

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155343	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2011
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LAGRANGE	STREET ADDRESS, CITY, STATE, ZIP CODE 0770 N 075 E LAGRANGE, IN46761
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F0000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: October 31, November 1, 2, 3, 4, 2011</p> <p>Facility number: 000235 Provider number: 155343 AIM number: 100267740</p> <p>Carol Miller, RN, TC Honey Kuhn, RN (October 31, November 1, 2, 3, 2011) Diane Nilson, RN (November 3, 2011)</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 5 Medicaid: 55 Other: 16 Total: 76</p> <p>Sample: 16 Supplemental sample: 1</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/9/11 by</p>	F0000	<p>The provider wishes this plan of correction be considered our allegation of compliance. The following response and corrective action stated within this 2567 plan of correction should not be considered as an admission of guilt or wrong doing on the part of Life Care Center of LaGrange. The plan of correction is prepared and executed solely because it is required by the provision of Federal and State laws.</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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F0328 SS=D	<p>Jennie Bartelt, RN.</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record reviews, and interviews, the facility failed to ensure a metered dose inhaler medication was administered correctly. This deficiency affected 1 of 2 residents observed who received a metered dose inhaler medication during the medication administration in a sample of 16 and a supplemental sample of 1. (Resident #51)</p> <p>Findings include:</p> <p>On 11/1/11 at 8:00 a.m. during medication administration, LPN #5 was observed as she administered Resident #51's Flovent HFA (a metered dose inhaler medication for asthma). LPN #5 gave one puff, and then waited 10 seconds and gave the resident the second puff of medication.</p> <p>A fax from the facility pharmacy in regard to how to use an inhaler was received from QMA (Qualified Medication Aide)</p>	F0328	<p>Corrective action accomplished for residents affected by the alleged deficient practice: Resident #51 was re-assessed on 11-1-11 and no negative outcome. LPN #5 was immediately re-educated on the policy and procedure regarding metered dose (MD) by the DON on 11/1/11. How the facility will identify other residents potentially affected by the same deficient practice: Nurse Management to review all residents who have current orders for MD inhalers to ensure proper protocol will be followed based on manufacturers guideline. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: RN's and LPN's were re-educated by the SDC on 11/1/11 on waiting the appropriate time between doses of MDI. Residents will benefit from following appropriate protocol of MDI based on manufacturer's guidelines. Any continued non-compliance shall result in 1:1</p>	12/04/2011

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	<p>#6 and reviewed on 11/1/11 at 10:30 a.m., and indicated, "...For inhaled quick-relief medicine (beta agonists), wait about 1 minute between puffs...."</p> <p>LPN #5 was interviewed on 11/1/11 at 11:00 a.m. in regard to waiting 1 minute in between puffs for Resident #51's Flovent HFA medication. LPN #5 indicated she should have waited 1 minute after she gave the first puff of medication.</p> <p>The Physician's Order Sheet for October 2011 indicated Resident #51 had orders for Flovent HFA 110 micrograms inhaler 2 puffs by mouth to be given once a day for the diagnosis of asthma.</p> <p>On 11/3/11 at 9:00 a.m., a request was made to the Director Of Nursing (DON) in regard to the policy for Flovent HFA medication administration. The DON indicated the facility did not have a policy for the Flovent HFA but used the manufacture's recommendations. The DON was queried in regard to the manufacture's recommendations for the administration of the Flovent HFA. The DON indicated the manufacture's recommendations for the Flovent HFA was to wait 1 minute in between the first and second puff of the medication</p> <p>3.1-47(a)(6)</p>		<p>re-education following progressive disciplinary guideline up to and including termination. DON/designee will monitor MDI administration daily 5 times weekly for 2 weeks, then 3times a week for 2 weeks, then once weekly until 100% competency is obtained.How corrective actions will be monitored to ensure the alleged deficient practice will not recur: Completed audits will be reviewed by the ED weekly and presented to QI monthly times 3 then quarterly thereafter to determine if further educational is needed.</p>		

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observations, record review, and interviews, the facility failed to ensure food was served in a sanitary manner as evidenced by grasping bowls with fingers touching the insides where food is placed and serving dry cereal which had been placed into bowls and stacked with the bottom of the bowls touching the uncovered cereal. This deficiency had the potential to affect all 76 of 76 residents when receiving food served in bowls residing in the facility with a census of 76.</p> <p>Finding includes:</p> <p>During the lunch food line observation, on 10/31/11 between 11:30 and 12:10 p.m., burgundy bowls were noted to be stacked upright and haphazardly in the allotted area of the dishware holder. Dietary Aide #2 was observed to take a bowl, as needed, from the dish stacker by grasping the inside of the bowl with fingers touching the inside surface area before</p>	F0371	<p>Corrective action accomplished for residents affected by the alleged deficient practice: Dietary aide #2 and #3 were both inserviced on facility's "Safe Food Handling" policy by the certified dietary manager on 11/02/2011. How the facility will identify other residents potentially affected by the same deficient practice: All dietary staff were inserviced on facility's "Safe Food Handling" policy by the certified dietary manager on 11/02/2011 and 11/03/2011. What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The certified dietary manager or designee will ensure food is served in a sanitary manner by observing that bowls are stacked properly (upside down) to prevent any potential contamination to the bowl's interior and covering dry cereal bowls with parchment paper before stacking bowls for the food line. The certified dietary manager will document these</p>	12/04/2011

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	<p>placing the food products in the bowls.</p> <p>During the breakfast food line observation, on 11/02/11 between 7:50 and 8:10 a.m., Dietary Aide #3 was observed to take bowls, stacked upright, from the dishware holder by grasping the inside of the top bowl with fingers touching the inside surface area before placing the food products in the bowls. This was observed four times.</p> <p>During the breakfast food line observation, on 11/2/11 between 7:50 and 8:10 a.m., a serving cart was noted next to the steam table. The top cart shelf held burgundy bowls and white china bowls containing dry cereal. There were 2 burgundy bowls noted to each have a burgundy bowl stacked on top, resulting in the bottoms of the stacked bowls touching the dry cereal. There were 3 white china bowls noted to each have a white china bowl stacked on top and 1 white china bowl noted to have 2 white china bowls on top, resulting in the bottoms of the stacked bowls touching the dry cereal.</p> <p>The CDM (Certified Dietary Manager) was interviewed on 11/02/11 at 9:00 a.m. The CDM indicated the dry cereal should have been covered with parchment paper before stacking bowls for the breakfast</p>		<p>observations on an audit sheet not less than three times weekly. How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The certified dietary manager or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits.</p>		

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	<p>food line. The CDM indicated the bowls could be stacked upside down to prevent any potential contamination to the bowl's interior.</p> <p>The DNS (Director of Nursing Services) indicated, on 11/03/11 at 8:15 a.m., all residents received diets or pleasure feedings.</p> <p>Review of a Policy & Procedure, provided by the Regional Nurse, on 11/03/11 at 8:50 a.m., indicated: "Safe Food Handling: 01/01/2007" "Policy: All food purchased, stored and distributed is handled with accepted food-handling practices... *Associates do not touch areas of utensils, dishware or flatware where the food or mouth is placed."</p> <p>3.1-21(i)(3)</p>				