

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 04/22/2016
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NAME OF PROVIDER OR SUPPLIER YORK PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 725 W 50TH ST MARION, IN 46953
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Date: April 22, 2016</p> <p>Facility Number: 004028 Provider Number: 004028 AIM Number: N/A</p> <p>Residential Census: 38</p> <p>Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on April 27, 2016.</p>	R 0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or that the statement of deficiencies was correctly cited and is also NOT to be construed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response or plan of correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
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 food was stored properly, vents and light covers over food prep areas in the kitchen</p>	R 0273	<p>1. The ice cream was disposed of immediately. The vents and lights were cleaned on 4/25/16 by the maintenance tech The Assistant Chef was trained by an Eco-lab</p>	05/22/2016

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>were kept clean and manufacturer guidelines were followed for chemical testing during sanitation of dishes. This deficiency potentially affected 38 of 38 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During a kitchen tour observation on 4/22/16 at 9:05 A.M., the following were observed:</p> <p>1. Six uncovered dishes of ice cream with chocolate syrup were in a freezer.</p> <p>During an interview with the Assistant Chef on 4/22/16 at 9:05 A.M., she indicated the dishes of ice cream were not supposed to be uncovered and should have been discarded.</p> <p>Review of a document titled, "LEFTOVERS AND PREPARED FOOD", dated 7/1/14, and provided by the Administrator on 4/22/16 at 2:27 P.M., included: "...All prepared foods in an appropriate container, covered with an airtight lid or cellophane, and label the container with the type of food and the date..."</p> <p>2. An accumulation of gray dust and debris hung from three air vents and two</p>		<p>representative on the proper testing procedures on 4/22/2016. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Staff members were in-serviced on proper food storage on 5/3/2016 by ED and DON. The Maintenance Tech cleaning schedule has been changed to include cleaning the kitchen vents and lights bi-weekly and as needed. The Assistant Chef will complete the 3-compartment sink chemical testing when the Chef is not available. 4. The Chef is responsible for sustained compliance. The Executive Director and/or designee will monitor food items, vents and lights, and the chemical testing to ensure procedures are being followed. Checks will be completed 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. Continued monitoring will be ongoing through routine random checks weekly at a minimum.</p>		

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	<p>light covers in the ceiling above the food prep area.</p> <p>The Assistant Chef indicated the vents and lights were dirty. She also indicated the vents and lights were on a cleaning schedule but was unsure of how often they were cleaned.</p> <p>During an interview with the Maintenance Tech on 4/22/16 at 10:13 A.M., he indicated he cleaned the vents and lights in the kitchen on a monthly basis but had not gotten to them for the month of April.</p> <p>During an interview with the Administrator 4/22/16 at 3:20 P.M., she indicated the vents and lights in the kitchen were cleaned monthly and documented in two areas - in a notebook kept by the Maintenance Tech and on a form kept in the kitchen area.</p> <p>Review of an untitled, undated and handwritten document, provided by the Maintenance Tech on 4/22/16 at 10:13 A.M., indicated the vents and lights in the kitchen were cleaned on a monthly basis. There was no checkmark for the month of April 2016.</p> <p>3. The dishwasher and 3-compartment sink were in use.</p>			

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	<p>The Assistant Chef indicated that she did not know how to test the chemical levels on the dishwasher and 3-compartment sink. She also indicated that the area chemical supplier came in on a bi-weekly basis and checked the chemical levels and, therefore, did not believe further testing was necessary.</p> <p>During an interview with the area chemical supplier on 4/22/16 at 1:34 P.M., he indicated that chemical levels should be checked on the dishwasher and the 3-compartment sink every shift it was used.</p> <p>Review of a document titled, "Section 1: SPECIFICATION INFORMATION", dated 10/29/07, and provided by the area chemical supplier, included: "...SANITIZING RINSE SOLUTION 50 PPM [parts per million] CHLORINE MINIMUM..."</p> <p>Review of a document titled, "Oasis 146 Multi-Quat Sanitizer", dated 2011, and provided by the Assistant Chef at 1:34 P.M., included: "...Sanitation Range Testing... Testing solution should be at room temperature... Withdraw and tear off approximately 2 inches of paper from dispenser. Dip paper for 10 seconds... Compare colors immediately with colors</p>			

