

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 02/11/2016
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NAME OF PROVIDER OR SUPPLIER  CHRISTINA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 CHRISTIAN BLVD FRANKLIN, IN 46131
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 9, 10, and 11, 2016.</p> <p>Facility number: 004017 Provider number: 004017 AIM number: N/A</p> <p>Census bed type: Residential: 57 Total: 57</p> <p>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 February 17, 2016.</p>	R 0000	Submission of this response and plan of correction is not a legal admission that a deficiency exists and is not to be construed as an admission against interest by the residence, 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 if the truth of any facts alleged or the correctness of any conclusions set forth in this summary by the survey agency.	
R 0092  Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the</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>transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 57 of 57 residents who reside in the facility.</p> <p>Findings include:</p> <p>Review of Christina Place Fire Drill documentation on 02/10/16 at 12:45 p.m., the facility lacked documentation of a fire drill for the third shift (10:00 p.m. to 6:00 a.m.) of the second quarter (April, May, and June) and of the third quarter (July, August, and September) of 2015.</p> <p>Interview with Maintenance Supervisor on 02/10/16 at 245 p.m., indicated that they did not have documentation of the</p>	R 0092	<p>1. Fire drills are presently on schedule with at least one drill per shift each quarter. The Executive Director has contacted the local fire department about coordinating a fire drill with the fire department on or before 6/30/16. The Maintenance Tech was in-serviced on 2/17/16 by the Executive Director on the requirements for conducting and documenting fire drills once per shift per quarter. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. The Executive Director or designee will schedule and conduct incomplete drills by the 10th week of the quarter. The Maintenance Tech will schedule and conduct silent fire drills for the third shift each quarter. Staff will be in-serviced on this</p>	03/21/2016			

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R 0217  Bldg. 00	<p>missing fire drills. The Maintenance Supervisor indicated they had provided all the documentation on the fire drills they had.</p> <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: (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. (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. (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. (4) No identification and documentation of services provided is needed if evaluations</p>				<p>requirement on 3/16/16 by the Maintenance Technician. 4. Fire drills are reviewed monthly at Safety Committee meetings. Drills not completed by the 2nd Safety Committee meeting of the quarter will be completed within one week of the meeting to maintain compliance. The Maintenance Tech is responsible for compliance. The Maintenance Tech will discuss fire drills in the monthly Safety Committee meetings to ensure compliance. Compliance will be ongoing.</p>		

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	<p>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 service plans were signed for 2 of 7 residents reviewed (Resident #36 and #45).</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #36 completed on 2/9/2016 at 12:40 p.m., indicated a facility admission date of 10/28/2015. Diagnoses included, but were not limited to, dementia.</p> <p>A review of the Assessment and Negotiated Service Plan Summary dated 10/28/2015 - 10/29/2015, lacked a signature from the Resident or Responsible Party until 1/15/2016.</p> <p>During an interview on 2/11/2016 at 2:15 p.m., the Care Service Manager (CSM) indicated the Negotiated Service Plans are to be signed by the Resident or Responsible Party upon admission to the facility. The CSM indicated Resident #36's signature was missed on the Negotiated Service Plan.</p> <p>2. The clinical record of Resident #45</p>	R 0217	<p>1. Care Service Manager and Executive Director will be re-educated that Negotiated Service Plans (Evaluations) are to be signed timely at the time of update on 3/1/16 by the Regional Director of Clinical Services. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. The Care Services Manager and/or designee will ensure that the resident or responsible party signs Negotiated Service Plans in a timely manner. The Care Services Manager may conduct a phone review with the resident's responsible party if he/she is unable to discuss the review in person. The review and any follow up will be documented in the resident service notes. 4. The Care Service Manager is responsible for compliance. The Executive Director or designee will check the newly updated negotiated Service Plans weekly for signatures for 3 months. Results will be discussed in the monthly Quality Assurance meeting. The Quality Assurance Committee will determine if continued audits are necessary based upon the 3 months of data presented. Compliance will be</p>	03/21/2016

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R 0243	<p>was reviewed on 2/9/16 at 12:45 p.m. Diagnoses for the resident included, but were not limited to, Parkinson's disease, dementia, hallucinations, paranoia, and depression.</p> <p>Review of an Assessment and Negotiated Service Plan (NSP) Summary dated 12/11/16, indicated Resident #45 needed an increase in services from the previous assessment dated 10/16/15. The NSP from 12/11/16, was not signed by the resident or the responsible party.</p> <p>On 2/11/16 at 9:20 a.m. the Executive Director (ED) provided a copy of the 12/11/16, NSP with a signature of the responsible party, signed on 2/11/16.</p> <p>On 2/9/16 at 11:32 a.m., the ED provided a State of Indiana Residency Agreement, dated November, 2012, and indicated it was the residency agreement currently used by the facility. The agreement indicated, "...The Negotiated Service Plan will be signed by the Residence Director and You. Your needs will re reviewed semiannually...or in the event of a significantly change in Your condition."</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency</p>		ongoing.		

