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| 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 09/25/2015 |
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| NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM | STREET ADDRESS, CITY, STATE, ZIP CODE 3177 MERIDIAN PARKE DR GREENWOOD, IN 46142 |
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| R 0000 Bldg. 00 | <p>This visit was for State Residential Licensure Survey.</p> <p>Survey dates: September 23,24, and 25, 2015</p> <p>Facility number: 011478 Provider number: 011478 AIM number: N/A</p> <p>Census bed type: Residential: 84 Total: 84</p> <p>Sample: 7</p> <p>These state findings are cited accordance with 410 IAC 16.2-5.</p> <p>QR completed by 14466 on September 30, 2015.</p> | R 0000 | <p><u>“This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of _____ as to the accuracy of the surveyors’ findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community’s policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.”</u></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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| R 0006 Bldg. 00 | <p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on record review and interview, the facility failed to ensure a resident was considered for discharge after having exhibited repeated behaviors of wandering, elopement, burning the floor with an iron, leaving a stove on and unattended, and repeated episodes of having fallen for 1 of 2 residents reviewed for scope of residential care. (Resident #110)</p> <p>Findings include:</p> <p>The clinical record of Resident #110 was reviewed on 9/24/15 at 10:45 a.m.</p> | R 0006 | <p>R006 Scope of Residential Care</p> <ol style="list-style-type: none"> Resident was given notice on 7/9/15 and was discharged on 7/9/15 to her daughter's residence pending admittance to a Long Term Care Facility. The ED and DON will review the care plans of all residents in the facility at the present time and determine if any remaining discharges are necessary to be in compliance with the State Law. An in-service will be | 10/16/2015 |

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| | <p>Diagnoses for the resident included, but were not limited to Alzheimer's disease and history of a stroke.</p> <p>Resident #110 was admitted to the facility on 8/31/14, and was discharged on 7/11/15.</p> <p>A Level of Service Assessment/Evaluation, dated 5/14/14, (prior to admission to the facility) indicated Resident #110 was, "Disoriented to the point of no longer able to function independently 3 or more days a week or part of every day for a 7-day period..." The assessment indicated the resident did not wander and did experience difficulty in decision-making when faced with new tasks or situations.</p> <p>Nurses' notes indicated:</p> <p>9/17/14 at 12:25 p.m., "Res [resident] noted wandering outside of apt [apartment] x two. Noted to be stuck in grass with walker, gait unsteady, needs assistance to walk up onto porch ledge. Res also noted to be outside this shift with a knife attempting to remove a tree branch..."</p> <p>10/31/14 at 1:24 p.m., "Family member came over & said res asked if she could</p> | | <p>conducted to inform all nurse of the criteria for discharge and proper documentation. The DON and ED will meet weekly to review residents who are at risk and determine if discharge is necessary according to the State regulations. Going forward all nursing staff will be in-serviced on adding any changes to resident's care plans as needed. Example: Friday ATB's, change in conditions, falls, N/O's etc. per the DON. Care plan meetings will be held with the families to update them of those changes and concerns and of discharges when needed to meet the State regulations.</p> <p>4. The DON and Ed will meet weekly to review residents who are at risk and determine if discharge is necessary according to the State regulations.</p> <p>5. Completion Date is 10/16/15</p> | |

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| | <p>come over & report that res burned floor. Staff went over, to see res floor. Res floor had a light imprint of an iron. Staff asked res what happened & res said her floor was wet, & she tried to dry it..."</p> <p>11/19/14 at 11:40 a.m., resident reported she had fallen.</p> <p>11/22/14 at 5:00 a.m., the resident was found on the kitchen floor.</p> <p>A Resident Care Plan/Service Plan, dated 11/22/14, indicated the resident made safe decisions in familiar situations but had difficulty with new tasks/situations, wandered outside the facility and needed to be monitored for wandering outside, could get around inside the facility but required presence of staff for safety outside.</p> <p>Continued nurses' notes indicated:</p> <p>12/1/14 at 4:15 p.m., the resident was found on the kitchen floor.</p> <p>1/12/15 at 9:00 p.m., a family member had reported the resident had fallen.</p> <p>2/27/15 (no time indicated) resident reported she had fallen in the kitchen.</p> <p>A physical therapy treatment note dated</p> | | | |

