

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/09/2012
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NAME OF PROVIDER OR SUPPLIER GARDENS AT LAKE CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 07, 08, and 09, 2012</p> <p>Facility Number: 011389 Provider Number: 011389 AIM Number: N/A</p> <p>Survey team: Julie Wagoner, RN, TC Tim Long, RN</p> <p>Census bed type: Residential 22 Total: 22</p> <p>Census payor type: Other: 22 Total: 22</p> <p>Sample: 07</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/16/12 by Suzanne Williams, RN</p>	R0000	Plan of correction sent via email 3-9-12	

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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R0036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview, the facility failed to notify the physician in a timely manner of the need for a medication prescription for 1 of 7 residents (Resident #19) reviewed for physician's orders in a sample of 7. The facility also failed to notify the physician in a timely manner of abnormal urinalysis and culture and sensitivity tests (UA with C&amp;S) for 1 of 2 residents with abnormal UA, C&amp;S, in a sample of 7. (Residents #12)</p> <p>Findings include:</p> <p>1. Resident #19's clinical record was reviewed on 2/8/12 at 9:15 A.M.. The record indicated the resident had a routine order for Ferrous Sulfate 325 milligrams (mg) daily for anemia originally ordered on 11/22/10.</p> <p>Review of the resident's Medication Administration Record (MAR) for</p>	R0036	<p>Resident #19 Medication Administration Record, MAR, reviewed with physician orders and current orders are in compliance. Resident #12's medical record was reviewed. Current laboratory reports are in the record. Resident's medication administration record, MAR, and physician orders were reviewed for accuracy. No deficiencies were found. Resident's medical records were reviewed and current residents with laboratory work had corresponding laboratory report in the medical record. No deficiencies were found. Wellness Director will review medication administration records and physician orders monthly for accuracy. Laboratory reports should be at facility within 3 days of laboratory draw. If not received in 3 days, the Wellness Director will call the laboratory for a copy of the results Wellness Director will review current laboratory reports on labs performed at the facility and will place on medical record.</p>	03/23/2012			

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	<p>December 2011 indicated the resident did not receive the physician's ordered Ferrous Sulfate 325 mg daily from 12/8/11 through 12/20/11.</p> <p>Review of a fax sent to the resident's physician on 12/16/11 indicated the resident needed a physician's order to resume Ferrous Sulfate 325 mg daily. On 12/16/11 the physician sent a physician's order for Ferrous Sulfate 325 mg daily for anemia.</p> <p>On 12/21/11 the resident began receiving physician's ordered Ferrous Sulfate 325 mg daily.</p> <p>An interview with the Director of Health Services (DHS) on 2/8/12 at 2:00 P.M. indicated when she noticed the resident was out of Ferrous Sulfate she faxed the physician on 12/16/11. The DHS indicated she did not know why the Ferrous Sulfate was not resumed until 12/21/11.</p> <p>2. Resident #12's clinical record was reviewed on 2/8/12 at 9:15 A.M.. The record indicated on 1/6/12 the resident had a UA completed with an order for a C&amp;S if indicated. The physician ordered an antibiotic, Cipro to start on 1/6/12 for an urinary tract infection (UTI) and a repeat, UA, with C&amp;S if indicated in 2</p>		Regional Director of Quality and Care Management (RDQCM) will monitor MAR and physician orders monthly for four (4) months and then quarterly thereafter for confirmation of compliance. Regional Director of Quality and Care Management will monitor lab reports on the medical record monthly for four (4) months and then quarterly thereafter for confirmation of compliance.				

