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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                    |  | X3) DATE SURVEY COMPLETED<br>08/16/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BEARDSLEY HOUSE |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>27833 CR 24<br>ELKHART, IN 46517 |  |   |  |
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| R0000   | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 15-16, 2012</p> <p>Facility number: 004353<br/>Provider number: 004353<br/>AIM number: N/A</p> <p>Survey team:<br/>Honey Kuhn, RN, TC<br/>Shelly Vice, RN</p> <p>Census bed type:<br/>Residential: 19<br/>Total: 19</p> <p>Census payor type:<br/>Other: 19<br/>Total: 19</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on August 17, 2012 by Bev Faulkner, RN</p> | R0000   |   |   |  |   |  |

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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| R0117   | <p>410 IAC 16.2-5-1.4(b)<br/>Personnel - Deficiency<br/>(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 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. Based on record review and interviews, the facility failed to ensure a minimum of 1 staff person with CPR (Cardio Pulmonary Resuscitation) and First Aid certification was scheduled for 9 of 15 night shifts reviewed for staffing. This deficiency had the potential to affect 19 of 19 residents residing in the facility.</p> <p>Finding includes:</p> | R0117   | <p><b>-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>No residents were found to be affected. The Residence Director made arrangements for IU Health Goshen Hospital, Community Wellness &amp; Education to hold CPR certification class on 8/27/2012 at Beardsley House. Class was completed to ensure</p> | 08/27/2012  |  |   |  |

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|   | <p>The staffing schedule for July 31, 2012 through August 27, 2012, was provided by the facility's Wellness Director (Director Nursing Services) on 08/15/12 at 2:00 p.m. The licensure and certification status of all employees was provided at the time. Review of the information indicated PSA (Personal Care Assistant) #2, DOH (Date of Hire) 06/25/12, and PSA #5, DOH: 07/12/11, were not certified in CPR or First Aid.</p> <p>Review of staffing, for the night shift, indicated staff scheduled for 9 of 15 nights, from 07/31/12 through 08/15/12, were not CPR and First Aid certified. The schedule indicated:</p> <p>PSA #2 and PSA #5 were scheduled and worked:<br/>07/31/12<br/>08/04/12<br/>08/05/12</p> <p>PSA #2 was the only staff member scheduled to work night shift:<br/>08/03/12<br/>08/07/12</p> <p>PSA #5 was the only staff member scheduled to work night shift:<br/>08/01/12<br/>08/06/12<br/>08/08/12</p> |   | <p>continued compliance with above referenced regulation. The Residence Director and/or Designee will ensure schedules are reviewed prior to posting to ensure continued compliance with Indiana state regulation R 117 410 IAC 16.2-5-1.4 (b) Personnel.</p> <p><b>-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>No other residents were found to be affected.</p> <p><b>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?</b></p> <p>The Residence Director and Wellness Director were re-educated to the Indiana state regulation R117 410 IAC 16.2-5-1.4 (b) Personnel. The Residence Director and/or Designee will be responsible to ensure at least one (1); awake staff person is on duty at all times with current CPR and First Aid certification.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</b></p> |   |  |   |  |

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|   | 08/14/12<br><br>An interview with the Regional Director on 08/16/12 at 10:00 a.m., indicated PSA #5 was the usual scheduled employee for night shift and had not been certified in CPR and First Aid. |   | <b>program will be put into place-</b><br><br>The Residence Director and/or Designee will conduct a random employee file audit monthly for a period of six months to ensure continued compliance with Indiana State ruling R117 410 IAC 16.2-5-1.4 (b) Personnel. The Community will evaluate the need for an ongoing monitoring plan after six months via the house internal QA process in order to determine the frequency of continued monitoring. Findings suggestive of compliance will result in cessation of QA monitoring plan.<br><br><b>By what date the systemic changes will be completed</b><br><br>Systemic changes put into effect as of 08/27/2012. |   |  |   |  |

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| R0145   | <p>410 IAC 16.2-5-1.5(b)<br/>Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on observations, record reviews and interviews, the facility failed to clean and sanitize the kitchen ice machine according to the manufacturer's guidelines. This affected 1 ice machine in a sample of 1. This had potential to affect 19 Residents.</p> <p>Findings include:</p> <p>On 8/15/12 at 11:45 a.m., an observation was made of the ice machine located within the kitchen. It was noted to have sediment type crustation at the bottom rim of the external front side of the ice machine indicative of mineral deposits.</p> <p>On 8/15/12 at 11:47 a.m., an interview was made of the Dining Service Coordinator (DSC). She indicated the ice machine was maintained and cleaned by the maintenance department. She indicated the maintenance man for the facility had resigned as of 8/14/12. She indicated she was not aware of when it had been cleaned and did not know how to clean the ice machine and indicated the maintenance director of a sister facility was in the facility and could answer</p> | R0145   | <p><b>-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>No residents were found to be affected. Kitchen ice machine was cleaned according to manufactures guidelines on 8/16/2012. An Ice Machine cleaning schedule is set up in the kitchen log book, as of 8/16.2012. The Dining Service Coordinator and/or Designee will be responsible to ensure future compliance with Indiana State regulation R 145 410 IAC 16.2-5-1.5 (b) Sanitation and Safety Standards.</p> <p><b>-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>No other residents were found to be affected.</p> <p><b>What measures will be put into place or what systemic changes the facility will make</b></p> | 08/16/2012  |  |   |  |

