

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2015
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NAME OF PROVIDER OR SUPPLIER EASTLAKE TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3109 E BRISTOL ELKHART, IN 46514
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 13, 14 and 15, 2015</p> <p>Facility number: 010065 Provider number: 010065 AIM number: N/A</p> <p>Census bed type: Residential: 81 Total: 81</p> <p>Sample: 07</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. On or before August 23, 2015 the Administrator will ensure all corrective action in the following POC has been completed.	
R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency</p> <p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure 22 of 26 facility employees had CPR (Certified Pulmonary Resuscitation) and 26 of 26 facility employees had first aid certification. (Employees #2, 5, 6, 8, 10, 11, 16, 18, 19, 20, 22, 24, 25, 33, 34, 35, 36, 37, 43, 46, 47, 51, 53, 54, 55 and 56.)</p> <p>Findings include:</p> <p>On 7/14/15 at 2:00 P.M., a review of employee files was conducted. Employees # 2, 5, 6, 8, 10, 11, 16, 18, 19, 20, 22, 24, 25, 33, 34, 35, 36, 37, 43, 46, 47, 51, 53, 54, 55 and 56 did not have current first aid certifications. Employees #2, 5, 6, 8, 11, 18, 19, 20, 22, 24, 25, 33, 34, 35, 43, 46, 47, 51, 53, 54, 55 and 56 did not have current CPR Certification.</p> <p>During an interview on 7/15/15 at 9:25</p>	R 0117	<ul style="list-style-type: none"> · The employees noted on the survey will receive the required First Aid and/or CPR certification. · Prior to posting the daily staff assignment sheets, the Director of Wellness will validate there is a CPR/First Aid certified staff member on each shift. · An audit will be completed to validate each new hire has completed their First Aid and CPR certifications within the first 90 days of hire. · Quarterly, the Quality Assurance program will review the nursing schedule and the personnel audit results to validate ongoing compliance for CPR and First Aide training. 	08/23/2015

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R 0123 Bldg. 00	<p>A.M., the Administrator indicated none of the staff in the building had current first aid certification, and that only 4 staff members had current CPR certification.</p> <p>On 7/15/15 at 9:40 A.M., review of the current policy, dated January 2007, titled "Staffing Requirements" received from the Administrator indicated "...The facility shall ensure that at least one awake nursing staff member is present when one or more resident is present, and is eighteen (18) years of age; is qualified to administer medication; and has a current certification in adult first aid...."</p> <p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the</p>			

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	<p>specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure the required specific job orientation was completed for 4 employees in a sample of 5. (Employee #6, 14, 26 and 36)</p> <p>Findings include:</p> <p>On 7/14/15 at 2:00 P.M., review of the 5 employee files sampled indicated there was no specific job orientations for Employee #6, hired on 5/4/15, Employee #14, hired on 6/16/15, Employee #26, hired on 3/16/15 and Employee #36, hired on 6/16/15.</p> <p>During an interview on 7/14/15 at 3:00 P.M., the Administrator indicated the corporation was bought by a new company on 5/15/15 and the old company took all of the job specific orientation documentation with them.</p> <p>On 7/15/15 at 9:40 A.M., record review of the current policy, dated January 2007, titled "Personnel Training" received from the Administrator indicated "...It is the policy...that all personnel receive orientation of the physical facility and</p>	R 0123	<p>· Staff Training Policy has been updated to say "Prior to unsupervised contact with residents, all employees will have completed the required job specific training." · Staff noted on the survey have received job specific orientation. · A job specific orientation check list will be completed by the employee and their trainer to validate completion of orientation to job specific duties prior to unsupervised contact with residents. · Prior to scheduling a staff member to work independently, the community will validate that the employee has completed their job specific orientation. · Quarterly, the Quality Assurance Committee will verify ongoing compliance with job specific orientation.</p>	08/23/2015			