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| | <p>3/3/15, indicated the resident required supervision for outdoor surfaces.</p> <p>A Resident Care Plan/Service Plan, dated 3/3/15, indicated the resident made safe decisions in familiar situations but had difficulty with new tasks/situations, did not wander, could get around inside the facility, but required presence of staff for safety outside.</p> <p>Continued nurses' notes indicated:</p> <p>3/25/15, no time indicated, physical therapy, "notified staff that res was walking unsafely & acting strange, staff observed res & noticed the same thing..."</p> <p>6/8/15 at 9:30 a.m., "Wrote work order for maintenance to unplug stove ASAP due to resident leaving pot on the burner so long the liquid dried up and the pot stuck to the burner. Resident also had the oven going and was not aware."</p> <p>6/8/15 at 10:55 p.m. indicated, "Follow up to the directly above entry [Nurse's note entry dated 8/8/15 at 9:30 a.m.]. Residents stove was already unplugged around 8 AM this morning by ED [Executive Director]."</p> <p>6/17/15 at 2:30 p.m., "This nurse noted res wandering in the 200 building</p> | | | |

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| | <p>attempting to go out the exit door to get to the 300 building. This nurse redirected the resident to the correct way of getting to the 300 building."</p> <p>7/4/15 at 10:00 p.m., "Kitchen staff came and got writer and stated that two gentlemen had just brought resident back to room after they helped her off the ground at corner of facility by white fence. Resident states, 'I was looking for my hearing aids and got lost. I climbed under a fence I didn't fall that's how I hurt my knee.' Another resident witnessed incident and stated, 'Resident fell and then crawled under fence.' Supervisor notified about resident wandering from facility and getting lost her response was to call family to come and get her. Resident's daughter notified and decided to come get resident and take her home to keep a closer eye on her..."</p> <p>7/6/15 at 9:45 a.m., Spoke to...residents daughter [power of attorney]...regarding residents return to facility after 7/4/15 incident. Per [power of attorney] resident is to stay with daughter for safety reasons until ED returns back tomorrow and then ED and DON with POA can discuss the next step..."</p> <p>7/11/15 at 10:15 a.m., "Notified by front desk resident outside 200 building with a</p> | | | |

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| | <p>neighbor [man] from houses behind 200 building. Man stated, 'She was heading up to my porch and asking me did I know where she lived.' Nurse escorted resident back into facility. Resident incontinent of bowels. CNA [Certified Nursing Assistant] escorted resident to residents apt and assisted incontinent care and sat with resident until POA/daughter...arrived to take resident to her...residence for safety. Notified ED and DON. Resident second episode of being unaware of surroundings [locations] in a week per ED's decision to allow resident in facility since 7/4/15 episode until nurse notified ED of todays incident. Nurse made aware to ED for residents safety nurse notified POA to pick up resident and monitor for safety. ED agreed and stated, 'We tried.' Resident left facility @ 11:15A via POA/daughter in personal vehicle..."</p> <p>On 9/24/15 at 4:05 p.m., the ED was asked for further information regarding the resident's continued stay at the facility. On 9/25/15 at 9:10 a.m., the ED provided undated notes she had written regarding what she remembered. The notes indicate the ED and DON met with the resident and her daughters on 7/10/15, and the resident stated she was very frightened and would not go outside alone anymore. "She said that what she</p> | | | | | | |

