

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 07/07/2016
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 11011 VILLAGE SQUARE LANE FISHERS, IN 46038
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 5, 6, and 7, 2016</p> <p>Facility number: 013163 Provider number: n/a AIM number: n/a</p> <p>Census bed type: Residential: 69 Total: 69</p> <p>Census payor type: Other: 69 Total: 69</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5</p> <p>Quality review completed by 30576 on July 8, 2016</p>	R 0000	<p>PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF STATE LAW.</p>	
R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance</p>			

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

TITLE

(X6) DATE

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

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	<p>with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was one staff person on each shift with First Aid certification. This had the potential to affect 66 of 66 residents residing at the facility.</p> <p>Findings include:</p> <p>The worked schedule, dated 6/26/16 through 7/31/16, was provided by the Director of Wellness on 7/6/16 at 10:50 a.m. The schedule indicated the following positions were without a staff person certified in first aid:</p>	R 0117	R 117 1. The Director of Wellness scheduled a Wellness meeting with all staff members to ensure that they had First Aid with the CPR. All Wellness team members that did not have Certification in First Aid are required to attend a First Aid class scheduled 7/21/16 & 7/22/16 by Director of Wellness with The American Heart Association or they cannot be scheduled to work. Monthly CPR and first aid classes will be held for the first 6 months, and then quarterly. 2. The Director of Wellness and Director of Resident Care will require that all	07/29/2016

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	<p>6/27/16 = 3rd shift, 6/28/16 = 3rd shift, 6/29/16 = 3rd shift, 6/30/16 = 3rd shift, 7/1/16 = 3rd shift, 7/2/16 = 3rd shift, 7/3/16 = 3rd shift, 7/5/16 = 3rd shift, 7/6/16 = 3rd shift.</p> <p>A staff CPR (Cardiopulmonary Resuscitation) certifications book was provided by the Executive Director on 7/7/16 at 9:00 a.m. There were no staff certified in First Aid during the above 3rd shifts.</p> <p>An interview was conducted with the Director of Wellness on 7/7/16 at 11:25 a.m. She indicated there were no staff certified in First Aid from 6/27/16 thru 7/6/16 on the 3rd shift. She indicated she would be providing the training for the First Aid with the staff.</p> <p>A policy titled, CPR and First Aid Training, dated 12/2014, was received from the Wellness Director on 7/7/16 at 12:30 p.m. The policy indicated, "...Policy The community will assure that all resident assistants, medication assistants, nurses, and resident care directors maintain and provide</p>		<p>new hire Wellness Team Members be Certified in First Aid as well as CPR and a copy will be placed in a wellness Certification Binder. The Director of Wellness and Director of Resident Care will complete monthly checks to ensure all staff members certification up to date on all shifts. The Directors will notify the team member of upcoming expiration dates. 3. This will be reviewed ongoing during monthly Quality Management Program meeting. 4. Executive Director will be responsible for ensuring all Policies & Procedures are followed.</p>				

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R 0119 Bldg. 00	<p>documentation of CPR training...5. The Team member will not provide care services to a resident until a valid CPR and First Aide card is provided..."</p> <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</p>			

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	<p>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 observation, interview, and record review, the facility failed to follow the policy in regards to wearing a hairnet during food preparation.</p> <p>Findings include:</p> <p>On 7/6/16 at 11:08 a.m., Server #2 was observed, with no hairnet in place, preparing scoops of ice cream into individual containers. Two containers of ice cream were observed prepared by Server #2 prior to applying a hairnet.</p> <p>An interview was conducted with Director of Dining Services (DODS) on 7/6/16 at 11:12 a.m. He indicated hairnets should be worn when in contact with food or food preparation was taking place. He further indicated a hairnet should be worn when in the food preparation area.</p> <p>An interview was conducted with the Executive Director (ED) on 7/6/16 at 2:55 p.m. She indicated staff should be wearing hairnets while preparing food or in the food preparation area.</p> <p>A policy titled "Criteria for Completion</p>	R 0119	<p>R 119 1. All Meadow Brook staff were in-serviced on Spectrum Policy & Procedure regarding proper use of hair restraints.</p> <p>2. Dining room manager, managers on duty and Executive Director will monitor use of hair restraints when Director of Dietary is not present. 3. This will be reviewed ongoing through monthly Quality Management Program meeting.4.Executive Director will be responsible for ensuring all Policies & Procedures are followed.</p>	07/29/2016			

