."</p> <p>The Wolters Kluwer Nursing 2015 Drug Handbook, 35th edition, copyright 2015 indicated, " ... After use, have patient rinse mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis [oral fungal infection] ..."</p> <p>2. Resident #5's clinical record was reviewed on 6/27/2016 at 1:50 p.m. Diagnosis included but, were not limited</p>		<ul style="list-style-type: none"> <li>· Director of Health Services, MDS, Medical Records/Designee will educate all current licensed nurses on current policy for administration of inhaled medications by 7/29/16.</li> <li>· Medical Records, Director of Health Services, Unt Manager/Designee will review orders in Clinical Meeting to ensure special instructions "rinse mouth after inhalation", are in place for steroid inhalers.</li> <li>· Director of Health Services, MDS, Medical Records/ Designee will observe administration of steroid inhalers, 2 x weekly/8 weeks then 1 x weekly/ 12 weeks to ensure proper administration compliance.</li> <li>· The results of audits will be reported, reviewed and trended for compliance through the campus QA monthly x 6 months.</li> </ul>		

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	<p>to: asthma.</p> <p>Current Physician's order dated June 2016, indicated Resident #5's medications included, but were not limited to Advair Diskus (a corticosteroid) blister with device 250-50 mcq (micrograms) dose, 1 puff twice a day.</p> <p>On 6/27/2016 at 8:51 a.m., Licensed Practical Nurse #2 (LPN) was observed to administer Advair Diskus inhaler to Resident #5. Resident #5 was observed to take 1 puff as ordered. LPN #2 was not observed to have Resident #5 rinse and spit after using the inhaler.</p> <p>On 6/27/2016 at 10:19 a.m., LPN #2 indicated the inhaler is a steroid and it is best if they rinse and spit.</p> <p>On 6/27/2016 at 1:41 p.m., the Director of Nursing (DON) provided the policy "Specific Medication Administration Procedures" dated 9/1/2013, and indicated the policy was the one currently being used by the facility. The policy indicated, " ... O. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back in cup ..."</p> <p>The Wolters Kluwer Nursing 2015 Drug</p>			

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F 0325 SS=D Bldg. 00	<p>Handbook, 35th edition, copyright 2015 indicated, " ... After administration, have the patient rinse his mouth without swallowing ..."</p> <p>3.1-35(g)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to ensure acceptable parameters of nutritional status were maintained for 2 of 4 residents reviewed for nutritional status during stage II in that residents had been identified with severe weight loss and decreased protein levels with no change in treatment interventions. (Resident #70</p>	F 0325	<p>Request change in scope and severity of the deficiency. It is the practice of StoneBridge Health Campus to use resources effectively and efficiently to attain or maintain the highest practicable physical, mental &amp; psychosocial well-being of each resident.</p>	07/29/2016	

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	<p>and Resident #113)</p> <p>Findings include:</p> <p>1.) On 6/23/16 at 1:38 P.M., the clinical record for Resident #113 was reviewed. Diagnoses included but, were not limited to fracture of right femur, muscle weakness, cardiomegaly, hypertension (htn), atrial fibrillation (afib), and hypothyroidism.</p> <p>The Minimum Data Set Assessment (MDS) dated 5/27/16, indicated a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident to be cognitively able to be interviewed. The MDS indicated the resident had no dental abnormalities or swallowing difficulties and required meal set up only. Diet orders with a start date of 5/22/16 and current through 6/28/16, were for regular diet.</p> <p>The admission weight for Resident #113 was recorded on 5/23/16, as 175 pounds. The recorded weight for 6/15/16, was 163 pounds. The recorded weight for 6/22/16 was 163 pounds. This indicated a weight loss of 6.85%. Weight loss greater than 5% in 30 days is severe.</p> <p>Lab Results dated 6/13/16, for Resident#113 indicated a protein</p>		<p>The facility failed to ensure acceptable parameters of nutritional status were maintained for 2 of 4 residents reviewed during stage II in that residents had been identified with severe weight loss and decreased protein levels with no change in treatment interventions.</p> <ul style="list-style-type: none"> <li>· Resident #70 and #113 were discharged from the facility to home.</li> </ul> <p>Immediate Interventions</p> <ul style="list-style-type: none"> <li>· All residents' weights were reviewed for significant changes by Director of Health Services and completed 7/11/2016.</li> <li>· All care plans for any affected residents were reviewed and updated with appropriate interventions and completed 7/11/2016 by Director of Health Services and MDS.</li> <li>· Director of Health Services will give in-service on weight tracking guidelines to be completed by all licensed nurses by 7/29/2016.</li> </ul> <p>To prevent future deficient practice with treatment the</p>	