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	<p>weeks. On 1/10/12 the C&amp;S results indicated the bacterial organism was resistant to Cipro, and the resident was started on a different antibiotic, Amoxil, for 10 days. On 1/24/12, a follow-up UA was completed and on 1/25/12 a physician's order was received to start Cipro for 7 days for an UTI. On 1/25/12, the facility sent a fax to the physician stating Cipro was not effective in the past for the UTI. The physician responded to continue Cipro, awaiting the C&amp;S. No further physician's notification was noted in the resident's record, regarding the C &amp; S results.</p> <p>On 2/3/12, the physician saw Resident #12 and noted the resident had a UTI, gross hematuria (blood in urine), despite Cipro. the physician also noted no C&amp;S was in the chart and gave a new order to discontinue Cipro and start Septra (an antibiotic) for 10 days.</p> <p>An interview with the DHS on 2/8/12 at 10:20 A.M. indicated the resident was receiving hospice care from an outside agency and they were responsible for the UA with C&amp;S completed on 1/24/12. The DHS indicated she knew previously the resident's UTI was resistant to Cipro if they would have asked her.</p> <p>An interview with the DHS on 2/9/12</p>			

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	indicated she did not know where the C&S results were, from the UA with C&S if indicated, from 1/24/12.						

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R0090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (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> <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</p>			

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	<p>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 ensure the Administrator thoroughly and timely investigated allegations of misappropriation of resident property. This affected 4 of 22 residents in the facility and potentially affected all 22 residents in the facility.</p> <p>Findings include:</p> <p>1. During an observation of resident care, conducted on 02/08/12 at 10:30 A.M., the Wellness Director, who was also acting as the Administrator, was noted to enter Resident #11's room with a gentleman after the care was completed. The gentleman introduced himself as a local police detective and interviewed Resident #11 regarding some missing money. The resident, who has dementia, could not remember many details of the matter. CNA #9, interviewed on 02/08/12 at 10:35 A.M., indicated a few months ago there were 4 residents who had money and/or valuables taken, but she did not know all of the details and was only aware of Resident #11's and Resident</p>	R0090	R # 11 and R #18 theft investigation complete. R 12 is no longer at facility. No known thefts with other residents. Current staff were re-educated on facility theft reporting. Residence Director was re-educated to company policy on thefts and state regulations regarding when to report an incident to the State. Residence Director will conduct theft investigation per company policy. The Regional Director Quality and Care Management and the Residence Director will review any incident reports for state reporting as completed	03/16/2012			

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	<p>#12's missing items. She indicated she thought they "caught" the person responsible for the thefts, but she was not sure.</p> <p>Review of the information received by the Department of Health from the facility, regarding the incidents, indicated the incident regarding Resident #12's missing coins was reported on 12/04/11 to the facility by the Resident's family and Resident #18 reported "missing items" on 12/06/11. The report was not submitted to the Department of Health until 01/20/12 and there was no further reports regarding the other two residents who had items taken.</p> <p>Review of the facility's investigation of the incidents, indicated on 12/06/11, Resident #12's family reported a missing coin collection. The family was able to provide a very specific 48 hour time frame in which the theft occurred. Resident #18 also reported missing "items," but the investigation was not specific as to what the items were missing. The investigation focused only on Resident #12's missing coins. There were statements from staff regarding their care of Resident #12, but not all employees were interviewed. No alert and oriented residents were interviewed at the time to determine if they had missing</p>						

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	<p>items. There was no information regarding Resident #18's missing items, Resident #11's missing money, or the other resident who was not identified. The fourth resident was never identified.</p> <p>Interview with the Wellness Director, who was also acting as the Administrator, on 02/09/12 at 11:00 A.M., indicated the former Administrator had initiated the investigation and had notified the authorities regarding the thefts. She indicated she had started "helping out" at the facility in mid December and right before Christmas had noticed one particular employee had just stopped showing up for work and no one had noticed. She indicated she thought that employee was responsible for the thefts, but she had never been interviewed regarding the thefts. She indicated she gave the employee's address to the police detective.</p> <p>Review of the facility's undated policy and procedures titled, "Suspected abuse/neglect/exploitation," provided as current policy by an Administrator from another facility in the corporation, included the following information: "5, Act quickly to gather pertinent information...A staff person suspected or accused of abuse, neglect, or exploitation should not have access to any resident</p>				

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	<p>until the Residence investigates and takes action to assure resident safety....7. Initiate an investigation. All staff on duty at the time of the alleged abuse occurred must be interviewed prior to leaving their respective shifts. This applies to all staff, as well as other residents in the area...."</p> <p>Review of the information received by the Department of Health from the facility, regarding the incidents indicated the incident regarding Resident #12's missing coins was reported on 12/04/11 to the facility by the Resident's family and Resident #18 reported "missing items" on 12/06/11. The report was not submitted to the Department of Health until 01/20/12 and there was no further reports regarding the other two residents who had items taken.</p>				