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| | <p>did was 'Stupid.' She was able to tell me most of the incident. After talking to [DON's name] we decided to let her come back because she knew where she was and where she was going. She seemed to understand the danger she was in and now appeared to be frightened by the event. So she returned on the afternoon of 7/10/15. The next morning she went over to the Main Building which she had done many times before but this time she went out the wrong exit and was in the yard of a neighbor. I was notified and the daughter was called resident was given notice and did not return to the property. Official letter was sent next business day and verbal notice was given on 7/11/15."</p> <p>An undated letter, provided by the ED on 9/24/15 at 2:10 p.m. indicated, "As we talked on Wednesday July 8 2015 due to your mother [name of resident] recent behaviors, we no longer feel that we can accommodate her needs. She is walking the hallways and entering other residents apartments, leaving back door open to hear apartment and does not use good judgement when going outside her building and has fallen in the grass because she does not use the sidewalks. Due to her mental decline, and her doctor's recommendation and for her safety we are giving [name of resident] a</p> | | | |

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| | <p>30 day notice asking that you seek a secured facility for your mother..."</p> <p>On 9/24/15 at 3:10 p.m., the ED indicated the facility, "does not have enough staff to provide 1:1 care for a resident after an elopement."</p> <p>On 9/24/15 at 3:30 p.m., the ED provided an undated policy titled Resident Agreement Policy and Procedure, and indicated it was the policy currently used by the facility. The policy indicated, "...Admission and Discharge Criteria for Residential Care...The resident must be discharged if the resident Is a danger to the resident or others..." The ED indicated she did not feel the resident was a danger to her self or others until after the second elopement on 7/11/15.</p> | | | |

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| R 0090 Bldg. 00 | <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> | | | |

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| | <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to notify the Indiana State Department of Health within 24 hours regarding a resident's elopement events, burning of a floor with an iron, and leaving a stove on and unattended for 1 of 1 resident reviewed for notification of unusual occurrences. (Resident #110)</p> <p>Findings include:</p> <p>The clinical record of Resident #110 was reviewed on 9/24/15 at 10:45 a.m. Diagnoses for the resident included, but were not limited to Alzheimer's disease and history of stroke.</p> <p>Nurses' notes indicated:</p> <p>10/31/14 at 1:24 p.m., "Family member came over & said res [resident] asked if she could come over & report that res burned floor. Staff went over, to see res</p> | R 0090 | R090Administration & Management 1. Resident #110 has been moved to a LTC facility. Resident 110 case was reviewed according to the State regulations for reporting unusual occurrences to gain better understanding of the Laws. 2. To be in compliance with the State regulations regarding reporting unusual occurrences the Ed will review the regulations to assure all reports are being made within 24 hours of occurrence. 3. Going forward all incidents will be closely reviewed by the ED in accordance to the State Laws in regards to unusual occurrences. All reports will be kept in a binder in the ED office to affirm all reports are being done according to the State regulations. 4. As administrator I will oversee and assist in making any required reports to the State within the corrected time period.5. Completed date is 10/7/15 | 10/07/2015 | | | |

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| | <p>floor. Res floor had a light imprint of an iron. Staff asked res what happened & res said her floor was wet, & she tried to dry it..."</p> <p>6/8/15 at 9:30 a.m., "Wrote work order for maintenance to unplug stove ASAP due to resident leaving pot on the burner so long the liquid dried up and the pot stuck to the burner. Resident also had the oven going and was not aware."</p> <p>6/8/15 at 10:55 p.m., "Follow up to the directly above entry [Nurse's note dated 6/8/15 at 9:30 a.m.]. Residents stove was already unplugged around 8 AM this morning by ED [Executive Director].</p> <p>7/4/15 at 10:00 p.m., "Kitchen staff came and got writer and stated that two gentlemen had just brought resident back to room after they helped her off the ground at corner of facility by white fence. Resident states, 'I was looking for my hearing aids and got lost. I climbed under a fence I didn't fall that's how I hurt my knee.' Another resident witnessed incident and stated, 'Resident fell and then crawled under fence.' Supervisor notified about resident wandering from facility and getting lost her response was to call family to come and get her. Resident's daughter notified and decided to come get resident and take her home to</p> | | | |