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	<p>(compounds which provide the amino acids necessary for human metabolism and tissue growth and repair) level of 5.0 grams per deciliter (GM/dl), which is below the reference range of 6.4-8.0 GM/dl and albumen (simple proteins) level of 2.7 GM/dl, which is below the reference range of 3.5-5.0 GM/dl.</p> <p>The 6/22/16 Monthly Nutrition Note indicated, "...significant weight loss with normal BMI of 26.3, no new recommendations, will followup per protocol..."</p> <p>The care plan for the category of Nutrition with a problem start date of 5/26/16 and current through 6/28/16, indicated a long term goal of, "Maintain my weight at a healthy range for me without any unwarranted significant weight changes..." The care plan included no revisions to address the severe weight change experienced by Resident #113. The clinical record lacked documentation to indicate Resident #113 had poor food intake.</p> <p>Observation on June 23, 2016 at 2:43 p.m.; Resident #113 was observed in her room, with family present, eating an apple. Resident #113 indicated she has, "had a better appetite lately and finds the food here agreeable." The family</p>		<p>following intervention will be put into place:</p> <ul style="list-style-type: none"> <li>· Director of Health Services, MDS, Medical Records, Unit Manager/Designee will monitor weights for significant changes in Clinical Meeting and make the proper referrals for nutritional support or needed for labs.</li> <li>· Director of Health Services, Unit Manager/Designee will review weight variance report for all assigned weights in the Clinically at Risk meeting every week and make the proper referrals for nutritional support or need for labs.</li> <li>· Director of Health Services, MDS will review care plans of all significant weight changes in Clinical Meeting and immediately update with appropriate interventions.</li> <li>· Director of Health Services/Designee will review all labs for significant weight loss residents in Clinical Meeting to ensure appropriate referral for nutritional support is made.</li> </ul>	

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	<p>member did not disagree.</p> <p>On 6/27/16 at 10:11 A.M., an interview with the Director of Nursing (DON) was conducted. The DON indicated tracking weights is important for ensuring the maintenance of optimal nutritional status. The DON indicated significant weight losses and gains are immediately reported to the DON. The dietician reviews the information on a weekly basis and makes recommendations to the physician. Care plan interventions are made as soon as possible, usually by the MDS coordinator and are also addressed in the daily clinical care meetings. The DON indicated there is no written facility policy regarding weight changes.</p> <p>2.) On 6/24/16 at 10:18 A.M., the closed clinical record for Resident #70 was reviewed. Diagnoses included, but were not limited to nondisplaced fracture of right lower leg, muscle weakness, and hypertension (htn).</p> <p>The Minimum Data Set Assessment (MDS) dated 1/8/16, indicated a Brief Interview of Mental Status (BIMS) score of 14, which indicated the resident to be cognitively able to be interviewed. The MDS indicated the resident had no dental abnormalities or swallowing difficulties and required meal set up only. Diet order</p>		<p>The results of audits will be reported, reviewed and trended for compliance through the campus QA weekly x 4 weeks, then, monthly x 6 months.</p>		

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	<p>dated 1/2/16 and current through the discharge date of 2/25/16, were for controlled carbohydrate diet (CCHO). The admission weight for Resident #70 was recorded on 1/1/16, as 185 pounds. The recorded weight for 1/18/16 was 175 pounds. This is a weight loss of 5.4%. Weight loss of greater than 5% in 30 days is severe.</p> <p>No nutritional notations are indicated in the progress notes.</p> <p>The care plan for the category of Nutrition with a problem start date of 1/7/16 and current through the long term goal target date of 4/8/16 indicated a long term goal of, "Maintain my weight at a healthy range for me without any unwarranted significant weight changes..." The care plan included no revisions to address the significant weight change experienced by Resident #70.</p> <p>On 6/27/16 at 10:11 A.M., an interview with the Director of Nursing (DON) was conducted. The DON indicated tracking weights is important for ensuring the maintenance of optimal nutritional status. The DON indicated significant weight losses and gains are immediately reported to the DON. The dietician reviews the information on a weekly basis and makes</p>			