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R0092	<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:</p> <p>(1) Fire exit drills in facilities shall include the 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 interviews, the facility failed to ensure there were 12 fire drills held in the past year for employees and residents. This potentially affected 22 of 22 residents in the facility.</p> <p>Finding includes:</p> <p>Review of the facility fire drill report records, from 02/01/11 - 02/01/12 indicated there were only 6 fire drills conducted. There was also a hand written</p>	R0092	<p>No specific resident concern. Current staff were re-educated on facility policy for safety procedures when fire alarm is sounding. Resident Director to conduct 12 fire drills every year or one drill a month. Regional Director of Operations will monitor fire drill reports monthly for four (4) months and then quarterly thereafter for confirmation of compliance</p>	03/16/2012			

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	<p>record of an actual smoke alarm activation and the actions taken by the staff.</p> <p>Interview with the Administrator from another facility, who was assisting the Wellness director at the facility, on 02/09/12 at 4:00 P.M. indicated he had conducted a drill in January but there was no more documentation available from previous facility administrators to ensure the required 12 drills had been conducted.</p> <p>Review of the 06/30/11 report when a smoke alarm had activated indicated the alarm company alerted the facility and told them where to look for the alarm. Staff found one of the resident rooms filled with smoke. Staff then asked the resident to leave and opened a window. Residents were evacuated from the back and side of the facility on which the alarm had been activated. The alarm company operator then asked nursing staff if they wanted "assistance" and nursing staff told the alarm company they did wish to have assistance. Apparently the alarm company then called the fire department and it was eventually discovered a resident had attempted to cook food without removing the plastic wrapper.</p> <p>There was no indication staff closed the resident door and notified the fire</p>						

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	<p>department in a timely manner. In addition, it was unclear why the alarm company had to telephone facility staff regarding the alarm instead of the staff hearing the audible sound from the smoke alarm. There was no indication the staff were aware of the potentially dangerous possibility of actually "feeding" any flames with an additional oxygen source. There was also no documentation any administrative staff re-educated the staff regarding the correct fire safety procedure.</p>			

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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.</p> <p>Based on observations, record review, and interviews, the facility failed to ensure there was always sufficient staffing to meet the scheduled and unscheduled needs of the residents. In addition, the facility failed to ensure there was at least one CPR (cardio-pulmonary resuscitation) and first aid certified staff member in the building at all times. This potentially affected 22 of 22 residents in the facility.</p>	R0117	Residents requiring two-person assistance have been assessed for 1 or 2 person mechanical lift assistance. Three of the five residents are still at the facility. Two resident assessments revealed the need for two person mechanical lift assistance and 1 resident requires a one-person mechanical lift assistance. Current residents requiring two-person assistance were evaluated. Four resident assessments revealed the need for two person	03/16/2012			

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	<p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 02/07/12 between 10:15 A.M. - 11:05 A.M., Licensed Nurse #7 indicated of the 22 residents in facility, 7 residents required extensive staff assistance to complete activities of daily living such as dressing, grooming, and personal hygiene, 9 residents required physical assistance for toileting needs, one resident required mechanical lift assistance for transferring needs, and 4 residents required transferring assistance of two staff.</p> <p>Review of the nursing schedule for February 5 - 18, 2012 indicated there were portions of each day where there was only 1 nursing staff member scheduled to be working. For example, on Sunday, February 5, 2012, there was only 1 certified nursing assistant scheduled to be working from 2:00 P.M. - 3:00 P.M. and 10:00 P.M. - 11:00 P.M. Interview with the Wellness Director, on 02/08/12 at 2:45 P.M. indicated she had been instructed to cut the nursing staffing hours due to the facility's census number.</p> <p>Interview with an anonymous alert and oriented resident, on 02/09/12 at 4:15 P.M. indicated he preferred to have a shower every night at 10:00 P.M. He</p>		<p>mechanical lift assistance and one resident for 1person mechanical lift assistance. Wellness Director will complete a mechanical lift assessment on current residents needing two-person assistance prior to initiating the mechanical lift. Residents requiring two-person assistance with mechanical lift will be reported to Resident Director for 24 hour staffing. Residents requiring a two person assist will have two people performing the transfer. The Regional Director Quality and Care Management will review two-person assistance records for four months then quarterly thereafter to ensure staffing compliance Current employees who are not CPR certified will be scheduled with other employees who are certified until certification can be obtained. Current employee files were reviewed and employees who needed current CPR certification were identified and scheduled to take re-certification training.</p> <p>Residence Director and/or Wellness Director will schedule quarterly CPR training sessions. CPR certification for each employee will be scheduled for the quarter prior to their expiration date. The Regional Director of Operations will review employee files quarterly to confirm</p>				