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R 0216 Bldg. 00	<p>of RD's Quarterly Report Assisted Living, " revised on 10/13/15, was provided by DODS on 7/7/16 at 10:30 a.m. The policy indicated the following, "...Personnel:...Hair restraints properly in place...b. All staff preparing food in the dietary department must wear hair restraints. Staff coming into the dietary department, i.e. maintenance, should also wear hair restraints...If staff has long hair, the hair must be restrained with a hair tie or similar restraint to prevent hair from touching the resident's meal.... "</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to assess a resident who self-administered nebulizer treatments for</p>	R 0216	R 216 1. Resident #51 is doing well and remains in our community. The self - medication order was	07/29/2016

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	<p>1 of 5 residents reviewed for medication review. (Resident #51)</p> <p>Findings include:</p> <p>On 7/5/16 at 12:50 p.m., the clinical record was reviewed for Resident #51. The diagnoses included, but were not limited to, anxiety state, bronchiectasis, and memory loss.</p> <p>The physicians orders, dated 5/3/16, indicated orders for the following medications:</p> <p>Budesonide 0.5 mg/ 2 mL susp (suspension), use one vial via nebulizer twice daily that was initiated on 4/5/15.</p> <p>Duoneb 2.5- 0.5 mg (milligrams), give 3mL via nebulizer four times a day initiated on 9/10/15.</p> <p>Moderate assistance with breathing treatments: set up breathing treatment equipment and observe resident begin treatment, may leave to perform other tasks while resident completes treatment that was initiated on 11/12/2014.</p> <p>The July, 2016 EMAR (Electronic Medicaiton Administration Review) documentation was provided by Director of Wellness (DOW) on 7/6/16 at 10:50 a.m. The EMAR included the following orders:</p> <p>Budesonide 0.5 mg/ 2 mL susp (suspension), use one vial via nebulizer twice daily.</p>		<p>discontinued on this resident. 2. Clinical reviews will be completed on all medication orders as well as all residents to ensure they are safe to administer medications. If the resident is not safe to administer medications the order will be discontinued and staff will administered the medication as ordered by Primary Care Physician. 3. On July 8, 2016 all wellness nurses were in-serviced on Policy and Procedure for self-medication assessments and medication orders 4. The Director of Wellness will require that all medication orders be copied and placed in her mailbox to determine if a self-medication test needs to be administered.5. This will be monitored through the monthly Quality Management Program meeting. Executive Director will be responsible all Policies & Procedures are followed.</p>				

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	<p>Duoneb 2.5- 0.5 mg (milligrams), give 3mL via nebulizer four times a day. Moderate assistance with breathing treatments: set up breathing treatment equipment and observe resident begin treatment, may leave to perform other tasks while resident completes treatment. A Self-Medication Assessment, completed on 11/11/14, indicated Resident #51 was unable to safely self-administer medications.</p> <p>On 7/6/16 at 12:22 p.m., an interview was conducted with QMA #3. She indicated Resident #51 does not self-administer medications. Further indicated the nurse completes nebulizer treatments for Resident #51.</p> <p>On 7/6/16 at 12:25 p.m., an interview was conducted with LPN #1. She indicated the staff monitor Resident #51 before and after nebulizer treatment and set up nebulizer treatment to be administered by Resident #51.</p> <p>On 7/6/16 at 1:10 pm., an interview was conducted with the Director of Wellness (DOW). She indicated there was a care plan for Resident #51 to have moderate assistance with nebulizer treatment but no self-administration assessment for nebulizer treatment.</p> <p>On 7/6/16 at 1:15 p.m., an interview was conducted with the Director of Resident</p>						