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R 0240 Bldg. 00	<p>training appropriate to staff responsibilities prior to direct contact with residents, and throughout employment...."</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review and interviews, the facility failed to ensure the service plan was followed and care was provided consistently for 1 resident in a sample of 7. (Resident #2)</p> <p>Finding includes:</p> <p>The clinical record for Resident #2 was reviewed on 07/13/15 at 2:30 P.M. Resident #2 was admitted to the facility on 11/18/12 with diagnoses, including but not limited to hypertension, hypothyroidism, zenker diverticula, anemia, constipation, retinal pigmenthiosc, atrial fibrillation, and declining function.</p> <p>The current service plan for Resident #2, completed on 02/20/15 and current through 08/20/15, indicated the resident</p>	R 0240	<ul style="list-style-type: none"> · The service plan for Resident #2 has been updated and staff will be in-serviced as to how and when services noted on the resident's service plan are to be implemented. · At the time of move in, every six months and with a significant change of condition, the resident's service plan will be updated to reflect the resident's current needs. All care staff will be informed of each resident's care needs prior to providing direct resident care. · All staff will receive job specific orientation to include being in-serviced on the requirement for providing care as directed by the resident's service plan. · Quarterly, the Quality Assurance committee will review a random sample of residents to validate the service plan addresses the resident's care needs and the staff are providing care to the resident as defined on the service plan. 	08/23/2015

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	<p>required a two person physical assist with her transfers, utilized a wheelchair, and required a two person assist with toileting and had incontinence.</p> <p>During an observation on 07/14/15 at 9:20 A.M., Resident #2 was seated in her room in a recliner. She remained in her recliner with no staff intervention from 9:20 A.M. - 11:37 A.M. At 11:37 A.M., CNA #49 entered Resident #2's room, transferred her into her wheelchair by herself. The CNA reached underneath both of the resident's arms and pivoted her into her wheelchair. The resident's legs were noted to be very stiff, her legs and ankles were extended during the transfer and she did not assist with the transfer in any way. The CNA did not use a gait belt or obtain another staff member to assist her with the transfer. CNA #49 then pushed her straight to the Cafe assisted dining room to be fed. She remained in the dining room until 12:50 P.M. when she was pushed back to her room, transferred by CNA #49 from her wheelchair to her bed and given incontinence care.</p> <p>During an interview on 07/14/15 at 12:55 P.M., CNA #49 indicated it took two staff to toilet Resident #2 and it was hard to transfer Resident #2 by herself due to the resident's low bed. CNA #49</p>			

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R 0241 Bldg. 00	<p>indicated she did not toilet Resident #2 because "she be dry sometimes."</p> <p>During an observation on 07/14/15 at 9:20 A.M., Resident #2 was seated in her wheelchair in the front lobby. She was not assisted to the bathroom at any time. At 11:43 A.M., she was pushed in her wheelchair by CNA #45 directly to the Cafe assisted dining room and positioned up to the table for lunch.</p> <p>During an interview on 07/15/15 at 10:30 A.M., the Administrator indicated there was no specific policy regarding the frequency in which incontinent residents who required assistance were to be toileted. She indicated the DON indicated they should be toileted upon rising, before and after lunch, before and after supper, and at bedtime. There was no policy regarding this issue.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interviews, the facility failed to administer</p>	R 0241	· Resident #4 and #5 will receive their medications as per physician orders. · All QMA and licensed	08/23/2015			

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	<p>medications as ordered by the physician for 2 of 5 residents in a sample of 7 for whom the facility handled medications. (Resident #4 and #5)</p> <p>Findings include:</p> <p>1. The medical record for Resident #5 was reviewed on 07/14/15 at 9:30 A.M. The physician's orders for medications and the Medication Administration Record (MAR) for July 2015 for Resident #5 indicated a handwritten order on the July 2015 MAR for Loperamide (an antidiarrheal medication) 2 mg (milligrams)take 2 tabs or 1 tab po (by mouth) dly (daily) not to exceed 16 mg in 24 hours. On July 1st the resident had been administered one tablet and all of the other days from July 2 - 14, 2015, the resident had been given two tablets.</p> <p>During an interview on 07/14/15 at 10:00 A.M., QMA #48 indicated she understood the resident's daughter wanted the resident to receive one tablet daily if the resident had not had any loose stools the previous day and two tablets daily if she had loose stools the previous day. She did not know where the documentation was regarding the consistency of the resident's stools or the parameters or instructions for giving one tablet versus two tablets of the</p>		<p>nurses will be in-serviced on the regulatory guidelines governing medication administration.</p> <ul style="list-style-type: none"> · Weekly, the MARS will be audited to validate the physician orders have been clarified if required and are being given as ordered. · Quarterly, the MAR audit will be reviewed at the Quality Assurance meeting to validate ongoing compliance. 				