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Bldg. 00	<p>(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:</p> <p>(A) time;</p> <p>(B) name of medication or treatment;</p> <p>(C) dosage (if applicable); and</p> <p>(D) name or initials of the person administering the drug or treatment.</p> <p>Based on record review and interview, the facility failed to ensure a sliding scale insulin dosage amount was documented for 1 of 7 residents reviewed for medications (Resident #36).</p> <p>Findings include:</p> <p>The clinical record review for Resident #36 was completed on 2/9/2016 at 12:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>A review of recapitulated physician orders for December, 2015, indicated Resident #36 was to receive NovoLog (medication used to lower blood glucose levels) per sliding scale. The order indicated to administer NovoLog three times a day as follows: 2 units for blood glucose level 140 - 180, 4 units for blood glucose level 181 - 220, 5 units for blood glucose level 221 - 240, 6 units for blood glucose level 241 - 280, 8 units for blood glucose level 281 - 300, 10 units for blood glucose level 301 - 320, and 12 units for 321 - 340.</p>	R 0243	<p>1. The MAR for resident #36 will be clarified and updated on 3/1/16 to reflect the current physician's order. Licensed Staff will be in-serviced regarding accurate documentation of sliding scale insulin administration on or before 3/16/16. 2. Current residents with orders for sliding scale insulin have the potential to be affected by the alleged deficient practice. 3. Licensed Staff will be in-serviced regarding accurate documentation of sliding scale insulin administration on or before 3/16/16 by the Care Services Manager. The Care Services Manager or designee will ensure that current medication administration records for residents with orders for sliding scale insulin are accurately written during the monthly recapitulation review. 4. The Care Services Manager or designee will audit medication administration record of Residents with sliding scale insulin daily for one month then weekly for two months. Results will be reviewed in the monthly Quality Assurance meeting. The Quality Assurance Committee will</p>	03/21/2016			

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R 0273 Bldg. 00	<p>A review of the Medication Administration Record (MAR) for December, 2015, indicated the blood glucose level result and a signature indicating NovoLog sliding scale was administered. The MAR lacked documentation indicating the dosage amount of NovoLog given 3 times a day, daily from December 1 - December 31, 2015.</p> <p>During an interview on 2/11/2016 at 2:15 p.m., the Care Service Manager (CSM) indicated the dosage amount of NovoLog administered should have been documented on the MAR.</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 local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview the facility failed to ensure 57 of 57 residents who received food prepared in the kitchens received food distributed and served under sanitary conditions as indicated by facility policy.</p> <p>Findings Include:</p>	R 0273	<p>determine if continued random checks are necessary based upon the 3 months of data presented.</p> <p>1. Dietary Aides 1 and 2 will be in-serviced on hand washing and glove use by the Executive Director and the Chef on 3/1/16. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Staff will be in-serviced on hand washing and glove use when working in the kitchen and dining</p>	03/21/2016			

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	<p>During the service of noon meal on 02-09-16 at 11:30 A.M., the following was observed:</p> <p>1) Dietary Aide # 1 was observed in the kitchen to be preparing drinks for residents. Aide was observed to have gloves on. She handled the ice scoop, then placed it on top of the fresh ice in the bin, poured the drinks and proceeded to carry the cups to the dining room to be served touching the doorknobs on her way out and back in the kitchen. She then returned to prepare more drinks without changing gloves. If a resident requested milk, she would go to the refrigerator and retrieve the milk, pour a glass, and return the milk to the refrigerator all while wearing the same gloves. She was then observed to remove her gloves, did not wash her hands, and began to prepare a turkey and cheese sandwich. She handled the bread packaging, went to the refrigerator and retrieved the packaged turkey and cheese, proceeded to open both packages with her gloved hands. She proceeded to a cabinet retrieved a bag of chips. She then put her gloved hand inside the bag of chips and placed a handful of chips on the plate. She removed her gloves, did not wash her hands and took the plate and placed it on a tray to be delivered to the dinning</p>		<p>room on or before 3/16/16 by the Executive Director. 4. The Chef is responsible for ongoing compliance. The Executive Director or designee will randomly check for hand washing and proper use of gloves 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then once a week for 4 weeks. The random checks will be inclusive of each meal 7 days a week. Results will be discussed in the monthly Quality Assurance meeting. The Quality Assurance Committee will determine if continued random checks are necessary based upon the 12 weeks of data presented.</p>				

