

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2013
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NAME OF PROVIDER OR SUPPLIER RESIDENCES AT DEER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST US 30 SCHERERVILLE, IN 46375
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R000000	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: September 16 and 17, 2013</p> <p>Facility number: 013069 Provider number: 013069 AIM number: NA</p> <p>Survey team: Lara Richards, RN-TC Cynthia Stramel, RN (9/17/13) Caitlyn Doyle, RN (9/17/13) Janelyn Kulik, RN (9/17/13)</p> <p>Census bed type: Residential: 59 Total: 59</p> <p>Census payor type: Other: 59 Total: 59</p> <p>Sample: 9</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on</p>	R000000	<p>Residences at Deer Creek (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</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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	September 22, 2013, by Janelyn Kulik, RN.			

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R000086	<p>410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the facility failed to ensure they applied for the Clinical Laboratory Improvement Amendments (CLIA) waiver in a timely manner. This had the potential to affect the 3 residents who resided in the facility that required blood glucose monitoring. (Residents #2, #3, and #9)</p> <p>Findings include:</p> <p>1. The record for Resident #2 was reviewed on 9/16/13 at 2:30 p.m. A Physician's order dated 8/27/13, indicated the resident's blood sugar was to be monitored daily.</p> <p>Interview with the Director of Nursing on 9/16/13 at 9:45 a.m., indicated staff observed the resident performing</p>	R000086	<p>No residents were adversely affected by The CLIA Waiver during the time of the survey. Resident #2 is not receiving medication services and our staff observes the resident self-performing her blood sugar. Residents #3 and #9 are unable to perform their own blood glucometer testing. An application for the CLIA Waiver was submitted by the facility on 9/16/13 and is pending approval from the Indiana Department of Health. Orders have been clarified for all residents requiring blood glucose monitoring. The facility has obtained orders for a lab with a current CLIA waiver in place to perform blood glucose monitoring until receipt of our CLIA Waiver. To prevent this from occurring in the future the CLIA waiver will be submitted through the accounts payable process upon routine renewal.</p>	10/11/2013			

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	<p>her blood sugar.</p> <p>Interview with the resident on 9/17/13 at 10:25 a.m., indicated that nursing staff completed her blood glucometer for her.</p> <p>2. The record for Resident #3 was reviewed on 9/16/13 at 11:45 a.m. A Physician's order dated 2/13/13 and listed on the September 2013 Physician's Order Summary (POS), indicated the resident's blood sugar was to be monitored every Wednesday and Sunday.</p> <p>Interview with LPN #1 on 9/17/13, indicated the resident was not able to perform his own blood glucometer.</p> <p>3. The record for Resident #9 was reviewed on 9/17/13 at 11:30 a.m. A Physician's order dated 5/30/13, indicated the resident's blood sugar was to be checked three times a week on Tuesday, Thursday, and Saturday.</p> <p>Interview with LPN #1 on 9/17/13 at 9:10 a.m., indicated that she had checked the resident's blood sugar that morning. She also indicated the resident was not able to complete his own glucometer.</p>						

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	<p>Interview with the Administrator on 9/16/13 at 9:15 a.m., indicated the facility did not have a current CLIA waiver, due to the residents being able to complete their own glucometers.</p> <p>Interview with the Administrator on 9/17/13 at 12:30 p.m., indicated the facility had applied for their CLIA waiver on 9/16/13.</p>			

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R000095	<p>410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia.</p> <p>Based on interview, the facility failed to ensure the Alzheimer's and dementia special care unit disclosure form had been submitted to the State Agency. This had the potential to affect the 18 residents residing on the Memory Care Unit.</p>	R000095	No residents were adversely affected by the Alzheimer's and dementia special care unit disclosure form not having been submitted to the state. The Alzheimer's and dementia special care unit disclosure form will be submitted to the State Agency. To prevent this from occurring in the future the Alzheimer's and	10/11/2013			

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	<p>Findings include:</p> <p>During the Initial tour on 9/16/13 at 9:45 a.m., the facility was identified as having a Memory Care Unit. The unit was a locked unit and required staff to unlock the door with their key fobs.</p> <p>Observation during the Initial tour on the Memory Care Unit, indicated some residents were wearing wander guard bracelets. Interview with the Director of Nursing at the time, indicated if a resident was wearing a wander guard, the doors would lock and the resident would not be able to exit the unit.</p> <p>Review of the Admission Packet on 9/17/13 at 12:30 p.m., indicated there was information related to the Memory Care Unit.</p> <p>Interview with the Administrator on 9/17/13 at 12:30 p.m., indicated the Special Care Unit disclosure form had not been submitted to the State Agency.</p>				<p>dementia special care unit disclosure form will be resubmitted annually to ensure ongoing compliance with this requirement.</p>		