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	<p>Loperamide.</p> <p>The original physician's order for the Loperamide medication, dated 08/20/14, indicated the following: "order for Immodium (Loperamide) A-D 2 mg tablets take 1 - 2 tablets po qd PRN (as needed) - do not exceed 16 mg in 24 hours." PRN was circled at the bottom of the prescription form and the physician had signed the form.</p> <p>During an interview on 07/14/15 at 10:38 A.M., the Director of Nursing (DON) indicated the order had not been clarified and she did not think the order indicated only PRN Loperamide administration had been intended.</p> <p>2. The clinical record for Resident #4 was reviewed on 07/14/15 at 10:37 A.M. Resident #4 was admitted to the facility on 11/22/14. A physician's order for an Exelon 13.3 mg patch daily was written on 05/08/15. The June 2015 Medication Administration Record indicated "On Hold per family MD (medical doctor) aware (Insurance not paying)" was handwritten next to the administration record for the Exelon patch medication. There was no physician's order to hold the medication and no nursing note documenting the physician had been notified of the issue with the medication.</p>						

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R 0242 Bldg. 00	<p>The July 2015 MAR did not have the Exelon patch medication on the form.</p> <p>During an interview on 07/15/15 at 9:30 A.M., the DON indicated she was aware of the issue and had notified the physician to obtain a discontinue order for the Exelon patch medication.</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on record review and interview the facility failed to notify the physician of a consistently low heart rate as a possible adverse side effect of medication for 1 of 5 residents in a sample of 7 for whom the facility handled medications. (Resident #4)</p> <p>Finding includes:</p> <p>The clinical record for Resident #4 was reviewed on 07/14/15 at 10:37 A.M. The resident was admitted to the facility on 11/22/14, with diagnoses, including but not limited to, congestive heart failure,</p>	R 0242	<ul style="list-style-type: none"> · Medication side effects and vital sign reporting parameters will be obtained for Resident #4. · Each resident will have resident specific parameters for reporting side effects and/or vital sign variances to the provider. · Upon move in, every six months, and with a significant change of condition, residents' health conditions and medications will be reviewed and if indicated reporting parameters will be obtained from the provider. · Quarterly, the Quality Assurance committee will review a random sample of resident MARs and service plans to verify ongoing compliance with report 	08/23/2015

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	<p>hypertension, atrial fibrillation and severe left systolic dysfunction. The service plan for Resident #4 indicated the facility administered medications to the resident.</p> <p>The physician's orders for medications and treatments indicated an order to assess the resident's blood pressure and pulse daily and to administer Amiodarone (a heart medication) 200 mg (milligrams) every other day and Bisoprolol Fumarate (a blood pressure medication) 5 mg once a day.</p> <p>The pulse assessments for June and July 1 - 14, 2015 indicated the resident's heart rate had fluctuated between 40 - 57, often in the 40's. There was no documentation the physician had been notified of the resident's low heart rate.</p> <p>During the daily exit conference, conducted on 07/14/15 between 3:30 - 3:45 P.M., a policy regarding when to notify the physician of abnormal heart rates was requested.</p> <p>During an interview on 07/15/15 at 9:10 A.M., Resident #4 indicated she had felt "weak" and "just not right" this morning and had summoned assistance. She indicated the nurse had assessed her and noticed her heart rate was low (in the 40's) and was going to call the physician.</p>		parameters based upon the individual resident's needs.				