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|   | <p>questions.</p> <p>On 8/15/12 at 12:00 p.m., an observation was made of a monthly cleaning schedule located on the outside of the kitchen refrigerator. This schedule was to account for the cleaning of the kitchen. This included a "monthly cleaning" noted by a "(MT)" placed following the "ice machine cleaning (MT)."</p> <p>Upon interviewing of the DSC of the ice machine notation, she indicated she was not aware of seeing a check mark indicating the ice machine had been cleaned on her historical documentation of the monthly cleaning schedule forms.</p> <p>On 8/15/12 at 3:45 p.m., an interview was conducted with the Maintenance Director. A record review was made of a piece of paper that supported a newly developed cleaning schedule for the ice machine maintenance and cleaning. He indicated there was no prior documentation of the ice machine having been cleaned.</p> <p>On 8/16/12 at 8:10 a.m. an interview and record review was conducted with the Maintenance Director. The manufacturer's manual was provided for review. "Section 4 Maintenance" was reviewed with the Maintenance Director. The "Interior Cleaning and Sanitizing" noted the following: "... General. Clean</p> |   | <p><b>to ensure that the deficient practice does not recur?</b></p> <p>The Dining Service Coordinator, Maintenance Director, and kitchen staff were re-educated to the newly developed ice machine cleaning schedule, log book, and Indiana state regulation R 145 410 IAC 16.2-5-1.5 (b) Sanitation and Safety Standards. The Dining Service Coordinator and/or Designee will be responsible to ensure continued compliance as to the cleaning and maintenance of the ice machine.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The Dining Services Coordinator will perform a random weekly review of the ice machine and kitchen log book for a period of six months to ensure future compliance. The Community will evaluate the need for an ongoing monitoring plan after six months via the house internal QA process in order to determine the frequency of continued monitoring. Findings suggestive of compliance will result in cessation of QA monitoring plan.</p> <p><b>By what date the systemic changes will be completed?</b></p> <p>Systemic changes to be in place as of 08/16/2012.</p> |   |  |   |  |

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|                    | <p>and sanitize the ice machine every six months for efficient operation..."</p> <p>On 8/16/12 at 8:40 a.m., an interview was conducted with the Maintenance Director. A record review was made of the "2011" maintenance record for cleaning which included the "ice machine." It was noted that the most recent documentation provided of the facility for the "ice machine cleaning" was noted for "January 2011" with the initials of "MMM." The Maintenance Director indicated there were no records available for 2012.</p> |               |   |                      |

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| R0408   | <p>410 IAC 16.2-5-12(c)<br/>Infection Control - Noncompliance<br/>(c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission.</p> <p>Based on record reviews and an interview, the facility failed to ensure a chest x-ray was completed prior to admission for 3 of 7 residents in a sample of 7. (Resident #8, Resident #12 and Resident #20)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 8/15/12, at 2:30 p.m., the record for Resident #8 was reviewed. Resident #8 was admitted to the facility on 01/20/11. Upon review of the clinical record, diagnostic chest x-rays completed within 6 months or less of admission dates were not found.</li> <li>On 8/15/12, at 2:45 p.m., the record for Resident #12 was reviewed. Resident #12 was admitted to the facility on 04/10/12. Upon review of the clinical record, diagnostic chest x-rays completed within 6 months or less of admission dates were not found.</li> </ol> <p>On 8/15/12 at 3:00 p.m., an interview was conducted with the Regional Registered Nurse. It was noted that Resident #8 and #12 had not had a diagnostic chest x-ray dated no more than</p> | R0408   | <p><b>-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>No residents were found to be affected. The Wellness Director and/or Designee will complete a chart audit of residents residing at the community as to the presence of a chest x-ray film no later than by 09/30/2012. The Wellness Director and/or Designee will obtain a chest x-ray within six months of move in or at the time of discovery in order to achieve compliance with Indiana state regulation R 408 IAC 16.2-5-12 (c) Infection control. The house administrative team has been re-educated to our policy and procedure regarding infection control and the Indiana state regulation referenced above to ensure future compliance.</p> <p><b>-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>No other residents were found to</p> | 09/30/2012  |  |   |  |

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|   | <p>6 months prior to their admission dates.</p> <p>3. The closed record of Resident #20 was reviewed on 08/16/12 at 8:30 a.m., Resident #20 was admitted to the facility on 09/30/11 with diagnoses including, but not limited to, pulmonary fibrosis, lung cancer, dementia, and diabetes. There was no documentation to indicate a pre-admission x-ray was obtained prior to the resident's admission.</p> <p>The Regional Nurse Consultant was interviewed on 08/16/12, at 9:00 a.m., and indicated the facility did not have any documentation in regards to a pre-admission x-ray.</p> |   | <p>be affected. The Wellness Director and/or Designee will review upcoming admissions prior to move in to ensure a chest x-ray is completed within six months prior to move in to move in. The Wellness Director and/or Designee will be responsible to ensure future compliance with our infection control and state regulation as referenced above going forward.</p> <p><b>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?</b></p> <p>The Wellness Director, Residence Director, and Residence Sales Manager were re-educated to our policy and procedure regarding infection control and the Indiana state regulation R 408 IAC 16.2-5-12 (c) Infection control. The Wellness Director and/or Designee will be responsible to ensure continued compliance with the above referenced citation through internal monitoring a chart auditing.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> |   |  |   |  |

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|   |  |   | <p>The Wellness Director and/or Designee will perform a random weekly review of new and current resident records to ensure a compliance with our infection control policy and procedures as well as Indiana state regulation as referenced above. The Community will evaluate the need for an ongoing monitoring plan after six months via the house internal QA process in order to determine the frequency of continued monitoring. Findings suggestive of compliance will result in cessation of QA monitoring plan.</p> <p><b>By what date the systemic changes will be completed?</b></p> <p>Systemic changes will be in place by 09/30/2012.</p> |                      |   |