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	<p>indicated he required extensive staff assistance of one staff member for completing his showers. He indicated during the time he was receiving his shower, there were no staff to assist other residents in the building and he felt bad about the situation and did not think there was enough staff to provide care to all the residents at all times.</p> <p>Interview with an anonymous nursing staff member, on 02/09/12 at 10:00 A.M., indicated there were not always two nursing staff members available to care for residents. The staff member indicated they had been instructed to transfer the resident who required a mechanical lift (#4) with only one staff member. She indicated she did not feel the practice was safe.</p> <p>Review of the manufacturer's instructions for the mechanical lift indicated the following instructions: "(manufacturer's name) recommends that two assistants be used for all lifting preparation and transferring to/from procedures; however, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case."</p> <p>Interview with the Wellness Director, on</p>		compliance with CPR certification training is obtained				

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	<p>02/09/12 at 2:00 P.M. indicated she had inserviced the staff on the use of the mechanical lift recently; however, there was no assessment produced for Resident #4 to indicate it was safe to perform mechanical lift transfers safely with one assistant.</p> <p>2. Review of employee files on 2/9/12 at 12:00 P.M. indicated four of the sixteen total licensed and certified staff members had CPR certification.</p> <p>Interview with the Wellness Director, on 02/09/12 at 4:30 P.M., indicated she knew some of the nursing staff had current CPR certifications, but she was unaware of which staff had their CPR certifications. She indicated she was CPR certified but was unable to produce a copy of a current CPR certification.</p> <p>Review of the nursing schedule as worked, from 01/22/12 - 02/04/12 indicated there was no CPR certified staff member working on 1st and 3rd shift on 01/22/12, 1st shift on 01/23, 01/24, 01/25, 01/28, 01/30, 01/31, 02/01, 02/02, and 02/04/12, and 1st and 3rd shift on 01/26 and 01/29.</p>						

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R0119	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interview, the facility failed to provide specific job orientation for 4 of 5 employees (#1, 10, 14, 16) records reviewed.</p>	R0119	No specific residents affected. Employees #1, #10, #14, #16, completed job specific orientation. Current Employee files were checked for job specific	03/16/2012			

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	<p>Findings include:</p> <p>Employee records were reviewed on 2/9/12 at 12:00 P.M.. The records indicated employees #1, 10, 14, 16 did not receive orientation specific to their positions and duties in the facility.</p> <p>Employees #1 and #10 were hired as CNAs but did not receive orientation specific to CNA duties in the facility.</p> <p>Employees #14 and 16 were hired as LPN's but did not receive orientation specific to LPN duties in the facility.</p> <p>An interview with the Director of Health Services (DHS) on 2/9/12 at 1:35 P.M. indicated for employee #14 there was a medication worksheet inservice completed but had no other specific orientation for employee #14 or employees #1, 10 and 16.</p>		<p>orientation. No other deficiencies were found.</p> <p>Residence Director will be responsible to ensure job specific orientations are complete.</p> <p>Residence Director and Wellness Director were re-educated regarding corporate policy and state regulations on employee orientation.</p> <p>Regional Director of Operations will audit employee files randomly for four months, then quarterly thereafter to ensure compliance.</p>				

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R0121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the 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>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

