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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>05/31/2016 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>BROOKDALE EVANSVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6521 GREENDALE DR<br>EVANSVILLE, IN 47711 |
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| R 0000<br><br>Bldg. 00 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: May 31, 2016</p> <p>Facility number: 010681<br/>Provider number: 010681<br/>AIM number: N/A</p> <p>Census bed type:<br/>Residential: 28<br/>Total: 28</p> <p>Census payor type:<br/>Other: 28<br/>Total: 28</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review was completed by #02748 on June 6, 2016.</p> | R 0000        | <p>The 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 the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as conformation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.</p> |                      |
| R 0026<br><br>Bldg. 00 | <p>410 IAC 16.2-5-1.2(a)<br/>Residents' Rights - Noncompliance<br/>(a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the</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>administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on observation and interview, the facility failed to ensure that Resident Rights were posted in a publicly accessible area for 28 of 28 residents residing in the facility.</p> <p>Findings include:</p> <p>On 5/31/16 at 2:50 p.m., during a tour of the facility, the posted Resident Rights could not be located.</p> <p>On 5/31/16 at 3:00 p.m., the ED (Executive Director) indicated she was unsure where the Resident Rights were posted. The ED further indicated they had recently remodeled and was unsure if the Resident Rights had been reposted.</p> <p>On 5/31/16 at 3:26 p.m., the ED indicated the facility lacked a policy</p> | R 0026        | Resident Rights poster was retrieved and placed in common area of community for review of residents and visitors on 6/1/16 Residents residing in community are at risk of being affected by alleged deficiency No residents were identified as being affected Executive Director/Designee will observe, check and document on a monthly basis that the poster remains in view | 06/01/2016           |

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| R 0090<br><br>Bldg. 00 | <p>related to the publicly posted Resident Rights.</p> <p>410 IAC 16.2-5-1.3(g)(1-6)<br/>Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:<br/>(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:<br/>(A) epidemic outbreaks;<br/>(B) poisonings;<br/>(C) fires; or<br/>(D) major accidents.<br/>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.<br/>(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.<br/>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.<br/>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> |               |   |                      |

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|  | <p>(A) employee's full name; and<br/>(B) dates and hours worked during the past twelve (12) months.<br/>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.<br/>(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 observation and interview, the facility failed to ensure the most recent state survey results were placed in a readily accessible place for residents to review, this had the potential to affect 28 of 28 residents residing in the facility.</p> <p>Findings include:</p> <p>On 5/31/16 at 2:50 p.m., the facility was observed for the accessibility of the most recent state survey results. The most recent state survey results were not observed to be present.</p> <p>On 5/31/16 at 3:00 p.m., CNA #1 indicated the survey results were located in the locked entrance to the facility. CNA #1 indicated residents were not able to freely pass through the door.</p> | R 0090  | Survey results were moved into front lobby on 6/1/16 to be easily accessible to residents and visitors Residents who reside in the community are at risk of being affected by alleged deficient practice No residents were identified as being affected Executive Director will in-service residents on the placement of survey results Executive Director/Designee will observe and document on a monthly basis that survey results are accessible to residents and visitors | 07/13/2016   |  |   |  |

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| R 0120<br>Bldg. 00 | <p>On 5/31/16 at 3:06 p.m., the ED indicated the survey results would be moved.</p> <p>On 5/31/16 at 3:26 p.m., the ED indicated the facility lacked a policy related to the placement of the survey results.</p> <p>410 IAC 16.2-5-1.4(e)(1-3)<br/>Personnel - Noncompliance<br/>(e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:<br/>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.<br/>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents</p> |               |   |                      |

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|  | <p>effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure annual inservices for Resident Rights was completed for 2 of 10 employee files reviewed. (Cook #1, CNA #2)</p> <p>Findings include:</p> <p>On 5/31/16 at 1:50 p.m., the employee files were reviewed. Cook #1 and CNA #2's employee files lacked an annual inservice regarding Resident Rights.</p> <p>On 5/31/16 at 3:26 p.m., the ED (Executive Director) indicated she was unable to locate an annual inservice training on Resident Rights for Cook #1 and CNA #2.</p> <p>On 5/31/16 at 3:26 p.m., the ED indicated the facility lacked a policy related to annual inservicing of Resident Rights.</p> | R 0120  | <p>There has been no apparent negative outcomes because of delayed Resident Rights training for two personnel Employee #1 and #2 Training will be completed by 6/30/16 The BOM has been re-educated by the Executive Director on training requirements log that will be used for tracking purposes An audit of employees will be completed to identify other employees that may be affected by alleged deficient practice Each employee will receive a sign in sheet with date, time, location, name of instructor, program content which will be signed by each employee when in-service has been completed The BOM/Designee will be responsible for verification that training has been completed within the appropriate time frame This change will be immediate and on-going to verify that regulatory standards are met The BOM/Designee will be responsible for monthly updates of the in-service sheets for associates BOM/Designee will</p> | 07/31/2016   |  |   |  |

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| R 0356<br>Bldg. 00 | <p>410 IAC 16.2-5-8.1(i)(1-8)<br/>Clinical Records - Noncompliance<br/>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> <li>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</li> <li>(2) The resident ' s hospital preference.</li> <li>(3) The name and phone number of any legally authorized representative.</li> <li>(4) The name and phone number of the resident ' s physician of record.</li> <li>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</li> <li>(6) Information on any known allergies.</li> <li>(7) A photograph (for identification of the resident).</li> <li>(8) Copy of advance directives, if available.</li> </ol> <p>Based on record review and interview, the failed to ensure an emergency file binder was up to date for 1 of 5 residents reviewed. One resident did not have the hospital preference available and the advanced directive was incorrect.<br/>(Resident #25 )</p> <p>Findings include:</p> | R 0356        | <p>complete monthly audits to verify compliance A report will be provided to the Executive Director who will be responsible for directing action, based on QA findings</p> <p>A audit of residents emergency files will be completed by Health &amp; Wellness Director and residents identified information will be updated as indicated to verify compliance Audit completion will be reported to Executive Director Individual resident emergency files shall be reviewed by Health &amp; Wellness Director/Designee upon admission, annually and with change of condition Health &amp;</p> | 06/30/2016           |

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|  | <p>The clinical record for Resident #25 was reviewed on 5/31/16 at 9:50 a.m. Resident #25 had diagnoses including, but not limited to, Alzheimer's disease, coronary artery disease, chronic obstructive pulmonary disease, and an abdominal aortic aneurysm. The clinical record indicated Resident #25 had changed his code status from a full code to a "No Code." The clinical record also indicated the hospital the resident requested to go to.</p> <p>The emergency file binder for each resident was reviewed on 5/31/16 at 11:15 a.m. Resident #25 did not have a hospital specified in the emergency binder and the emergency file did not contain the advanced directive regarding the code status of Resident #25.</p> <p>During an interview on 5/31/16 at 2:10 p.m., the ED (Executive Director) indicated the facility would update Resident #25's emergency file immediately.</p> <p>During an interview on 5/31/16 at 3:25 p.m., the ED indicated the facility did not have a policy for updating or maintaining the emergency file binder.</p> |   | Wellness Director will utilize tickler file system to track review of emergency files Executive Director will review tickler file monthly to verify compliance and any further corrective action as indicated |  |  |   |  |

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