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R 0246 Bldg. 00	<p>During an interview on 7/15/15 at 10:30 A.M., the Administrator indicated the facility would call the physician if the heart rate was below physician prescribed parameters. She indicated there were no parameters given for Resident #4. She did add the physician had just been notified on 07/15/15 of the resident's low heart rate. There was no explanation given as to why the low heart rate, assessed from June 2015 through July 14, 2015 had not previously been discussed with the physician.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interviews, the facility failed to ensure there was documentation of nurse authorization prior to the administration of as needed</p>	R 0246	· Staff member providing PRN medications to resident #5 will be in-serviced regarding the requirement to obtain authorization prior to	08/23/2015

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	<p>medication for 1 of 5 residents in a sample for whom the facility administered medications. (Resident #5)</p> <p>Finding includes:</p> <p>The clinical record for Resident #5 was reviewed on 07/14/15 at 9:30 A.M. Resident #5 was admitted to the facility on 10/28/10, with diagnoses, including but not limited to, anxiety and a history of a removed gallbladder.</p> <p>The current physician's orders for medications for Resident #5 included an order for Alprazolam (an antianxiety medication) .25 mg (milligrams) one tablet as needed and Loperamide 2 mg give two tablets orally after first loose stool, then one tablet orally after each following BM (bowel movement) as needed.</p> <p>The July 2015 MAR (medication administration record) indicated, on 07/01/15, the resident had been administered both an Alprazolam tablet and two Loperamide tablets by a nursing staff member. During an interview on, 07/14/15 at 10:00 A.M., nursing staff member #48, a QMA (qualified medication aide) indicated she had administered both medications. When queried as to whom had given her prior</p>		<p>administering PRN medications.</p> <ul style="list-style-type: none"> · All QMA's will be in-serviced on the regulatory requirement for obtaining authorization prior to giving a PRN medication. · Weekly, the Director of Wellness will audit administration records to verify compliance with obtaining authorization to administer a PRN medication. · Quarterly, the Quality Assurance committee will review a random sample of resident MARs and progress notes to verify ongoing compliance with regulations governing administration of PRN medication by QMA staff. 				

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R 0270 Bldg. 00	<p>approval to give the as needed medications she indicated it would have been the "nurse on duty." She indicated there was no place to document the name of the nurse and she could not remember whom she had spoken to about the prior approval. QMA #48 indicated there was no place staff were supposed to document the approval as far as she knew.</p> <p>410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room.</p> <p>Based on observation, record review and interview, the facility failed to ensure modified diets were served appropriately as ordered by the physician for 1 of 1 residents who required pureed food (Resident #2) and 3 of 3 resident who required mechanically altered and/or modified texture food (Residents #10, 13, and 32)</p> <p>Finding includes:</p>	R 0270	<ul style="list-style-type: none"> · The diets of resident #2, #10, #13, and #32 will be reviewed and modified to be consistent with ordered texture modifications. · The community will review and if indicated revise its policy and procedure for preparing and serving modified diets. · Monthly compliance with diet orders including texture modification will be audited to validate compliance. · Quarterly, the Quality Assurance committee will review a random sample of resident diet orders and food 	08/23/2015

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	<p>During observation of the noon meal, conducted on 07/13/15 from 11:10 A.M. - 12:00 P.M., the Food Service Supervisor indicated the facility had only one Resident who required a modified diet, Resident #2. She indicated Resident #2 required a pureed diet.</p> <p>Cook #41 was observed to prepare a plate with a serving of mashed potatoes and pureed carrots. CNA #45 then took the covered plate and left the kitchen to feed Resident #2. Cook #41 was queried regarding the lack of pureed meat for Resident #2. Cook #41 indicated she could not "find" any prepared pureed meat for Resident #2 so she had not served the food item. When further queried regarding the lack of meat, Cook #41 then indicated "I guess I can make some if you (the surveyor) think I should." She eventually pureed some beef cubes and sent them to the Cafe dining room where Resident #2 was being fed.</p> <p>In addition, Cook #41 had prepared beef cubes and/or ham and cheese sandwiches for the noon meal. There was no mechanically ground beef or lunch meat noted to have been prepared for any residents.</p> <p>During the observation of the noon meal</p>		served to verify ongoing compliance with therapeutic diet orders.				