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| | <p>keep a closer eye on her..."</p> <p>7/11/15 at 10:15 a.m., "Notified by front desk resident outside 200 building with a neighbor [man] from houses behind 200 building. Man stated, 'She was heading up to my porch and asking me did I know where she lived.' Nurse escorted resident back into facility. Resident incontinent of bowels. CNA [Certified Nursing Assistant] escorted resident to residents apt and assisted incontinent care and sat with resident until POA/daughter...arrived to take resident to her...residence for safety. Notified ED and DON. Resident second episode of being unaware of surroundings [locations] in a week per ED's decision to allow resident in facility since 7/4/15 episode until nurse notified ED of today's incident. Nurse made aware to ED for residents safety nurse notified POA to pick up resident and monitor for safety. ED agreed and stated, 'We tried.' Resident left facility @ 11:15A via POA/daughter in personal vehicle..."</p> <p>On 9/25/15 at 9:20 a.m., the ED indicated she did not report the incidents of 10/31/15 with the iron, 6/8/15 with the oven and stove burner being left on, and the elopements on 7/4/15 and 7/11/15. She indicated she did feel these were unusual occurrences.</p> | | | |

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| R 0144 Bldg. 00 | <p>On 9/24/15 at 3:30 p.m. the ED provided a policy dated 2002, titled Abuse Prohibition and indicated it was the policy currently used by the facility. The policy did not contain any references to unusual occurrences, but did indicate the facility should report allegations of abuse, neglect, or misappropriation of property within 3 days of the occurrence.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the residents'</p> | R 0144 | R144 Sanitation & Safety | 10/13/2015 |

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| | <p>environment was maintained in a sanitary, orderly, and comfortable interior for 24 of 24 residents residing on the 300 and 400 halls of the facility.</p> <p>Findings include:</p> <p>On 9-23-15 at 2:25 p.m., the following was observed:</p> <p>1.) In the far right corner of the 400 hall dining room there was house plant that was a wilted to the point of deterioration. This caused the leaves to discolor and fall well past the confinements of the pot. Also the soil was very dry and cracked.</p> <p>On 9/24/15 at 12:15 P.M. the following was observed:</p> <p>2.) Prior to the service of the noon meal, there were food crumbs and particles located under the dinning room tables.</p> <p>On 9/23/15 at 12:45 P.M. the following was observed:</p> <p>3.) In the 300 hall dining room the large coffee table located in front of the back window was covered with a heavy layer of dirt and dust. There was a collection of cobwebs between the window sill and the table and also in the four corners of the windows. Cobwebs had also collected in</p> | | <ol style="list-style-type: none"> To ensure the resident's environment is maintained in a sanitary, orderly and comfortable fashion, the Ed completed a thorough audit of the facility for cleanliness or items that need repair. The Housekeepers check off list will be update to include a check off sheet for cleaning the common areas to avoid omitting areas of concern. The house plant noted in the citation was removed and discarded. All housekeepers will attend an in-service for training on the new check off sheets and cleaning procedures. ED will have all housekeepers hand in these forms each week along with the apartment check off sheet already given the ED The ED or designee will audit the dining rooms 5xs a week for a month and then weekly along with the weekly audits to assure compliance. Completed by 10/13/15 | |

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| | <p>the spaces between the bottom of the table and the legs. Over the middle dining room table the light and ceiling fan fixture had also accumulated cobwebs including dead insects. Three of the five chairs at the dining room table with the puzzles were covered with dust and cobwebs. The chairs and the small table near the fireplace had a layer of dirt and dust and approximately 8 dead insects on the floor. Three of 3 ceiling fan blades had a heavy accumulation of dirt and dust to the point of it hanging off the blades in loose strands. The two windows on the right side of the room had heavy dust and dirt on the ledges and heavy cobweb accumulation.</p> <p>4.) The two ceiling vents located in the the three hundred hall had near rooms 301 and 303 had a heavy accumulation of dust and dirt.</p> <p>5.) In resident rooms 301 and 310 and the dining room of the 300 hall the outside of the windows were so laden with dirt and debris that visibility through the windows was extremely poor.</p> <p>6.) Resident #A and Resident #B (who wished to remain confidential) had concerns with soiled windows and indicated that the windows hadn't been cleaned in over a year.</p> | | | |