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R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure pasteurized eggs in the shell were in use for residents requesting poached and/or fried eggs. The facility also failed to ensure boxes of juice and pudding were not stored on the floor and that facility staff did not touch residents' food with their bare hands. This had the potential to affect the 59 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation tour on 9/16/13 at 10:30 a.m., with the Dietary Food Manager, the following was observed:</p> <p>a. A tray of eggs were observed in the walk in refrigerator. There was no "P" on the eggs to indicate they were pasteurized.</p> <p>Interview with the Dietary Food Manager at the time, indicated the facility had liquid pasteurized eggs for scrambling. However, he was not aware if the eggs in the shell were</p>	R000154	<p>No residents were adversely affected by the eggs, boxes on floor in the food storage area or sandwich preparation on the date of this finding. The Culinary staff were inserviced on the date of this finding regarding eggs in shells which are pasteurized. The culinary staff had not prepared non pasteurized eggs on the date of this finding and would have taken temperature of the eggs prior to serving to the resident requesting eggs. The Executive Chef, on the date of this finding, removed non-pasteurized eggs in shell from the inventory. To prevent this from occurring in the future, the Executive Director or Designee will only order pasteurized eggs. The Executive Chef will monitor food orders on a monthly basis to ensure compliance. No residents were affected by the two unopened boxes of pudding and four unopened boxes of juice which were on the Floor of the dry storage room. The Executive Chef placed the items on a rack immediately upon this finding. To prevent this from occurring in the future, random inspections by the Executive Chef or Designee of</p>	10/11/2013			

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	<p>pasteurized.</p> <p>b. Two boxes of pudding were observed on the floor in the dry storage room. Further, four boxes of juice were also observed on the floor in the dry storage room.</p> <p>Interview with the Dietary Food Manager at the time, indicated the boxes should not have been stored on the floor.</p> <p>2. On 9/17/13 at 12:10 p.m., CNA #1 was observed preparing sandwiches on the Memory Care Unit. The CNA was not wearing gloves and she was observed to cut five sandwiches in half. The CNA touched the bun of each sandwich with her bare hand.</p> <p>Interview with LPN #1 on 9/17/13 at 12:15 p.m., indicated the CNA should have been wearing gloves and she should have used a fork and knife to cut the sandwich in half.</p>		<p>the dry storage area will be made at least weekly to ensure items are not placed on the floor of the dry storage area.No residents were adversely affected by the staff not wearing gloves when preparing food on memory care. On the date of this finding, the staff member was immediately instructed on appropriate technique and gloves were applied. Registered Dietician, Resident Services Director or Chef will complete random infection control rounds and meal observations and report in Quality Assurance meetings for three months. Inservice education to be provided by Registered Dietician on infection control and dining service practices on October 4, 2013. The corrective action will be monitored via the aforementioned audits and results of audits will be shared in Quality Assurance meetings monthly for three months to ensure ongoing compliance with this requirement.</p>				

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure the Service Plan was signed by the resident and/or their responsible party for 4 of 7 Service Plans reviewed. (Residents #1, #3, #4, and #6)</p>	R000217	No residents were adversely affected. The service plans for residents 1, 4, 6, and 3 have been signed by the appropriate party. An audit has been completed of all resident charts and all records were reviewed and signed by the appropriate party. Semi-annual review of evaluation and service plans will	10/11/2013			

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	<p>Findings include:</p> <p>1. The record for Resident #1 was reviewed on 9/16/13 at 2:45 p.m. Review of the Service Plans dated 4/20/13 and 7/17/13, indicated they had not been signed by the resident.</p> <p>Interview with the Director of Nursing on 9/17/13 at 2:30 p.m., indicated the Service Plans should have been signed by the resident.</p> <p>2. The record for Resident #4 was reviewed on 9/16/13 at 12:30 p.m. Review of the Service Plans dated 3/30/13 and 7/1/13, indicated the Service Plans had not been signed by the resident and/or their responsible party.</p> <p>Interview with LPN #1 on 9/17/13 at 11:30 a.m., indicated the Service Plans should have been signed by the resident's responsible party.</p> <p>3. The closed record for Resident #6 was reviewed on 9/17/13 at 10:30 a.m. Review of the Service Plans dated 5/15/13 and 7/1/13, indicated the Service Plans had not been signed by the resident and/or their responsible party.</p> <p>Interview with the Director of Nursing</p>				<p>be conducted by the Director of Resident Services or Designee to ensure they have been reviewed and signed by the resident and/or responsible party. Results of the semi-annual audit will be reported in Quality Assurance meetings to review compliance.</p>		

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	<p>on 9/17/13 at 2:30 p.m., indicated the Service Plans should have been signed by the resident's responsible party.</p> <p>4. The record for Resident #3 was reviewed on 9/16/13 at 11:45 a.m. Review of the Service Plans dated 3/30/13 and 6/21/13, indicated the Service Plans had not been signed by the resident and/or their responsible party.</p> <p>Interview with LPN #1 on 9/17/13 at 11:30 a.m., indicated the Service Plans should have been signed by the resident's responsible party.</p>			