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F 0371 SS=E Bldg. 00	<p>recommendations to the physician. Care plan interventions are made as soon as possible, usually by the MDS coordinator and are also addressed in the daily clinical care meetings. The DON indicated there is no written facility policy regarding weight changes.</p> <p>3.1-46(a)(1)</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 kitchen staff stored clean cookware in a sanitary manner, dated opened food, and discarded outdated foods as indicated by the facility policy for 1 of 1 kitchen.</p> <p>Findings include:</p> <p>1.) On 6/20/16 at 10:10 a.m., during a</p>	F 0371	<p>The facility failed to ensure kitchen staff stored clean cookware in a sanitary manner, dated opened food, and discarded outdated foods as indicated by the facility policy.</p> <p>Immediate Interventions:</p> <ul style="list-style-type: none"> <li>· All cookware improperly stored was</li> </ul>	07/29/2016

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	<p>tour of the kitchen with the Dietary Manager (DM) present, the following was observed:</p> <p>a.) 2 containers of opened cereal without an open date or expiration date. The DM was observed to tell kitchen staff to removed the cereal from the shelf.</p> <p>b.) A loaf of turkey meat with a discard date of 6/13/16. The DM indicated it should have been removed and was observed to remove the turkey from the refrigerator.</p> <p>2.) On 6/29/16 at 11:48 a.m., in the clean storage area a pan was observed to be stacked and contain a wet substance. The DM removed the pan and indicated it should not be stored wet.</p> <p>On 6/27/16 at 1:41 p.m., the Director of Nursing provided the facility policy, "Food Labeling &amp; Dating Policy," undated, and indicated it was the policy currently being used. The policy indicated, "FOOD LABELING ... MUST have a label that contains the following ... Date &amp; Time (that the food was labeled) Use BY Date ..."</p> <p>On 6/29/16 at 1:00 p.m., the Administrator provided the facility policy, "Dishmachine Guidelines,"</p>		<p>removed for cleaning and then placed in storage in a sanitary manner. All undated and outdated foods were immediately discarded by Director of Food Services. To prevent future deficiencies with compliance of this policy the facility will:</p> <ul style="list-style-type: none"> <li>· The Director of Food Services/Assistant Director of Food Services will Inservice all Dietary staff on proper storage, dating and discarding of outdated foods by 7/29/2016.</li> <li>· The Director of Food Services/Assistant Director of Food Services will audit for compliance of storage of clean cookware 5 x week/ 4 weeks, 3 x week/ 4 weeks and weekly/ 4 months. The Director of Food Services/Assistant Director of Food Services will audit for outdated foods daily x 4 weeks, 3 x week / 4 weeks, and then weekly x 4 months. Results of audits will be reported, reviewed and trended for compliance through the campus QA</li> </ul>	

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F 0431 SS=D Bldg. 00	<p>revised on 4/25/13, and indicated it was the policy currently being used by the facility. The policy indicated, ".... Dishes must be dry before storing..."</p> <p>3.1-21(i)(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>		monthly x 6 months.	

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	<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 dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure insulin was discarded after being expired and an opened date was listed on opened insulin pens for 1 of 3 medications carts observed during Medication Storage. (Resident #63, Resident #54, Resident #16, Resident #17).</p> <p>Findings include:</p> <p>On 6/27/2016 at 11:00 a.m., during observation of the Unit 200 medication cart, the following was observed:</p> <ol style="list-style-type: none"> <li>1. An insulin pen of Humalog still in use for Resident #63 with a delivery date of 5/17/2016, and an opened date of 5/18/2016.</li> <li>2. An insulin pen of Humalog still in use for Resident #54 with a delivery date of 5/5/2016, and an opened date of 5/6/2016.</li> <li>3. An opened Lantus pen for Resident</li> </ol>	F 0431	<p>F 431</p> <p>The facility failed to ensure insulin was discarded after being expired and an opened date was listed on opened insulin pens for 1 of 3 medication carts observed during Medication Storage.</p> <p>Immediate interventions:</p> <ul style="list-style-type: none"> <li>· All residents medications have the potential to be affected.</li> <li>· Director of Health Services immediately removed expired insulin pen from cart and completed proper disposal on 6/27/2016.</li> <li>· All medication carts were immediately audited for expired medications with zero findings by Director of Health Services on 6/27/2016.</li> </ul> <p>To prevent future deficiencies of expired insulin the facility will:</p>	07/29/2016