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| R 0217 Bldg. 00 | <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(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:</p> <p>(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 interview and record review, the facility failed to ensure a service plan was signed and dated by 1 of 7 residents</p> | R 0217 | <p>R217 Evaluations</p> <p>1. The Service Plan for Resident #40 was signed and dated on</p> | 10/22/2015 |

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| | <p>reviewed for service plans (Resident #40).</p> <p>Findings include:</p> <p>The clinical record review for Resident #40 was completed on 9/24/15 at 9:30 a.m. Diagnoses included, but were not limited to anxiety and hypothyroidism.</p> <p>A review of the Level of Service Assessment for Resident #40, dated 8/17/15, lacked a signature from Resident #40.</p> <p>During an interview on 9/24/15 at 11:50 a.m., LPN #1 indicated a Level of Service Assessment signed by the resident was not available.</p> | | | | <p>10/7/15</p> <p>2. All service plans were reviewed for signatures. All service plans that were not signed by a resident have been reviewed and were completed with signatures.</p> <p>3. Going forward to assure that all service plans are signed by the resident the DON will be taking on the task to get the signatures on all the service plans after reviewing the service plan with the residents</p> <p>4. This correction will be monitored by the ED weekly and the ED will sign the service plan signaling completion of obtaining all required signatures.</p> <p>5. The completion date will be 10/22/15</p> | | |
| R 0272 Bldg. 00 | <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation and interview, the facility failed to maintain food temperatures for food held on the steam table at a safe serving temperature for 12</p> | | | R 0272 | <p>R272 Food and Nutritional Services 1. The ED and dietary manager observed the kitchen steamtables in all 3 buildings for food temperatures. The 400</p> | | 10/07/2015 |

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| | <p>of 12 residents who were served food from the 300 hall satellite kitchen.</p> <p>Finding include:</p> <p>On 9/23/15 at 12:40 P.M., the following observations were made:</p> <p>1.) On the steam table of the 300 hall kitchen the following food temperatures were measured: meatloaf was 82 degrees Fahrenheit, pork chops were 90 degrees Fahrenheit, and cabbage was 123 degrees Fahrenheit.</p> <p>An interview with Dietary Aid #3 on 9/23/15 at 12:55 p.m., indicated the temperatures should be maintained at 135-140 degrees Fahrenheit or above. It was indicated that this well on the steam table doesn't work as well and doesn't maintain the appropriate temps.</p> <p>On 9/24/15 at 12:30 P.M., the following observations were made:</p> <p>2.) On the steam table of the 300 hall kitchen the following food temperatures were measured: Smothered steak was 122 degrees Fahrenheit, mixed vegetables were 122 degrees Fahrenheit, and potatoes 117 degrees Fahrenheit.</p> <p>An interview with Dietary Aid #1 on</p> | | <p>steamtable was found to not keeping proper temperature and was repaired immediately by maintenance. It was also observed that improper levels of water in the steam tables. 2. The dietary manager or designee will 5 x's week observe the temperature log kept by the dietary aids for food temperatures. Temperatures will be checked at all buildings and at different meals each week. 3. The dietary manager will conduct an in-service regarding food temperatures, reporting improper temperatures and procedures. 4. Dietary manger will conduct an audit of the food temperatures in the 3 kitchens until next survey 5. Correction will be completed on 10/7/15</p> | | | | |

