

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 10/02/2014
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NAME OF PROVIDER OR SUPPLIER EMERALD PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: 10/02/14</p> <p>Facility number: 004904 Provider number: NA AIM number: NA</p> <p>Survey team: Terri Walters RN TC Dorothy Watts RN Amy Wininger RN</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Census payor type: Other: 37 Total: 37</p> <p>Sample: 07</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on October 3, 2014 by Jodi Meyer,</p>	R000000		
R000356	410 IAC 16.2-5-8.1(i)(1-8)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p><b>Clinical Records - Noncompliance</b></p> <p>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on interview and record review, the facility failed to ensure emergency files were complete, in that, the emergency file of a resident lacked a photograph for 1 of 5 residents who met the criteria for review of emergency files. (Resident #35)</p> <p>Findings include:</p> <p>Resident #35's clinical record was reviewed on 10/02/14 at 10:16 A.M.</p> <p>Resident #35 was admitted to the facility on 09/23/14 with diagnoses including, but not limited to, Parkinson's disease, anxiety, and osteoarthritis.</p>	R000356	<p>Upon admission, all new residents will have a picture taken and placed in the emergency file, MAR, and resident chart within 12 hours. ED and /or Designee shall review for completeness. A random weekly audit of the Emergency Binders will be reviewed to make sure all photographs are in place and correctly marked. ED or designated person shall review for completeness. This will be an ongoing process. All charts were reviewed for completeness and no other charts were missing items. Staff was re in-serviced concerning our correct procedure and time frames. Charts will be reviewed on an ongoing basis.</p>	11/07/2014			

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R000409	<p>The emergency file for Resident #35 was reviewed at 10:30 A.M., on 10/02/14. The emergency information did not include a picture of the resident. On 10/02/14 at 10:42 A.M., the Director of Nursing (DON) was made aware Resident #35's photograph was not present in Resident #35's emergency file. On 10/02/14 at 11:10 A.M., the DON provided a photography of Resident #35 to be placed in the resident's emergency file.</p> <p>On 10/02/14 at 2:25 P.M., during interview with the DON, she indicated there was no facility policy in regard to what information should be included in the resident emergency files.</p> <p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure resident health statements were obtained annually,</p>	R000409	The following statement, "The resident is free from Communicable disease including TB in an infectious stage" will be	11/07/2014			

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	<p>in that, annual health statements were lacking in 3 of 7 clinical records reviewed. (Resident #24, Resident #18, Resident #28)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The Clinical Record of Resident #24 was reviewed on 10/02/14 at 10:00 A.M. The record lacked any documentation of an annual health statement.</li> <li>2. The Clinical Record of Resident #18 was reviewed on 10/02/14 at 10:45 A.M. The record lacked any documentation of an annual health statement.</li> <li>3. The Clinical Record of Resident #28 was reviewed on 10/02/14 at 11:00 A.M. The record lacked any documentation of an annual health statement.</li> </ol> <p>During an interview on 10/02/14 at 11:45 A.M., the DON (Director of Nursing) indicated annual health statements were obtained upon admission and PPD's (purified protein derivative) were then conducted yearly. The DON further indicated annual health statements were not done for Resident #24, Resident #18, and/or Resident #28.</p>		<p>added to all monthly orders and will be signed by the attending physician quarterly as well as the yearly health screening and yearly TB testing on each resident. All charts were reviewed and physicians contacted and the statement was signed by each individual's physician. The statement and TB testing is done upon admission along with the chest x-ray also. Monitoring will be done upon admission and monthly when MARs are completed by the CSM and/or Designee on an ongoing basis. Nursing staff were re in-serviced concerning the changes.</p>				