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	<p>Care (DRC). She indicated the nursing staff set up nebulizer treatment, assess Resident #51 prior to nebulizer treatment, and come back in 10-15 minutes to reassess Resident #51 after nebulizer treatment was completed.</p> <p>A document titled Assisted Living Assessment was provided by ED on 7/7/16 at 9:00 a.m. The document indicated the following, "...Medication Management...Can the resident safely self administer medication?...[checkmark in box] Not Applicable - community to assist with all medications...."</p> <p>A policy titled Self-Administration of Medication Assessment " was provided by the Executive Director (ED) on 7/6/16 at 3:20 p.m. The policy indicated the following, " Policy ...Only Residents that are able to successfully pass a self-medication assessment and have written permission from the Primary Care Provider may self-administer medications in the community ...Procedure ...1. The Director of Wellness [DOW] or designee will complete a Self-Medication Assessment in the Electronic Health Record [EHR] for any Resident wishing to self-administer medications: ... a. Upon admission ...b. Prior to self-administration ...c. After a significant change of condition ...d. Re-assess every</p>			

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R 0217 Bldg. 00	<p>6 months "</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (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>			

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	<p>Based on interview and record review, the facility failed to ensure a Resident had a signed Service Plan for 1 of 5 Resident's service plans reviewed (Resident #55).</p> <p>Findings include:</p> <p>The clinical record for Resident #55 was reviewed on 7/6/16 at 9:50 a.m. The diagnoses for Resident #55 included, but were not limited to, atrial fibrillation, pressure ulcer-stage 2, and hypothyroidism. Resident #55 was admitted to the facility on 11/11/15 and was re-admitted to the facility on 5/31/16.</p> <p>A list of interviewable residents was received from the Executive Director, on 7/5/16 at 12:03 p.m. The list did not indicate Resident #55 was interviewable.</p> <p>There was not a Service Plan located in the hard chart during review.</p> <p>During an interview with LPN #1, on 7/6/16 at 10:00 a.m., she indicated there should be a Service Plan located in the hard chart, but she can print one out since she was not able to locate one in the hard chart.</p> <p>There was not a POA (power of</p>	R 0217	<p>R 217 1. Resident #55 is doing well and remains in her home within the community. Family returned the signed Service Plan on 7/7/16. 2. The Director of Wellness and Director of Resident Care will ensure that after completion of Service/Care plan the POA/ Resident or responsible party sign off the service plan. Should they refuse to sign, it will be noted and witnessed by community representative. A copy will be made for the POA/family member if requested. The original service plan will remain in the resident chart. 3. Policy and procedure was reviewed by the Director of Wellness and Director of Resident Care; all family members/residents/POA will be notified that copies may be obtained, but original must be signed and remain in the chart for clinical records.4. This will be monitored ongoing through the monthly Quality Management Program meeting. Executive Director will be responsible for ensuring all Policies & Procedures are followed.</p>	07/29/2016			

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	<p>attorney)/health care representative's signature on the Service Plan printed out by LPN #1.</p> <p>At 3:20 p.m., on 7/6/16, the Executive Director (ED) indicated the facility was unable to locate a signed Service Plan for Resident #55.</p> <p>On 7/7/16, at 10:10 a.m., the ED indicated a Service Plan conference was held on 5/6/16, and the family member that attended did not want to sign the Service Plan at that time, because she wanted to review the plan at home. The ED further indicated at this time, she will try to locate a signed Service Plan from when Resident #55 was initially admitted 11/11/15.</p> <p>During an interview with the Director of Wellness (DOW) and Director of Resident Care (DRC), on 7/7/16 at 11:29 a.m., the DOW and DRC indicated they were not able to locate a signed Service Plan from Resident #55's initial admittance to the facility or any other time during Resident #55's stay at the facility.</p> <p>A policy titled, Care Plan, dated 6/2015, was received from the ED, on 7/7/16 at 10:35 a.m. The policy indicated, "...The care plan is designed to be Resident</p>			

