

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 04/13/2015
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 W SYCAMORE ST KOKOMO, IN 46901
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R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: April 13, 2015</p> <p>Facility number: 011075 Provider Number: 011075 Aim Number: N/A</p> <p>Census Type: Residential: 23 Total: 23</p> <p>Census Payor Type: Other: 23 Total: 23</p> <p>Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by Tammy Alley RN on April 16, 2015.</p>	R 000	<p>The following is the Plan of Correction for Sterling House of Kokomo in regards to the Statement of Deficiencies for the annual survey completed on April 13th, 2015. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.</p>	
R 119 Bldg. 00	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance (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</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>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 ensure new employee received training specific to dementia populations. This deficient practice affected 1 of 10 employee records reviewed.</p> <p>Findings include:</p> <p>During a review of employee records on 4/13/15 at 1:30 p.m., the personnel</p>	R 119	<p><u>R119 Personnel-Noncompliance</u></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>No residents were affected by the alleged deficient practice; Associate #14 has now received the required Dementia Care training as required by regulation. This training was</p>	05/15/2015

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	<p>records of Employee #14 were reviewed for inservices for dementia. No dementia training was in the personnel file. The hire date for Employee #14 was 8/1/14.</p> <p>During an interview with Executive Director (ED) and Health and Wellness Director (HWD) on 4/13/15 at 4:30 p.m., the HWD indicated this employee made a transition from volunteer to employee and did not receive the Dementia Specific Training.</p> <p>A review on 4/13/15 at 4:15 p.m., of the document titled "Indiana Associate Training Requirements" updated January, 2014, indicated Dementia Specific Training is required at a level of 6 hours within 6 months of employment.</p>		<p>completed by the Executive Director, Health and Wellness Director and Designee on 4/24/15.</p> <p><i>How will the facility identify other associates with the potential to be affected by the same alleged non-compliant practice and what corrective action will be taken?(this question was missing on original submission)</i></p> <ul style="list-style-type: none"> · An audit tool was developed and utilized to verify compliance of other associates for this purpose. · The audit was completed by the Administrative Assistant/Human Resources designee, and findings reported to the Executive Director for further action, if indicated. <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> · The audit tool has will be utilized by the Administrative Assistant/Human Resources Designee to assist with tracking the training and orientation of new hires, as well as training provided on an annual or as needed basis. · The Administrative Assistant/HR Designee has been re-educated by the Executive Director/Designee on the onboarding processes and 				

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			<p>required orientation and training , and will monitor utilize the tracking system to verify and audit the progress of each new hire.</p> <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</i></p> <ul style="list-style-type: none"> · The results of the audits are to be routinely provided by the Administrative Assistant/Designee to the HWD and the ED. This information will be used to verify proper on-boarding. · In the event of non-compliance with the above expectations, an associate may be removed from the schedule until such time as the proper orientation is completed by his/her supervisor or designee. · The Executive Director (E.D.) will be provided a copy of the Administrative Assistant's audit of current associates and their completions of orientation/training. This process will continue monthly and on-going to audit for continued compliance with the state requirement. · Additional action will be taken by the E.D. as warranted, based on results of audits. 	

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R 121 Bldg. 00	<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 personnel were screened for Tuberculosis (TB) using the two-step procedure. This deficient practice affected 3 of 10 employees reviewed for TB screening. (Employee #6, Employee #14, and Employee #17)</p> <p>Findings include:</p> <p>During a review of personnel health screenings on 4/13/15 at 1:30 p.m., the following was found:</p> <ol style="list-style-type: none"> Employee #6 started working in the facility on 11/16/14, the first step of the Mantoux skin test was read on 11/19/14, the first step was read as negative. No second step Mantoux skin test was done. Employee #14 started working in the facility on 8/1/14, the first step of the Mantoux skin test was read on 7/28/14, the skin test was read as negative. The second step of the Mantoux was done on 1/12/15, outside the recommended 2 week period after the the first Mantoux skin test, if the first test was negative. Employee #17 starting working in the facility on 9/23/14, the first step of the Mantoux skin test was read on 9/19/14, it was read as negative. The second step of the Mantoux skin test was not done. 	R 121	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> · Associates #6, #14, and #17 will have Mantoux skin tests re-administered with 2 step process followed. <p><i>How will the facility identify other associates with the potential to be affected by the same alleged non-compliant practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> · An audit of associate files will be completed by the Business Office Manager to verify expiration dates TB (tuberculin) skin tests, and a tickler file will be initiated to track such due dates in an on-going manner. · In the event other associates are found to be due for annual TB (tuberculin) testing, the Business Office Manager (BOM) is to notify the Health and Wellness Director (HWD) in order for the HWD to schedule required testing be administered. <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged non-compliant practice does not recur?</i></p>	05/15/2015