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	<p>Based on record review and interview the facility failed to ensure 3 of 5 employees (#1, 10, 16) reviewed had a health screen completed before employment and 3 of 5 employees (#1, 10, 16) did not have a negative tuberculin skin test before the start of employment.</p> <p>Findings include:</p> <p>1. Employee records were reviewed on 2/9/12 at 12:00 P.M.. The records indicated 3 of the 5 employees (#1, 10, 16) reviewed did not have a health screen completed before employment started.</p> <p>An interview with the Director of Health Services (DHS) on 2/9/12 at 3:25 P.M. indicated she could not locate health screenings for employees #1, 10, 16).</p> <p>2. Employee records indicated 3 employees (#1, 10, 16) did not have negative Tuberculin skin tests before employment began.</p> <p>Employee #1's record indicated she was hired on 11/15/11. Employee #1 had a negative skin test read on 11/22/11.</p> <p>Employee #10's record indicated she was hired on 11/18/11. Employee #10 had a negative skin test on 1/16/12.</p>	R0121	<p>No specific residents affected. Employee's #1 #10, #6 health screens has been completed. Current Employee files were checked for TB tests and health screens. No other deficiencies were found.</p> <p>Residence Director will not schedule a new employee to work without a TB test and a completed health screen. Residence Director and Wellness Director were re-educated regarding corporate policy and state regulations for TB test requirements.</p> <p>Regional Director of Operations will audit employee file randomly for four months then quarterly thereafter to ensure compliance.</p>	03/16/2012			

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	<p>Employee #16's record indicated she was hired on 10/24/11. Employee #16 had a negative skin test on 12/18/11.</p> <p>An interview with the DHS on 2/9/12 at 12:30 P.M. indicated she could not find employee's #10 and 16's negative Tuberculin tests when she started work so she administered the Tuberculin tests at that time.</p>						

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R0148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure the facility sewer plumbing was functioning properly in that there was a strong, noticeable sewer gas odor noted in the front entry way and northwest corner of the facility.</p> <p>Findings include:</p> <p>Upon entering the facility, on 02/07/12 at 10:00 A.M., there was a very noticeable sewer type smell in the entryway and around the front office area of the facility. The smell was very strong in the public restrooms and hallway by the laundry room and beauty shop.</p>	R0148	<p>No specific residents affected. Current residents were at potential risk. Sewage smell was corrected on 2-10-12. Staff was re-educated to report any maintenance issue to the Maintenance Tech and/or Residence Director. Residence Director and Wellness Director were re-educated regarding timeliness of reporting sanitation issues. Regional Director of Operations will audit facility for sanitation issues quarterly to ensure compliance. Sewage smell observation has been added to the quarterly maintenance house review.</p>	02/10/2012			

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	<p>Interview, on 02/07/12 at 10:30 A.M., with an Administrator from another building who was helping out in the facility, indicated he was pouring "water and vegetable oil" into a drain because it was "dry" in an attempt to eradicate the odor.</p> <p>The odor remained throughout the day on 02/07/12, during the day on 02/08/12, and was very strong and noticeable on 02/09/12 in the A.M.</p> <p>On 02/09/12 at 11:30 A.M., a local septic cleaning company truck was noted in the parking lot of the building. Interview with the representative from the company, on 02/09/12 at 12:10 P.M. indicated he had been notified by the facility in the early part of January 2012 and had discovered a "dry drain" in the storage closet close to the women's restroom. He indicated he had poured water down the drain and had not been contacted regarding any further issues until 02/09/12. He indicated the odor was probably because the sewer drainage pipe had "bowed" out and some of the waste had not drained into the lift station tank properly. He indicated he had flushed the line with a "power" flush to fix the issue. He also indicated the septic pipe was partially obstructed with debris when he had checked the pipe.</p>			

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	<p>On 02/09/12 at 1:00 P.M., the same local septic cleaning company truck was noted to again return to the facility. Interview with a corporate maintenance supervisor indicated about a year ago the facility had a similar issue with the odor and septic drain and the local septic cleaning company had dug up the "bowed" pipe and fixed the pipe. He also indicated he felt the odor was because the same local septic cleaning company had not "flushed" the drain properly when they had routinely emptied the septic tank recently. He indicated he had called the company back to the facility to "hold them accountable" and to have them flush the drain properly. He indicated if the septic pipe was "bowed" then pouring water and vegetable oil down the drain would not solve the problem and it would reoccur. He indicated when the septic tank was emptied the drain opening coming into the tank from the underground pipe coming from the facility had to be flushed to ensure there was no blockage.</p> <p>Review of the invoice records for the septic company indicated they had "pumped the grease trap" on 01/10/12 and there were no other invoices until the invoice dated 02/09/12.</p>						