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	<p>service, conducted on 07/14/15 at 11:40 A.M. - 12:50 P.M., the menued item was breaded pork. Interview with the FSS (Food Service Supervisor) and observation of meal trays indicated Resident #10 and 13 were served a breaded pork cutlet with gravy on it. When queried as to why it was not ground, the FSS indicated the resident's meat was cut up for them. Resident #32 was served a hamburger with a tomato slice and two large bun sized lettuce leaves. His hamburger was not ground.</p> <p>On 07/14/15 at 12:20 P.M., Resident #2 had been fed a white and pale brown colored pureed food item by LPN #46. The LPN was queried as to any pureed lima beans and she indicated they must have been "mixed" in with the other pureed food items. It was not clear if the lima beans on the menu had been served to Resident #2. When queried regarding the lack of a pureed dessert she indicated because Resident #2 required pureed food she did not always receive a dessert. The menued dessert was a fruit cobbler. After being queried as to whether Resident #2 liked desserts LPN #46 left the Cafe, assisted dining room area and returned 10 minutes later with a pureed dessert for Resident #2.</p> <p>During an interview on 07/15/15 at 10:00</p>			

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R 0273 Bldg. 00	<p>A.M., the Administrator indicated the corporation's dietician did not provide a modified menu for the pureed or mechanically soft residents. She indicated the facility did not currently have policies in place regarding these dietary issues. She provided a "guideline" sheet the FSS utilized when training her staff. Review of the sheet indicated the following: "The soft diet limits or eliminates foods that are hard to chew and swallow, such as raw fruits and vegetables, chewy breads, and tough meats...The mechanical soft diet is a close cousin of the soft diet...In contrast to the soft diet, the mechanical soft diet does not restrict fat, fiber, spices or seasonings. Only the texture and consistency of foods are changes. Fruits and vegetables may be soft -cooked or pureed. Meats, fish, and poultry can be cooked, ground, and moistened with sauce or gravy to make chewing and swallowing more comfortable...."</p> <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</p>			

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	<p>local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview the facility failed to ensure food was prepared and served with properly stored equipment and failed to ensure dietary staff handled food properly when preparing and serving food in 1 of 1 kitchens. This potentially affected all 81 residents who consumed food in the facility.</p> <p>Findings include:</p> <p>During the kitchen sanitation tour, conducted on 07/13/15 between 10:30 A.M. and 11:00 A.M. the following was noted:</p> <p>The shelves underneath two food preparation counters, utilized to store clean baking sheets and bowls was noted to have a build up of dust and food debris. The tops of the convection oven and steamer, utilized to store hot pads had a build up of dust and food debris. One of 5 pans, stacked together on an open shelf had visible wet droplets of water inside</p> <p>During the observation of the food preparation and service of the noon meal, conducted on 07/13/15 between 11:10 A.M. - 12:00 P.M. the following was</p>	R 0273	<ul style="list-style-type: none"> · All food service areas will be in compliance with sanitation and safe handling practices. · Staff having dietary service responsibilities will be oriented to their specific job duties including food and nutritional services regulatory requirements. · Weekly, the food service manager or designee will audit for compliance with food and nutritional services standards. · Quarterly, the Quality Assurance committee will review the audit finding of the food service manager to validate ongoing compliance. 	08/23/2015

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	<p>noted:</p> <p>The cook, Employee #41 was noted checking the temperature of cooked mixed vegetables. She obtained an uncovered thermometer from an open container of various items such as small boxes, alcohol packages, rolls of stickers, and markers and placed the thermometer into the vegetables without sanitizing the thermometer. She repeated the process with another uncovered, unsanitized thermometer to check the roast beef cubes. She obtained a brand new thermometer and without sanitizing the new thermometer checked the temperature of the mashed potatoes.</p> <p>Another dietary employee, Employee #42 was observed wearing gloves on both hands and washing dishes. She was noted to repeatedly place dirty dishes onto a tray and place them into the dishwasher, then without changing her gloves or washing her hands, handle the clean dishes. She was also noted to be drying the clean dishes with a dish towel. The FSS (Food Service Supervisor), Employee #43 was noted to tell Employee #42 not to use a dish towel to dry the dishes. Employee #43 indicated Employee #42 was brand new and another employee was supposed to be coming soon to train her. The FSS did</p>						