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	<p>During an interview with the Health and Wellness Director on 4/13/15 at 4:15 p.m., she indicated the employees did not receive the Mantoux skin testing in the appropriate time frame.</p> <p>Policy Review completed on 4/13/15 at 5:30 p.m., of the corporate handbook section titled "Tuberculosis Testing" no date, indicated "... All new associates including temporary staff and volunteers who come in contact with residents must be screened for tuberculosis (TB). TB screening may be conducted on a continuing basis throughout your employment according to Brookdale standards or state requirements...."</p>		<ul style="list-style-type: none"> ·The BOM has been re-educated on the use of an audit tool by the E.D. ·The results of the audits are to be routinely provided by the BOM to the HWD and the ED. The HWD will utilize this information when scheduling associates. ·All associates will be required to have current TB (tuberculin) skin tests in order to be scheduled for their shift. ·In the event of non-compliance with scheduled TB testing, the associate may be removed from the schedule until such time as TB shots are current. <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</i></p> <ul style="list-style-type: none"> ·The Executive Director (E.D.) will be provided a copy of the BOM's audit of current associates and the expiration dates of their current TB (tuberculin) skin tests. ·This process will continue monthly and on-going to audit for continued compliance with the state requirement. ·Additional action will be taken by the E.D. as warranted, based on results of audits. 	

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R 156 Bldg. 00	<p>410 IAC 16.2-5-1.5(m) Sanitation and Safety Standards - Deficiency (m) The facility's food supplies shall meet the standards of 410 IAC 7-24.</p> <p>Based on observation, record review and interview, the facility failed to ensure food was labeled, and dated in the freezer and refrigerator, the freezer and refrigerator temperature logs were completed and accurate in two of two kitchens in the facility and a garbage can lid was utilized in the dining room . This deficiency had the potential to affect 23 residents out of 23 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>During the tour of the kitchens on 4/13/2015 at 9:00 a.m., the following observations were made:</p> <ol style="list-style-type: none"> 1. The freezer in the main kitchen was observed to have 13 chicken patties in a package, and 8 waffles in a package opened and not dated. 2. The freezer in the main kitchen was observed to have two boxes of donuts dripping water. 3. The freezer in the main kitchen was observed to have a temperature of 22 degrees Fahrenheit. 	R 156	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> ·Waffles and chicken patties in the main kitchen freezer were immediately marked and dated appropriately. ·The freezer in the main kitchen was immediately recalibrated and temperature was at the target temperature of 0 degrees Fahrenheit within an hour. ·Block cheese in main kitchen area was immediately properly dated and marked. ·All food and drink items in the activities room refrigerator were immediately properly dated and marked. ·The temperature log for the refrigerator in the activities room was immediately updated and properly marked. <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <ul style="list-style-type: none"> ·Refrigerators utilized by dietary services in the community will be monitored and audited by dietary services manager with the Resident 	05/15/2015			

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	<p>4. The refrigerator in the main kitchen area was observed to have a block of sliced yellow cheese opened and not dated.</p> <p>5. The refrigerator in the activities room was observed to have a roll of salami, a sliced cheese block, a bottle of white wine, a bottle of water, and 2 bottles of red wine opened and not dated.</p> <p>6. The refrigerator in the activities room did not have a thermometer and the refrigeration daily temperature log did not have an entry for 4 days.</p> <p>A record review of the Equipment "Freezer" HACCP Temperature Log on 4/13/2015 at 10:00 a.m., for the month of March indicated 30 days out of 31 days in March, the freezer did not register the target temperature of 0 degrees Fahrenheit or lower.</p> <p>A record review of the Equipment "Freezer" HACCP Temperature Log on 4/13/2015 at 10:05 a.m., for the month of February indicated 24 days out of 28 days in February, the freezer did not register the target temperature of 0 degrees Fahrenheit or lower.</p> <p>During an interview with the Resident Programs Coordinator on 4/13/2015 at</p>		<p>Programs coordinator monitoring and auditing the refrigerator in the activities area.</p> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <ul style="list-style-type: none"> ·An audit tool for temperature readings and proper storage, marking and dating of food items in all community refrigerators and freezers has been implemented. ·The appropriate staff has been trained on usage and documentation requirements. <p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</i></p> <ul style="list-style-type: none"> ·An audit tool for temperature readings and proper storage, marking and dating of food items in all community refrigerators and freezers has been implemented, and will be provided to the Executive Director upon request or at least monthly for the next three months in order to verify compliance 	