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| R 0273 Bldg. 00 | <p>9/24/15 at 12:45 P.M., indicated she is aware that the food doesn't stay as hot and the well itself doesn't work as well as the others.</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.</p> <p>Based on observation and interview, the facility failed to ensure 84 of 84 residents who received food prepared in the kitchens received food distributed and served under sanitary conditions from 1 of 1 kitchen, from the 300 hall satellite kitchen, and from the 400 hall satellite kitchen.</p> <p>Findings include:</p> <p>During the service of noon meal on 09-24-15 at 11:20 A.M., and the evening meal at 5:00 P.M., the following were observed:</p> <p>1) Dietary Cook #1 was observed on 9/24/15 at 11:35 A.M., in the kitchen, to handle the packaged buns with gloved hands. The dietary staff was observed performing multiple tasks i.e.; touching plates, touching handles of serving</p> | R 0273 | <p>R273 Food and Nutritional Services 1. To be in compliance with the state regulations regarding the use of gloves in the workplace the Ed and Dietary manager reviewed the company policy and procedures and orientation process. 2. An in- service was held on 9/25/15 to retrain all dietary staff of the policy on the use of gloves and washing of hands when handling food. 3. The policy on using gloves was posted together with the policy of handwashing in all 3 kitchens The Dietary manager will observe all dietary workers 5 x 's week for 4 weeks and 3x "s weekly until next survey. This observation will be done in all buildings and different meal times during the week. Also the Dietary Manager will observe proper hand washing technique 5 x's a week for 1 month and 3 x s a week until next survey. This will be conducted on</p> | 09/28/2015 |

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| | <p>utensils, leaving the service line twice to enter the dish room carrying soiled dishes, returning to the kitchen to retrieve to-go containers, touching serving pans, and then going back to handling buns and bun packaging with out changing gloves once.</p> <p>2) Dietary Aide #1 was observed on 9/24/15 at 12:10 P.M., in the 400 hall satellite kitchen, to prepare and serve seven glasses of lemonade and three cups of coffee. She then opened the refrigerator removed and served a tray of desserts, opened the cabinet and handled the salt and pepper shakers and delivered them to the residents' tables. She was then observed to handled the silverware, soup ladle, soup bowls, and crackers. Then she handled the buns to prepare the sloppy Joe sandwiches all the while touching her apron, the residents and the residents' dining room chairs multiple times. Her gloves weren't changed at all during the observation.</p> <p>3) Dietary Aide #2 was observed on 9/24/15 at 5:10 P.M., in the 300 hall satellite kitchen, taking food temps with gloved hands. She was observed to handle the hot cart handle, steam table pans containing the food, and baked potatoes. She changed gloves and proceeded to extract a knife from a</p> | | <p>various shifts and during food preparation and serving of the meals. 4. The ED will monitor compliance by observing monthly and by yearly in- service on use of gloves and handwashing. All new hires will be orientated on the use of gloves along with our hand washing in-service. 5. To be completed on 9/28/15</p> | |

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| | <p>utensil drawer to cut the potatoes. She then exited the kitchen. When she returned, she changed gloves again. She then went to the refrigerator and retrieved butter, ham, and cheese. She handled the bread and knife to spread the butter, opened up the ham and placed ham slices on the bread, unwrapped the cheese and placed a slice on the ham. She then proceeded to prepare grilled ham and cheese sandwiches. She was then observed to throw away the trash from the sandwich prep and returned to handling the potatoes. She removed her gloves and exited the kitchen to retrieve the sloppy Joe buns. When she returned she put on a fresh pair of gloves and started to prepare the sloppy Joe's. During meal service Dietary aid #2 was observed to leave the kitchen to serve each individual plate to the residents each time failing to change gloves or wash hands. Although Dietary Aid #2 changed gloves multiple times she failed to wash her hands in-between glove changes.</p> <p>On 04/23/15 at 10:30 a.m., the Administrator provided an undated policy titled: Proper Use of gloves. The administrator indicated it was the current policy in use by the facility. Review of the policy indicated:</p> | | | |