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	<p>not correct the misuse of gloves and lack of hand washing.</p> <p>Cook #41 had served Resident #2, who required pureed food only mashed potatoes and pureed carrots. When she was queried regarding the lack of pureed meat, Cook #41 was observed to prepare a serving of pureed beef cubes. She donned a pair of gloves, touched the outside of a small blender, the handle of a large spoon, a drawer handle, and the handle of a spatula and placed the beef cubes into the blender. She then reached in with her contaminated gloved hand and adjusted the blade on the blender.</p> <p>Dietary Employee #44, the "trainer" for new Employee #42 was noted to have arrived and initially was noted to dry the clean dishes with the same dishtowel until she was informed to allow the dishes to "air" dry. Both she and Employee #42 were noted to wear disposable gloves and handle both clean and dirty dishes and the dish washer machine without changing gloves or washing their hands.</p> <p>During observation of the meal service, conducted on 07/14/15 between 11:40 A.M. - 12:50 P.M. the following was noted:</p>			

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R 0299 Bldg. 00	<p>Dietary Employee #47 entered the kitchen from the dining room wearing disposable gloves on both hands. She opened a refrigerator, walked to the back of the kitchen and retrieved a gallon of unopened milk from the walk in cooler, then walked back to the front of the kitchen and reached up to retrieve a glass, touching the rim and top of the cup with her contaminated gloved hand. She then poured milk into the glass and delivered it to a resident in the dining room. With the same contaminated gloved hands, she touched two glasses on the rim and poured ice water into the glasses.</p> <p>During an interview on 7/15/15 at 9:30 A.M., the Administrator indicated the building had new ownership starting in May 2015 and new policies and procedures regarding dietary sanitation and food service had not been implemented with the new company as of 07/15/15.</p> <p>410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on record review and interviews,</p>	R 0299	· Resident #5's physician was	08/23/2015			

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	<p>the facility failed to ensure the physician was notified timely and a response received regarding a pharmacy recommendation for 1 of 5 residents in a sample of 7 for whom the facility handled medications. (Resident #5)</p> <p>Finding includes:</p> <p>Review of the physician's orders for medications and the Medication Administration Record (MAR) for July 2015 for Resident #5, conducted on 07/14/15 at 9:30 A.M., indicated a handwritten order on the July 2015 MAR for Loperamide (an antidiarrheal medication) 2 mg (milligrams) take 2 tabs or 1 tab po (by mouth) dly not to exceed 16 mg in 24 hours. On July 1st the resident had been administered one tablet and all of the other days from July 2 - 14, 2015, the resident had been given two tablets.</p> <p>During an interview on 07/14/15 at 10:00 A.M., QMA #48 indicated she understood the resident's daughter wanted the resident to receive one tablet daily if the resident had not had any loose stools the previous day and two tablets daily if she had loose stools the previous day. She did not know where the documentation was regarding the consistency of the resident's stools or the</p>		<p>advised of the pharmacist's recommendations regarding a PRN medication for the resident which the physician then provided clarification. · Recommendations by the pharmacist will be reviewed and acted upon; a record of which will be retained by the Director of Wellness. · Quarterly, the Director of Wellness will validate that there has been follow up on pharmacist recommendations. · Quarterly, the Director of Wellness will report to the QA committee the status of compliance with follow up on pharmacist recommendations.</p>				

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	<p>parameters or instructions for giving one tablet versus two tablets of the Loperamide.</p> <p>Review of the original physician's order for the Loperamide medication, dated 08/20/14 indicated the following: "order for Immodium (Loperamide) A-D 2 mg tablets take 1 - 2 tablets po qd PRN (as needed) - do not exceed 16 mg in 24 hours." PRN was circled at the bottom of the prescription form and the physician had signed the form.</p> <p>During an interview on 7/14/15 at 10:38 A.M., the Director of Nursing (DON) indicated the order had not been clarified and she did not think the order indicated only PRN Loperamide administration was intended.</p> <p>A pharmacy consultation report, dated 04/09/15, for Resident #5 indicated clarification for daily use of the Loperamide both one and two tablets was requested for the diagnosis, specific dose, frequency and indication for all PRN medication was needed "to avoid confusion and potential for inappropriate use."</p> <p>There was no physician response to the request. During an interview on 07/14/15 at 10:38 A.M., the DON indicated the</p>			