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	<p>1:30 p.m., she indicated all opened food in the activities refrigerator should have been dated and a refrigerator temperature should have been taken for the dates 4/10, 4/11, 4/12, and 4/13/ 2015.</p> <p>During an interview on 4/13/2015 at 2:00 p.m., with the Dietary Manager, she indicated opened food should have been dated and stored and all items in the refrigerator and freezer needed to be dated.</p> <p>During an interview with the Dietary Manager on 4/13/2015 at 12:05 p.m., she indicated the freezer did not register the target temperature of 0 degrees Fahrenheit or lower for the month of April as indicated on the Equipment "Freezer" HACCP Temperature Log.</p> <p>The facility policy for "Side Work Helper" dated 7/15/2014 , received on 4/13/2015 at 3:00 p.m. from the Dietary Manager., indicated, "...Make sure all products in cooler are covered, labeled and dated...."</p>			

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R 410 Bldg. 00	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p> <p>(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.</p> <p>(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.</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 screen a new resident for Tuberculosis (TB). This effected 1 of 7 resident reviewed for Tuberculin skin tests in a sample of 7 (Resident #8).</p> <p>Findings include: The clinical record of Resident #8 was reviewed on 4/13/2015 at 11:00 a.m. Diagnosis included, but were not limited</p>	R 410	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>-Resident #8 was immediately (on 4/13/15) administered a Mantoux, and it was read within 48 hours. The second step will be administered on 4/28/15 and read on 4/30/15.</p> <p><i>How will the facility identify other</i></p>	05/15/2015

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	<p>to, Diabetes 2, Congestive Heart Failure, and Heartburn.</p> <p>A Mantoux (Tuberculin skin test) Test record for Resident #8 indicated the first of the two step method TB skin test was administered on 10/6/14.</p> <p>A review of the Medication record for October 2014 indicated the first step was completed but the second step was not completed.</p> <p>During an interview with the Health and Wellness Director, on 4/13/2015 at 1:50 p.m., she indicated the second step TB skin test for Resident #8 was not done.</p> <p>A facility Policy for "Tuberculosis Screening/ Testing Policy-Residents - IC-2," dated 7/1/2003 received from the Health and Wellness Director, indicated "...Residents will be screened or tested for TB per state guidelines 1. Testing should be performed on each new resident within three months prior to admission or within one week of admission or per state regulation...Mantoux skin test - using the 2 step method...."</p>		<p><i>associates with the potential to be affected by the same alleged non-compliant practice and what corrective action will be taken?</i></p> <p>·An audit of associate files will be completed by the Health & Wellness Director to verify expiration dates TB (tuberculin) skin tests, and a tickler file has been initiated to track such due dates in an on-going manner.</p> <p>·In the event other residents are found to be due for annual TB (tuberculin) testing, the Health and Wellness Director (HWD) will schedule & required testing be administered.</p> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged non-compliant practice does not recur?</i></p> <p>·The HWD has re-educated the nursing staff on the use of an audit tool and all nurses are helping to monitor and ensure compliance. HWD will audit monthly.</p> <p>·The results of the audits are to be routinely provided to the ED. The ED will ultimately supervise and make sure that the HWD is on track and using the tool to ensure compliance.</p>				

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 04/13/2015
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NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 W SYCAMORE ST KOKOMO, IN 46901
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			<p><i>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</i></p> <p>·The Executive Director (E.D.) will be provided a copy of the HWD's audit of current residents and the expiration dates of their current TB (tuberculin) skin tests.</p> <p>·This process will continue monthly and on-going to audit for continued compliance with the state requirement.</p> <p>·Additional action will be taken by the E.D. as warranted, based on results of audits.</p>	