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	<p>room. She then put on a new pair of gloves and began prepping a peanut butter and jelly sandwich. She went to the cabinet and retrieved the peanut butter and jelly containers and then handled the bread packaging. She then opened all containers and spread both peanut butter and jelly on the bread , cut the sandwich in half, placed it on a plate, and placed the plate on a tray to be served.</p> <p>2) Dietary Aide #2 was observed to put on a pair of gloves and arrange cookies on plates and placed the plates on a cart to be served in the dinning room. She then handled the bowls and ladle and dipped up peaches and placed them on the cart as well. She removed her gloves and took the cart into the dining room and served the cookies and peaches. She then returned to the kitchen, did not wash her hands, put on a new pair of gloves and returned to arranging cookies on plates.</p> <p>3) Dietary Aide #1 was observed to be clearing off the tables in the dining room with gloved hands. She took all the glasses off the tables and emptied the ones that had remaining liquid in them into a bucket. She took the glasses and put them in a glass tray. She then handled the tops of the salt and paper shakers, removed the table cloths and moved to</p>			

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	<p>the next table. When the tray was full she went into the kitchen to the dish machine and began putting away clean dishes. She placed the tray of glasses into the dish machine and then returned to the dining room to continue clearing tables. These actions were repeated to clear 17 of 18 tables without once changing gloves or washing hands.</p> <p>On 02-10-16 at 09:00 a.m., the Administrator provided a policy titled: Safe Food Handling. The administrator indicated it was the current policy in use by the facility.</p> <p>Policy:</p> <p>1. All foods will be handled using safe-handling practice, using appropriate methods when cleaning counters, food contact surfaces, and utensils...</p> <p>6. During food preparation, food items that will not be cooked before being served to a resident should be handled with utensils or gloved hands.</p> <p>During an interview with the Administrator and Dietary Manager on 02-11-16 at 2: 40 p.m. they indicated the staff received training and facility policies are gone over during orientation. They indicated that employees are expected to use a spatula or tongs , or</p>			

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R 0349 Bldg. 00	<p>wear disposable gloves when handling food. They also indicated the staff is expected to wash hands and change gloves each time they change jobs or leave the line to prevent contamination of food, equipment, and utensils.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were complete in that residents' diet orders were not found for 2 of 7 records reviewed for clinical documentation. (Residents #39 and #12)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #39 was reviewed on 2/9/16 at 2:45 p.m. Diagnoses for the resident included, but</p>	R 0349	<p>1. The diet order for resident # 39 will be clarified with the physician on 3/1/16 and updated in the resident's record. The diet order for resident # 12 will be clarified with the physician on 3/1/16 and updated in the resident's record. 2. Current residents have the potential to be affected by the alleged deficient practice. 3. Staff nurses will be in-serviced on or before 3/16/16 by the Care Services Manager regarding the need for current and accurate diet orders, including on the monthly</p>	03/21/2016

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	<p>were not limited to, high blood pressure and heart disease.</p> <p>The resident was admitted to the facility on 1/10/16. A Resident Medical History and Examination dated 1/7/16, signed by a physician, indicated the resident was prescribed a regular cardiac diet.</p> <p>Recapitulated physician orders for February, 2016, did not indicate what kind of a diet the resident was to receive.</p> <p>2. The clinical record of Resident #12 was reviewed on 2/10/16 at 9:15 a.m. Diagnoses for the resident included, but were not limited to, depression and diabetes mellitus.</p> <p>Recapitulated orders for January and February, 2016, signed by the physician, indicated, "Please clarify diet orders."</p> <p>The recapitulated orders for February, 2016, did not indicate what kind of a diet the resident was to receive.</p> <p>On 2/10/15 at 10:40 a.m., the Care Services Manager indicated Residents #39 and #12 did not have current diet orders on the February recapitulated orders.</p>		<p>recapitulation. The Care Services Manager and/ or designee will audit monthly recapitulated orders for accuracy of diet orders monthly for 3 months. Results will be reviewed in the monthly Quality Assurance meeting. The Quality Assurance Committee will determine if continued random checks are necessary based upon the 3 months of data presented.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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