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R 0301 Bldg. 00	<p>pharmacy request was faxed to the physician by the previous DON and she was supposed to follow up with the physician if a response was not given timely.</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation and interview, the facility failed to ensure the open date on a bottle of Novolog insulin for 1 of 5 residents observed for medication pass was not over the 28 day expiration period. (Resident #4)</p> <p>Finding includes: On 7/14/15 at 11:00 A.M., the clinical record for Resident #4 was reviewed. Resident #4 was admitted on 11/22/14</p>	R 0301	<ul style="list-style-type: none"> · A new bottle of insulin for Resident #4 was provided and dated at the time of opening. · All staff responsible for administration of medications will be in-serviced on the dating of specific medications requiring a date the medication was opened. · Each working day, the person(s) responsible for administering medications will date medications requiring an open date at the time of opening and will check any previously opened medication they are 	08/23/2015

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	<p>with diagnoses included, but not limited to: "...congestive heart failure and diabetes...."</p> <p>A physician order, dated 6/5/15, indicated Novolog insulin 3 units SQ (subcutaneous) three times a day after meals.</p> <p>On 7/14/15 at 12:35 P.M., an observation of a medication pass with LPN #36 was conducted. LPN #36 was observed to remove a bottle of Novolog insulin from the medication drawer for Resident #4 and prepared to draw up the insulin dose for the resident. A sticker on the outside of the Novolog insulin bottle indicated the open date of the bottle was 5/9/15. An interview with LPN #36, at that time, indicated insulin should be discarded after it has been open for 28 days and this insulin was past the expiration date. LPN#36 was observed to discard the expired bottle of insulin and obtained a new bottle of Novolog insulin for Resident #4.</p> <p>During an interview on 7/15/15 at 9:45 A.M., the Administrator indicated the facility did not have a policy regarding storage and dating of insulin vials. She further indicated the corporation was bought by a new company on 5/15/15 and the old company took the policies with</p>		<p>administering for an opening date as required. · Monthly, the medication carts will be audited for appropriate medication dates. · Quarterly, the audit will be reviewed at the Quality Assurance meeting to validate ongoing compliance.</p>				

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R 0328 Bldg. 00	<p>them, she also indicated the current corporation just developed a new policy regarding storage and dating of insulin vials but it was not implemented yet.</p> <p>410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division.</p> <p>Based on record review and interview, the facility failed to ensure the Activity Director obtained her certification within 1 year of employment. (Employee #23)</p> <p>Finding includes:</p> <p>On 7/14/15 at 2:00 P.M., review of the employee files indicated Employee #23 was hired on 3/18/13 as the Activity Director. There was no Activity Director certification located in the file.</p> <p>During an interview on 7/14/15 at 3:45 P.M., the Administrator indicated Employee #23 has been employed for over 2 years at the facility and had not yet</p>	R 0328	<p>· Employee #23 no longer is employed at the community. The community's current Activity Director will receive quarterly consultation until satisfactory completion of the Activity Certification course. · The Administrator has reviewed the regulatory requirements for an Activity Director and has incorporated the requirements into the Activity Director's job description. · At the time the community is hiring an Activity Director, the job requirements and applicant's qualifications will be reviewed. Additional training will be scheduled and successful completion will be validated as required by regulation. · At the time of hiring of an Activity</p>	08/23/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R 0329 Bldg. 00	<p>completed her certification. She further indicated an action plan has been implemented and Employee #23 has 60 days to complete her certification.</p> <p>On 7/15/15 at 9:40 A.M., review of the current policy, dated January 2007, titled "Staffing Requirements" received from the Administrator indicated "...Life Enrichment Director for the facility shall meet the requirements; a recreation therapist; an occupational therapist or certified occupational therapy assistant; an individual who has completed an activities director course approved by the division...."</p> <p>410 IAC 16.2-5-7.1(d)(1-3) Activities Programs - Noncompliance (d) After July 1, 1984, any person who has not completed an activities director course approved by the division shall receive consultation until the person has completed such a course. Consultation shall be provided by: (1) a recreation therapist; (2) an occupational therapist or occupational therapist assistant; or (3) a person who has completed a division approved course and has two (2) years of experience.</p> <p>Based on record review and interview, the facility failed to ensure there was an Activity Director consultant in place as</p>	R 0329	<p>Director, the successful applicant's resume and education development plan will be reviewed by the Quality Assurance committee and will be tracked by the committee until all required components are met.</p> <p>· Employee #23 no longer is employed at the community. The community's current Activity Director will receive quarterly</p>	08/23/2015			