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	<p>#16 with a delivery date of 6/6/2016, and no opened date.</p> <p>4. An opened bottle of NovoLog for Resident #17 with a delivery date of 6/6/2016, and no opened date.</p> <p>On 6/27/2016 at 11:00 a.m., the Director of Nursing (DON) did not deny the opened insulin pens should no longer be in use or that the opened date should have been listed on the insulin.</p> <p>On 6/27/2016 at 1:41 p.m., the DON provided an untitled document dated March of 2015, with expiration dates for insulin. The list indicated, " ... Humalog ... Pen expiration, 28 days ... Lantus ... Pen expiration, 28 days ... NovoLog ... Vial expiration, 28 days ..."</p> <p>On 6/27/2016 at 2:00 p.m., the DON provided the policy Preparation and General Guidelines dated 9/1/2013, and indicated it was the one currently being used by the facility. The policy indicated, " ... B. The date opened and the initials of the first person to use the vial are recorded ..."</p> <p>3.1-25(k)(6)</p>		<ul style="list-style-type: none"> <li>· Director of Health Services, MDS, Unit Manager, Medical Records/ Designee will In-service all current licensed nursing staff on the campus guidelines for open date/expiration and destruction of expired medication by 7/29/2016.</li> <li>· Director of Health Services, MDS, Unit Manager, Medical Records/ Designee will audit all 3 health campus medication carts 2 times a week x 8 weeks, then 1 time weekly x 16 weeks for compliance.</li> <li>· The results of audits will be reported, reviewed and trended for compliance through the campus QA monthly x 6 months.</li> </ul>		

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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential census: 30 Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on July 06, 2016.</p>	R 0000		
R 0273 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, interview, and record review, the facility failed to ensure staff stored clean cookware in a sanitary manner, dated opened food, and</p>	R 0273	The facility failed to ensure kitchen staff stored clean cookware in a sanitary manner, dated opened food,	07/29/2016

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	<p>discarded outdated foods as indicated by the facility policy for 1 of 1 kitchen and stored food in a sanitary manner for 1 of 1 activity room.</p> <p>Findings include:</p> <p>1.) On 6/20/16 at 10:10 a.m., during a tour of the kitchen with the Dietary Manager (DM) present, the following was observed:</p> <p>a.) 2 containers of opened cereal without an open date or expiration date. The DM was observed to tell kitchen staff to remove the cereal from the shelf.</p> <p>b.) A loaf of turkey meat with a discard date of 6/13/16. The DM indicated it should have been removed and was observed to remove the turkey from the refrigerator.</p> <p>2.) On 6/28/16 at 1:18 p.m., in the activity room a container of popcorn seasoning with a date of 4/29/15, which did not specify a preparation date nor a discard date and a container of an oily substance with no identifying label or dates. Both container lids did not completely cover the containers. At that time, the Administrator did not deny the containers should be labeled and be completely covered. Staff was observed</p>		<p>and discarded outdated foods as indicated by the facility policy.</p> <p>Immediate Interventions:</p> <ul style="list-style-type: none"> <li>· All cookware improperly stored was removed for cleaning and then placed in storage in a sanitary manner. All undated and outdated foods were immediately discarded by Director of Food Services. To prevent future deficiencies with compliance of this policy the facility will: <ul style="list-style-type: none"> <li>· The Director of Food Services/Assistant Director of Food Services will Inservice all Dietary staff on proper storage, dating and discarding of outdated foods by 7/29/2016.</li> <li>· The Director of Food Services/Assistant Director of Food Services will audit for compliance of storage of clean cookware 5 x week/ 4 weeks, 3 x week/ 4 weeks and weekly/ 4 months.</li> <li>· The Director of Food Services/Assistant Director of Food Services will audit for outdated foods daily x 4</li> </ul> </li> </ul>	

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	<p>to remove the containers from the popcorn area.</p> <p>3.) On 6/29/16 at 11:48 a.m., in the clean storage area a pan was observed to be stacked and contain a wet substance. The DM removed the pan and indicated it should not be stored wet.</p> <p>On 6/27/16 at 1:41 p.m., the Director of Nursing provided the facility policy, "Food Labeling &amp; Dating Policy," undated, and indicated it was the policy currently being used. The policy indicated, "FOOD LABELING ... MUST have a label that contains the following ... Date &amp; Time (that the food was labeled) Use BY Date ..."</p> <p>On 6/29/16 at 1:00 p.m., the Administrator provided the facility policy, "Dishmachine Guidelines," revised on 4/25/13, and indicated it was the policy currently being used by the facility. The policy indicated, ".... Dishes must be dry before storing..."</p>		<p>weeks, 3 x week / 4 weeks, and then weekly x 4 months. Results of audits will be reported, reviewed and trended for compliance through the campus QA monthly x 6 months.</p>	