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	Review of intracorporate email documentation, presented by the Administrator from another facility who was present at the facility during the survey, indicated several electronic mail correspondences between corporate personnel, dating back to January 04, 2011 regarding the strong septic type "BM" smell in the facility.			

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R0246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 7 residents (#12) received his as needed medications (PRN) by a qualified medication aide (QMA) with appropriate authorization by a licensed nurse or physician, in a sample of 7 residents.</p> <p>Findings include:</p> <p>Resident #12's clinical record was reviewed on 2/7/12 at 3:30 P.M.. The record indicated the resident had a physician's order started on 11/27/11 for Ativan 0.5 milligrams (mg) by mouth twice daily as PRN anxiety. Resident #12 also had a physician's order started 12/21/11 for ABH Gel, apply 0.5 milliliters topically to inner wrists every 6 hours PRN anxiety/restlessness.</p> <p>Review of the resident's medication administration record (MAR) for</p>	R0246	<p>Residents #12 given PRN medication without authorization and assessed for side effects and none found. Wellness Director reviewed Resident files to determine if any other resident was given PRN medication without authorization. Residents assessed for side effect of drugs given without authorization. No other Residents were given PRNs without authorization. Clinical staff were re-educated on corporate policy and state regulations regarding proper medication distribution and authorization. They were also re-educated as to documentation required when administering PRN medication. Regional Director of Quality and Clinical Management will review MARS bi-weekly for 4 months then quarterly thereafter to ensure compliance.</p>	03/16/2012			

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	<p>December 2011 and January 2012 indicated a QMA (employee #17) administered Ativan without receiving authorization on: 12/15/11; 1/3/12; 1/4/12. The MAR also indicated the same QMA administered ABH Gel without receiving authorization on: 1/3/12; 1/4/12; 1/6/12; 1/7/12.</p> <p>An interview with the Director of Health Services (DHS) on 2/9/12 indicated she inserviced all staff who pass medications on medication administration the previous week.</p>			

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R0272	<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.</p> <p>Based on observation, interview and record review, the facility failed to ensure food was served at the proper temperature for 19 of 19 residents served a meal, during one of two meal observations.</p> <p>Findings include:</p> <p>On 2/7/12 at 11:45 A.M. the Dietary Manager (DM) was observed preparing lunch for the residents. The lunch included bacon wrapped chicken. When the temperature was taken out of the oven and first checked by the DM at 11:50 A.M., she indicated the chicken was not hot enough (the internal temperature was 112 degrees). The DM placed the chicken in a pan and fried the chicken on the stove top. At 12:02, the DM took the internal temperature of the chicken which was 134 degrees. The DM fried the chicken another 5 minutes and began serving the chicken. The chicken continued to fry as the DM prepared each plate for serving for the following 10 minutes.</p> <p>An interview with the DM on 2/8/12 at 11:42 A.M. indicated the chicken served on 2/8/12 needed to be between 145 degrees and 160 degrees.</p>	R0272	<p>No specific residents affected. Current residents were at potential risk. Dietary Manager, Dining Services Coordinator, to cook meat to appropriate temperature per recipe. Dietary manager, Dining Services Coordinator, and cooking staff re-educated on procedure for testing meat temperatures. Resident Director to review meat temperature logs weekly for 6 weeks and then monthly thereafter to ensure compliance.</p>	03/16/2012			

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	Review of the facility provided recipe for chicken, bacon wrapped on 2/8/12 at 11:45 A.M. indicated the internal temperature was to cook to a minimum internal temperature of 165 degrees for 15 seconds.				