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| | <p>"Policy:</p> <ol style="list-style-type: none"> 1. Hands must be washed and dried thoroughly. <ul style="list-style-type: none"> - Before wearing gloves - When changing to a new pair of gloves - After removing the gloves 2. A new pair of gloves must be worn <ul style="list-style-type: none"> -When changing tasks (e.g. when moving to a new work station, after handling raw meats, before handling ready to eat foods such as sandwiches, after cleaning duties, etc.) - After covering mouth during sneezing or coughing, blowing nose , or touching hair. (again, hands must be washed after gloves have been removed.) - As frequently as possible. A pair of gloves should not be worn for more than 4 hours. Prolonged use of a single pair of gloves can result in excess perspiration on hands, which provides ideal conditions for bacterial growth on the skin. Gloves are also more likely to leak or tear if worn for extended periods." <p>During an interview with the Administrator on 09/25/15 at 10:30 a.m., she indicated the staff received training and facility policies are gone over during orientation. She indicated employees are expected to use a spatula or tongs, or wear disposable gloves when handling food. She also indicated the staff is</p> | | | |

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| R 0306 Bldg. 00 | <p>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 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on record review and interview, the facility failed to ensure the disposition of a discharged resident's medication was documented in the clinical record for 1 of 2 discharged residents reviewed for disposition of medications. (Resident #110)</p> | R 0306 | <p>R306 Pharmaceutical Services</p> <p>1. To be in compliance with the State regulation regarding the disposal of all medications the DON reviewed all records of medication disposal to assure that there were no other incidents of noncompliance. None noted</p> | 10/06/2015 |

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| | <p>Findings include:</p> <p>The clinical record of Resident #110 was reviewed on 9/24/15 at 10:45 a.m. Diagnoses for the resident included, but were not limited to high blood pressure, Alzheimer's disease, hyperlipidemia, stroke and heart attack.</p> <p>Resident #110 was discharged from the facility on 7/11/15.</p> <p>Recapitulated physician's orders for July, 2015, indicated, at the time of her discharge, the resident was receiving the following medications, administered by the facility:</p> <p>meloxicam 7.5 mg (milligrams) - a non-steroidal anti-inflammatory medication hydrochlorothiazide 12.5 mg - a diuretic and anti-hypertensive medication Aspirin 81 mg Crestor 40 mg - a medication used to treat high cholesterol potassium 20 milliequivalents citalopram 20 mg - an antidepressant Namenda XR 28 mg - a medication used to treat Alzheimer's dementia Aricept 10 mg - a medication used to treat Alzheimer's dementia Procardia XL 30 mg - a medication used</p> | | <p>2. Director of Nursing reviewed our policy regarding disposition of Medications upon Discharge. An In-Service was given to all nursing staff for review of disposition of Medications upon Discharge. This in-service was held on 10/5/15. The Director of Nursing will from this date on oversee all disposition of medications when a resident is discharged from the facility.</p> <p>3. The Community off site pharmacy will monitor quarterly all disposition of medications to assure compliance with the State regulation</p> <p>4. Completion date: 10/6/15</p> | |

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| 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 09/25/2015 |
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| NAME OF PROVIDER OR SUPPLIER COUNTRY CHARM | STREET ADDRESS, CITY, STATE, ZIP CODE 3177 MERIDIAN PARKE DR GREENWOOD, IN 46142 |
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| | <p>to treat heart pain Tylenol Arthritis 650 mg</p> <p>A nurse's note dated 7/11/15 at 10:15 a.m. indicated, ".Resident/POA [power of attorney] sent with all medications in bottles."</p> <p>No documentation in the resident's record was found which indicated the name and strength of the medications, the prescription number, the number of medications, nor the signature of the person receiving the medications.</p> <p>On 9/25/15 at 12:40 p.m., Licensed Practical Nurse #1 provided an undated policy, titled, "Disposition of Medications upon Discharge of a Resident," and indicated it was the policy currently used by the facility. The policy indicated, "Upon discharge from [name of facility] nursing staff will determine if residents medications should be given to family/resident, sent with the resident or return to pharmacy, or destroyed."</p> <p>On 9/24/15 at 10:10 a.m., the Director of Nursing indicated no further information could be found in Resident #110's record regarding the medications, other than that the resident's daughter had taken all of the resident's medications with her when the resident was discharged.</p> | | | |