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NAME OF PROVIDER OR SUPPLIER  STONEBRIDGE HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 SHAWNEE DR S BEDFORD, IN 47421			
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R 0410  Bldg. 00	<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 interview and record review, the facility failed to ensure staff administered a two-step tuberculin skin test to residents upon admission as indicated by the facility policy for 3 of 7 residents who were reviewed for tuberculin (TB) testing. (Resident #3, Resident #1, and Resident #2)</p> <p>Findings include:</p> <p>1.) On 6/28/16 at 2:38 p.m., Resident #3's clinical record was reviewed. The resident was admitted on 3/4/16.</p>	R 0410	<p>The facility failed to ensure staff administered a two-step tuberculin skin test to residents upon admission as indicated by the facility policy for 3 of 7 residents who were reviewed for tuberculin testing.</p> <p>Immediate Interventions</p> <ul style="list-style-type: none"> <li>All current Assisted Living records were reviewed to ensure compliance with tuberculin skin test by Director of Health Services on</li> </ul>	07/29/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155727	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2016
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	<p>A Preventative Health note, dated 4/6/16, indicated a TB test administered on 4/6/16.</p> <p>Resident #3's clinical record lacked documentation of a two-step tuberculin skin test completed on admission.</p> <p>On 6/29/16 at 10:10 a.m., the Director of Nursing (DON) indicated she could not find a second step TB test for Resident #3 and did not deny she should have had a two-step testing completed.</p> <p>On 6/29/16 at 10:21 a.m., the DON provided the facility policy, "Guidelines for TB Results Summary Documentation: Residents," and indicated it was the policy currently being used by the facility. The policy indicated, "1. Upon admission each resident shall receive a Two Step Mantoux PPD [purified protein derivative] test to ensure they are free from tuberculosis ... "2.) Resident #2's clinical record was reviewed on 6/28/2016 at 2:30 p.m. Diagnosis included, but were not limited to dementia. Resident #2 was admitted to the facility on 5/15/2016.</p> <p>Physician's order dated 5/15/2016, indicated an order for Aplisol (tuberculin purified protein derivative) solution, 5 tuberculin units/0.1 milliliter (ML)</p>		<p>6/30/2016.</p> <p>To prevent further deficiencies with screening policy the facility will:</p> <ul style="list-style-type: none"> <li>· Director of Health Services, MDS, Unit Manager, Medical Records/ Designee will In-service all staff on following guidelines of Tuburculin Screening policy and procedures by 7/29/2016.</li> <li>· Director of Health Services, MDS, Unit Manager, Medical Records/ Designee will review preventative health record on all new admissions for compliance with tuberculin skin test in Clinical Meeting x 6 months.</li> <li>· The results of audits will be reported, reviewed and trended for compliance through the campus QA monthly x 6 months.</li> </ul>	

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	<p>intradermal. Schedule annual PPD according to admission date.</p> <p>The clinical record lacked documentation which indicated Resident #2 received the required two-step tuberculin administration upon admission or 3 months prior to admission.</p> <p>On 6/29/2016 at 10:07 a.m., the Director of Nursing (DON) indicated, Resident #2 admitted during the time when they were transitioning from paper to the computer and she could not find where a two-step tuberculin test was administered prior to admission.</p> <p>On 6/29/16 at 10:21 a.m., the DON provided the facility policy, "Guidelines for TB Results Summary Documentation: Residents," and indicated it was the policy currently being used by the facility. The policy indicated, "1. Upon admission each resident shall receive a Two Step Mantoux PPD [purified protein derivative] test to ensure they are free from tuberculosis ... "</p> <p>3.) On 6/28/16 at 2:38 p.m., Resident #1's clinical record was reviewed. The resident was admitted on 5/15/16.</p> <p>Resident #1's clinical record lacked documentation of a two-step tuberculin skin test completed on admission.</p>			

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	<p>On 6/29/16 at 10:10 a.m., the Director of Nursing (DON) indicated she could not find a record of a two-step tuberculin skin test for Resident #1.</p> <p>On 6/29/16 at 10:21 a.m., the DON provided the facility policy, "Guidelines for TB Results Summary Documentation: Residents," and indicated it was the policy currently being used by the facility. The policy indicated, "1. Upon admission each resident shall receive a Two Step Mantoux PPD [purified protein derivative] test to ensure they are free from tuberculosis ... "</p>			