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R 0296 Bldg. 00	<p>on the test strip package to determine ppm. ALWAYS COMPARE AGAINST PACKAGE SCALE... Testing solution should be between 150 - 400 ppm..."</p> <p>No further documentation was provided by the time of exit on 4/22/16.</p> <p>410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered according to manufacturer guidelines for 1 of 1 observation of insulin administration out of a sample of 8 (Resident E).</p> <p>Findings include:</p> <p>During an observation of an insulin administration on 4/22/16 at 11:34 A.M., the Director of Nursing (DON) removed the cap from a Novolog FlexPen, removed the protective tab from a disposable needle, screwed the needle onto the FlexPen, and removed the needle cap. She then dialed the dose</p>	R 0296	<p>1. The DON was immediately in-serviced by the Executive Director (RN) regarding the insulin pen manufacturer's instructions on 4/22/2016.</p> <p>2. Current residents receiving insulin have the potential to be affected by the alleged deficient practice. 3. Licensed staff on duty, on 4/22/16, were in-serviced on 4/22/2016 by the DON regarding the insulin pen manufacturer's instructions. Other licensed personnel were in-serviced on the procedure on 5/3/2016 by the DON. 4. The DON is responsible for sustained compliance. The ED and/or designee will monitor licensed staff at least once weekly at a minimum, to ensure</p>	05/22/2016

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	<p>selector to 18, cleansed Resident E's abdomen, and injected the insulin into the abdomen.</p> <p>During an interview with the DON on 4/22/16 at 11:52 A.M., she indicated that was her normal procedure and she would not do anything differently. She further indicated that it was facility policy to follow manufacturer guidelines when administering insulin with a Novolog FlexPen.</p> <p>Review of the manufacturer's guidelines for "Novolog FlexPen", undated, and provided by the Director of Nursing on 4/22/16 at 1:26 P.M., included the following: "... Step 1: Preparing your Novolog FlexPen... Pull off the cap. Wipe the rubber stopper with an alcohol swab... Step 2: Doing the airshot before each injection... Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to 2 units Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle..."</p>		<p>manufacturer's guidelines are being followed during insulin administration, for 1 month. Monitoring results will be discussed in the monthly QA meeting. The QA committee will determine if continued monitoring is necessary based on full compliance for the month.</p>				

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R 0406 Bldg. 00	<p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation, interview and record review, the facility failed to administer eyes drops in a manner that would prevent infection for 1 of 3 eye drops administration (Resident H).</p> <p>Findings include:</p> <p>During an observation of eye drops administration on 4/22/16 at 11:34 A.M., the Director of Nursing (DON) pushed Resident H in her wheelchair from the dining room to a lounge next to the dining room. No hand hygiene was performed and gloves were not donned. The DON then used her ungloved thumb and forefinger to hold open Resident H's left eye. She administered an eye drop into the left eye and as she did, the tip of the eye drops bottle touched the inner top eyelid of Resident H. The DON then used her ungloved thumb and forefinger</p>	R 0406	<p>1. The DON was in-serviced on administering eye drops on 5/3/16 by the Executive Director(RN). 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Licensed staff and QMA's were in-serviced on administering eye drops on 5/6/16 by the DON. 4. The DON is responsible for sustained compliance. The ED and/or designee will monitor administration of eye drops 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. The monitoring results will be discussed in the monthly QA meetings. The QA committee will determine if ongoing monitoring is necessary based on three consecutive months of full compliance.</p>	05/22/2016			

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	<p>to hold open Resident H's right eye. She administered an eye drop into the right eye and as she did, the tip of the eye drops bottle touched the inner bottom eyelid of Resident H.</p> <p>During interviews with the DON on 4/22/16 at 11:52 A.M. and 2:40 P.M., she indicated she should have performed hand hygiene and donned gloves after pushing Resident H in the wheelchair and before administering eye drops. She also indicated she was unaware that the tip of the eye drops bottle touched Resident H's inner eyelids. Furthermore, she indicated that the bottle of eye drops should have been discarded after the tip touched Resident H's left eye.</p> <p>A request for an eye drop administration policy was made on 4/22/16 at 11:52 A.M. from the DON. She indicated there was no policy specific to eye drop administration.</p> <p>Review of a document titled, "How to administer eye drops and ointments", dated 1/10/14, and available at http://www.dorsetccg.nhs.uk/Downloads/partners/Care%20homes/011014-How-to-administer-eye-drops-and-ointments.pdf, included: "...BOX 1. PROCEDURE FOR INSTILLING EYE DROPS... Wash hands before and after instilling eye</p>			

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	<p>drops to prevent cross infection... non-sterile gloves are used when instilling eye drops...."</p> <p>No further information was provided before exit on 4/22/16.</p>						