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R0273	<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, the facility failed to maintain safe food handling practices during observation of 1 of 2 meal services for 19 of 19 residents served food.</p> <p>Findings include:</p> <p>On 2/7/12 at 12:15 P.M., the dietary manager (DM) was observed during meal preparation for 19 residents. During the placing the food on plates for all 19 residents the DM was observed touching pan handles, utensil handles with gloved hands, then picking up rolls from a pan with same gloved hands. The DM did not change gloves during the entire food service.</p>	R0273	No specific resident identified. Current residents were at potential risk. Dietary staff re-educated on safe food handling practices related to gloved hands. Dietary Manager, Dining Services Coordinator will observe gloved hand food handling practices. Residence Director will perform random checks of kitchen to assure safe food handling standards are maintained.	03/16/2012			

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R0297	<p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on record review and interview, the facility failed obtain a physician's ordered medication in a timely manner for 2 of 7 residents (#19, #6) reviewed for medications in a sample of 7.</p> <p>Findings include:</p> <p>1. Resident #19's clinical record was reviewed on 2/8/12 at 9:15 A.M.. the record indicated the resident had a routine order for Ferrous Sulfate 325 milligrams (mg) daily for anemia originally ordered on 11/22/10.</p> <p>Review of the resident's Medication Administration Record (MAR) for December 2011 indicated the resident did not receive the physician's ordered Ferrous Sulfate 325 mg daily from 12/8/11 through 12/20/11.</p> <p>Review of a fax sent to the resident's physician on 12/16/11 indicated the resident needed a physician's order to resume Ferrous Sulfate 325 mg daily. On</p>	R0297	<p>Resident #19's Medication Administration Record was reviewed with physician orders. Current orders are in compliance. Resident #12's medical record was reviewed and current laboratory reports are in the record. Residents' medication administration record, MAR, and physician orders were reviewed for accuracy. No deficiencies were found. Residents' medical records were reviewed and current residents with laboratory work had corresponding laboratory report in the medical record. No deficiencies were found. Wellness Director will review medication administration records and physician orders monthly.</p> <p>Wellness Director or designee will review any physician or hospital orders the day a resident returns from an acute-care facility.</p> <p>Documentation of review and residents condition will be kept in the Resident's Service Notes. Wellness Director will review current laboratory reports on labs performed at the facility and will place in medical record. Regional</p>	03/16/2012			

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	<p>12/16/11 the physician sent a physician's order for Ferrous Sulfate 325 mg daily for anemia.</p> <p>On 12/21/11 the resident began receiving physician's ordered Ferrous Sulfate 325 mg daily.</p> <p>An interview with the Director of Health Services (DHS) on 2/8/12 at 2:00 P.M. indicated when she noticed the resident was out of Ferrous Sulfate she faxed the physician on 12/16/11. The DHS indicated she did not know why the Ferrous Sulfate was not resumed until 12/21/11.</p> <p>2. During the initial tour of the facility, conducted on 02/07/12 between 10:15 A.M. - 11:05 A.M., LPN #7 indicated Resident #6 was confused , incontinent of urine, assisted to the toilet, and was recently treated for a urinary tract infection.</p> <p>The clinical record for Resident #6 was reviewed on 02/08/12 at 9:50 A.M. Review of the resident service note, dated 01/24/12 at 1:05 P.M. indicated the resident's blood sugar level was very low and she was "barely responsive." The resident was transferred to the hospital at 1:40 P.M.</p>		<p>Director of Quality and Care Management will monitor MAR and physician orders monthly for four (4) months and then quarterly thereafter for confirmation of compliance. Regional Director of Quality and Care Management will monitor lab reports on the medical record monthly for four (4) months and then quarterly thereafter for confirmation of compliance.</p>				