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	<p>the Activity Director was not yet certified. (Employee #23)</p> <p>Finding includes:</p> <p>On 7/14/15 at 2:00 P.M., review of the employee files indicated Employee #23 was hired on 3/18/13. There was no Activity Director certification located in the file.</p> <p>During an interview on 7/14/15 at 3:45 P.M., the Administrator indicated Employee #23 has been employed for over 2 years at the facility and has not completed her certification. She further indicated Employee #23 has not received any consultation from a recreation therapist, an occupational therapist or occupational assistant or from a person that has completed the course.</p> <p>On 7/15/15 at 9:40 A.M., review of the current policy, dated January 2007, titled "Staffing Requirements" received from the Administrator indicated "...Life Enrichment Director for the facility shall meet the requirements; a recreation therapist; an occupational therapist or certified occupational therapy assistant; an individual who has completed an activities director course approved by the division...."</p>		<p>consultation until satisfactory completion of the Activity Certification course. · The Administrator has reviewed the regulatory requirements for an Activity Director and has incorporated the requirements into the Activity Director's job description. · At the time the community is hiring an Activity Director, the job requirements and applicant's qualifications will be reviewed. Additional training will be scheduled and successful completion will be validated as required by regulation. · At the time of hiring an Activity Director, the successful applicant's resume and education development plan will be reviewed by the Quality Assurance committee and will be tracked by the committee until all required components are met.</p>				

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R 0410 Bldg. 00	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p> <p>(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.</p> <p>(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.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure a newly admitted resident was given a tuberculin skin test prior to or on admission to the facility for 1 of 7 residents reviewed for tuberculin skin tests. (Resident #7)</p> <p>Finding includes:</p> <p>On 7/14/15 at 10:00 A.M., the clinical record for Resident #7 was reviewed. Resident #7 was admitted on 4/8/15, with</p>	R 0410	<p>· Resident #7 no longer resides at this community. · Prior to or at the time of move in the community will obtain a physician's order for tuberculin screening using the Mantoux skin test unless otherwise contraindicated. · Each new resident's orders and documentation will be audited by the Director of Wellness to verify the order for tuberculosis screening is in place and staff have initiated the required screening. · Quarterly, the Quality Assurance committee will review</p>	08/23/2015

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	<p>diagnoses included, but not limited to: "...leukemia and diabetes...."</p> <p>A form titled, "Resident Tuberculosis Testing Record," dated 4/8/15, indicated there was an area to document the 1st and 2nd tuberculin skin tests, but the entire form was blank.</p> <p>During an interview on 7/14/15 at 3:30 P.M., the Director of Nursing indicated she could not find any documentation of a tuberculin skin test being given to Resident #7 before or on admission to the facility.</p> <p>During an interview on 7/15/15 at 9:45 A.M., the Administrator indicated the facility did not have a policy regarding administering tuberculin skin tests to residents on admission. She further indicated the corporation was bought by a new company on 5/15/15 and the old company took the policies with them, she also indicated the current corporation just developed a new policy regarding administering tuberculin skin tests but it was not implemented yet.</p>		the Director of Wellness findings to validate ongoing compliance.				