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| R 0349 Bldg. 00 | <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 interview and record review, the facility failed to ensure recapitulated physicians' orders were updated for 1 of 7 residents reviewed for accuracy of documentation. (Resident #85).</p> <p>Findings include:</p> <p>The clinical record review for Resident #85 was completed on 9/23/15 at 2:30 p.m. Diagnoses included, but were not limited to, congestive heart failure and hypothyroidism.</p> <p>A physician's order dated 1/5/15, indicated to discontinue the order for BMP lab every other week and to start</p> | R 0349 | <p>R349 Clinical Records</p> <ol style="list-style-type: none"> The records for resident noted was reviewed and correction was done on 9/22/15 when observed. All rewrites for all the residents for the present month were reviewed to ensure lab compliance. The DON or designated person when doing monthly rewrites will also review the current labs during their monthly rewrites The DON will receive all Lab orders and will review weekly until survey to ensure lab compliance. The Pharmacy Reviews per a | 10/05/2015 |

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| R 0410 Bldg. 00 | <p>obtaining BMP (basic metabolic panel) lab monthly starting 2/6/15.</p> <p>Recapitulation of Physician orders for September 2015, indicated Resident #85 was to have a basic metabolic panel (BMP) lab completed every other week.</p> <p>During an interview on 9/25/15 at 10:30 a.m., RN #1 indicated the pharmacy failed to update the order dated 1/5/15, on the recapitulation of physician orders. Resident #85 is to have a BMP drawn monthly.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing</p> | | <p>pharmacy representative will also review the labs for non-compliance.</p> <p>5. Completion will be 10/5/15</p> | | | | |

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| | <p>should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure two-step tuberculin skin tests were administered as indicated by facility policy to newly admitted residents for 2 of 7 residents reviewed for receiving tuberculin (TB) skin tests. (Residents #40 and #63)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #40 was reviewed on 9/24/15 at 10:50 a.m. The resident was admitted to the facility on 8/27/15.</p> <p>The resident's record indicated the 1st step of the two-step TB skin test was administered on 9/14/15, 18 days after the resident was admitted to the facility.</p> <p>2. The clinical record of Resident #63 was reviewed on 9/23/15 at 2:00 p.m. The resident was admitted to the facility on 4/2/15.</p> | R 0410 | <p>R410 Infection Control</p> <p>1. Resident #40 and #63 were reviewed and our company policy was reviewed and rewritten to assure compliance with the State Law of 24 hours or 3months prior to admission.</p> <p>2. To be in compliance with the State Regulations the records of all new residents were reviewed until all were in compliance with the state regulations that a TB test be done prior to admission or within 24 hours of an admission.</p> <p>3. Action was taken to correct the policy to state the correct procedure of 24 hours. All new admits paperwork will be checked for pre admittance TB tests and if not done the DON will be responsible to oversee that upon admittance that the new resident receive a TB shot and the second TB test within 10 days.</p> | 10/07/2015 | | | |

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| | <p>The resident's record indicated the 1st step of the two-step TB skin test was administered on 4/12/15, 10 days after the resident was admitted to the facility.</p> <p>On 9/24/15 at 11:50 a.m., Licensed Practical Nurse #1 indicated she was unable to find any other TB skin tests administered to Residents #40 and #63.</p> <p>On 9/24/15 at 3:00 p.m., Licensed Practical Nurse #1 provided an undated policy titled, Mantoux Testing, and indicated it was the policy currently used by the facility. The policy indicated, "All Residents must have a Mantoux method TB test within 30 days of their move-in date to the Community (or per state regulation [within 3 month prior to admission or upon admission])..."</p> | | <p>4. The ED will audit all new admissions for the next 60 days to observe compliance to the State regulation regarding TB testing for residents.</p> <p>5. To be completed on 10/7/15</p> | | | | |