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	<p>The resident returned to the facility on 01/24/12 (no time documented in the resident service notes). There was a physician's order, dated 01/24/12, from the acute care center, for the antibiotic, Keflex, to be given every six hours. The accompanying documentation from the acute care center emergency room indicated the resident was diagnosed with a urinary tract infection and had been treated for hypoglycemia. In addition, the acute care center sent a list of every laboratory test and medication given while the resident was in the emergency room. The list included the laboratory test, urinalysis and urine culture. Both tests were ordered "stat."</p> <p>Review of the urine culture results for Resident #6, completed on 01/26/12 at 13:10 (1:10 P.M.) indicated the resident's infection was resistant to the antibiotic, Keflex. There was a handwritten note, dated 01/30/12 at 3:30 P.M., indicating the physician had either been notified by the facility or noted the laboratory results and had changed the antibiotic, on 01/30/12 to Macrobid.</p> <p>Interview with the Wellness Director on 02/09/12 at 9:00 A.M., indicated because Resident #6 had the laboratory test completed at the hospital, the physician was notified by the hospital of the</p>			

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	<p>laboratory result. She indicated the facility was not aware of the urine culture results until 01/30/12 when the physician's office faxed them a copy and called the order to change the antibiotic to the facility. The Wellness Director indicated no one from the facility had attempted to call the acute care facility to obtain the urine culture results in a timely manner.</p> <p>In addition, the physician's order for the antibiotic, Macrobid, received on 01/30/12 at 3:30 P.M., was not faxed to a local pharmacy until 01/31/12. There was no reason given to the delay in obtaining the new medication.</p>				

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R0407	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 housekeeping staff utilized the correct disinfectant to effectively clean hard surfaces and multiple use items. This potentially affected 22 of 22 residents in the facility.</p> <p>Findings include:</p> <p>During the environmental tour of the facility, conducted on 02/08/12 between 1:10 P.M. - 2:00 P.M., with a maintenance technician from another facility and an administrator from another "sister" facility, the following was noted:</p> <p>In the housekeeping closet, there were 3 different bottles of automatically dispensed cleaners. Interview with the housekeeper, employee #8 indicated she was only utilizing the pink colored</p>	R0407	<p>No specific residents affected. Current residents were at potential risk. Residence Director will re-educate staff on corporate policy and state regulations for disinfectants. Residence Director and/or designee will perform random checks of housekeeping to assure proper disinfectants are utilized.</p>	03/16/2012			

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	<p>solution to clean bathrooms and hard surfaces. She indicated she sprayed the cleaner onto the surface, waiting "maybe a little bit" and then wiped off the surface.</p> <p>There was a bottle of purple colored disinfectant, but the housekeeper indicated she did not utilize the purple disinfectant at all because no one had ever told her to use it.</p> <p>Review of the product guidelines for the pink colored solution, labeled "Oasis 299" indicated the product was effective against HIV virus, Herpes Simplex Type 1, Staphylococcus aureus, Salmonella enterica, Enterococcus faecalis, Adenovirus Type 2, Influenza A2/Hong Kong, Athletes foot fungus, and Pandemic 2009 H1N1 Influenza A virus. There was no documentation that the Oasis 299 was effective against Hepatitis B, Tuberculosis, or the Norovirus.</p> <p>Review of the manufacturer's instructions for the purple colored cleaner, not utilized by the housekeeper, indicated it was effective against Hepatitis B and tuberculosis when left wet on a surface for 10 minutes.</p>						

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R0410	<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 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. (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 1 of 7 residents in a sample of 7 had a second step tuberculin Mantoux test completed upon admission to the facility. (Resident #25)</p> <p>Finding includes:</p> <p>1. Review of the closed clinical record for Resident #25, completed on 02/09/12 at 1:30 P.M. indicated the resident had been admitted to the facility on 09/08/11.</p> <p>Review of the Mantoux testing records</p>	R0410	Resident #25 no longer at residence. Current Residents files were reviewed to confirm there was a first step and second step Mantoux. No other residents' files were found out of compliance. Residence Director will re-educate staff on corporate policy and state regulations for TB skin testing. Residence Director will review new resident paperwork and confirm compliance. The Regional Director of Operations will audit random files monthly for 4 months and quarterly thereafter to ensure compliance.	03/16/2012			

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	<p>indicated the resident had a 1st step Mantoux tuberculin test completed on 09/09/12 but there was no second step Mantoux test documentation located for Resident #25.</p> <p>Interview with the Wellness Director, on 02/09/12 at 3:45 P.M. indicated she was not working at the facility at the time of Resident #25's admission and she could not locate any second step Mantoux testing for the resident.</p>			