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R 0410 Bldg. 00	<p>centered and meet the specific needs and preferences of the Resident and serves as a communication tool for team members that assists the providing quality, individualized service...The care plan will be signed and dated by all individuals involved in the development...."</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 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</p>			

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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK SENIOR LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 11011 VILLAGE SQUARE LANE FISHERS, IN 46038			
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	<p>laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure a Resident had a second step tuberculin test completed, and also failed to administer an annual PPD (purified protein derivative) in a timely manner for 3 of 5 residents reviewed for immunizations. (Resident #51, Resident #55 and Resident #70)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #55 was reviewed on 7/6/16 at 9:50 a.m. The diagnoses for Resident #55 included, but were not limited to, atrial fibrillation, pressure ulcer-stage 2, and hypothyroidism. Resident #55 was admitted to the facility on 11/11/15.</p> <p>An Immunization Record indicated Resident #55 had an initial Mantoux (tuberculin) test/step on 11/3/15 and was read on 11/5/15 with a result of zero millimeters.</p> <p>A document titled, Assisted Living Physician Admission Orders indicated, "...The Community is unable to care for a resident with active tuberculosis. Please complete the below information...Date of first step mantoux [sic] tuberculin skin test 11/3/15 Date Read 11/5/15...."</p>	R 0410	<p>R 410 1. Residents #51, #55 and #70 are doing well and remain in the community. All 3 residents have completed TB testing and/or had annual PPD testing. 2. The Director of Wellness contacted the pharmacy and ECP computer system to add all PPD due dates to EMAR . 3. Second step PPD's listed under treatment on EMAR as well as Annual PPD testing. The care plan now reflects the date of testing to be completed by wellness nurses. The Director of Wellness will complete monthly review to ensure all residents are up to date on immunizations.4. This will be monitored ongoing through the monthly Quality Management Program. The Executive Director will be responsible for ensuring all Policies & Procedures are followed.</p>	07/29/2016			

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	<p>There wasn't a second step Mantoux (tuberculin) test located in the clinical record.</p> <p>During an interview with the Executive Director (ED), on 7/6/16 at 3:20 p.m., the Executive Director indicated the facility was not able to locate a second step tuberculin test/step for Resident #55.</p> <p>A policy titled, Tuberculosis Testing, dated 6/2015, was received from the Executive Director, on 7/7/16 at 10:35 a.m. The policy indicated, "...Prior to admittance to the community all residents are required to be tested for tuberculosis (TB) via tuberculin skin testing...3. The second Mantoux skin test will be administered 1-3 weeks following the initial test, unless the initial test was positive..."2.) On 7/5/16 at 12:20 p.m., the clinical record was reviewed for Resident #70. The record indicated Resident #70 was admitted on 4/3/15. A first step PPD was administered on 1/1/15, and a second step PPD was administered on 1/15/15. There was no record of Resident #70 receiving an annual PPD.</p> <p>On 7/5/16 at 12:50 p.m., the clinical record was reviewed for Resident #51. The record indicated Resident #51 was</p>			

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	<p>admitted on 11/28/14. A first step PPD was administered on 11/24/14 and a second step PPD was administered on 12/8/14. There was no record of Resident #51 receiving an annual PPD.</p> <p>An interview was conducted with Executive Director (ED) on 7/7/16 at 10:35 a.m. She indicated Resident #51 and Resident #70 had not received an annual PPD since the first and second step was administered.</p> <p>An interview was conducted with the Director of Resident Care (DRC) on 7/7/16 at 10:50 a.m. She indicated the annual PPDs are to be completed for every resident that was appropriate.</p> <p>An interview was conducted with Director of Wellness (DOW) on 7/7/16 at 11:18 a.m. She indicated the annual PPDs for Resident #51 and Resident #70 were unable to be located.</p> <p>A policy titled "Tuberculosis Testing," effective 6/2015, was provided by ED on 7/7/16 at 10:35 a.m. The policy indicated the following, "...Procedure...Annual Tuberculosis [TB] Screening...Annually the Resident will be screened for symptoms of TB...."</p>			

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

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