

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155821	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER ASPEN TRACE HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 S SR 135 GREENWOOD, IN 46143
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure.</p> <p>Survey dates: March 16, 17, 18, 19, 20, 23, 24, and 25, 2015.</p> <p>Facility number: 013185 Provider number: 155821 AIM number: 201221460</p> <p>Survey team: Marcy Smith, RN-TC Dottie Plummer, RN (March 16, 17, 18, 19, 20, 23, and 24, 2015) Patti Allen, SW (March 16, 17, 18, 19, 23, 24, and 25, 2015) Jessica Parsley, RN (March 16, 17, 18, 19, and 20, 2015)</p> <p>Census bed type: SNF: 47 SNF/NF: 51 Residential: 35 Total: 133</p> <p>Census payor type: Medicare: 33 Medicaid: 38 Other: 27 Total: 98</p>	F 000		
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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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F 279 SS=D Bldg. 00	<p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 30, 2015; by Kimberly Perigo, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans</p>	F 279	This plan of correction is to serve as Aspen Trace Health and Living	04/24/2015	

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	<p>were developed for a resident at risk for developing a pressure ulcer (Resident #90) and a resident who had an indwelling urinary catheter (Resident #166)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #90 was reviewed on 3/20/15 at 4:18 p.m. Diagnoses for the resident included, but were not limited to, history of a pressure ulcer and muscle weakness.</p> <p>Resident #90 was admitted to the facility on 1/13/15. An admission Minimum Data Set assessment dated 1/20/15, indicated the resident was at risk for developing skin breakdown. A current care plan was not found in the resident's record which indicated the resident was at risk, with interventions in place to help prevent skin breakdown.</p> <p>On 3/23/15 at 10:56 a.m., the Assistant Director of Nursing (ADON) indicated the facility did not have a care plan in place for Resident #90 being at risk for skin breakdown. The ADON indicated Resident #90 was at risk and should have a care plan for potential for skin breakdown.</p> <p>2. The clinical record of Resident #166</p>		<p>Community credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Aspen Trace or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We would like to request a desk review for Aspen Trace Health and Living Community's annual 2015 survey.</p> <p>F279 483.20 (d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>Resident #90 has had their care plan updated to include that the resident is at risk for skin breakdown with appropriate interventions put into place.</p> <p>Resident #166 has had their care plan updated to include that an indwelling urinary catheter is in place with appropriate diagnosis and interventions.</p> <p>All residents at high risk for skin breakdown have been reviewed</p>	

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	<p>was reviewed on 3/20/15 at 8:56 a.m. Diagnoses for the resident included, but were not limited to bladder disorder and pressure ulcer.</p> <p>Resident #166 was admitted to the facility on 3/13/15. A nursing admission assessment, dated 3/13/15, indicated the resident had an indwelling urinary catheter in place.</p> <p>A care plan for the resident's urinary catheter was not found in the resident's record. On 3/20/15 at 2:10 p.m., the Director of Nursing indicated the facility had not created a care plan for Resident #166's indwelling urinary catheter.</p> <p>3.1-35(a)</p>		<p>with care plans in place.</p> <p>All residents with an indwelling catheter have been reviewed with care plans in place.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> A new admission chart review will be completed by nursing administration within 72 hours of the admission. This chart review includes a review of pertinent diagnosis and care plan for all residents at high risk for skin breakdown and all residents who have an indwelling catheter. All new admission documentation will be reviewed at the morning clinical meeting (Monday through Friday) for verification that care plans are in place for high risk for skin break down, and that care plans and appropriate diagnosis are in place for with residents with an indwelling catheter. <p>Education will be provided for licensed nurses regarding developing an appropriate care plan for residents at high risk for skin break down and residents who have an indwelling catheter. In addition, education will be provided to nursing administration regarding the new admission chart review and development of individualized care plan per the systemic change.</p>	

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F 282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to assess a residents receiving antipsychotic medications for	F 282	The Director of Nursing or designee will review all new admissions and identify those residents that are high risk for skin break down and who have an indwelling catheter to verify that an appropriate diagnosis and care plan is in place. This audit will be completed 5 days a week for 30 days, then weekly for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: 4/24/15. The Administrator at Aspen Trace Health and Living Community is responsible in ensuring compliance in this Plan of Correction.	04/24/2015
			F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE	

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	<p>abnormal involuntary movements as indicated by the written plans of care for 1 of 5 residents reviewed for unnecessary medication use. (Resident #130)</p> <p>Findings include:</p> <p>The clinical record review of Resident #130, completed on 3/20/15 at 11:43 a.m., indicated the resident had diagnoses including, but not limited to, dementia with behavioral disturbances.</p> <p>The current recapitulation of physician's orders indicated Resident #130 was receiving quetiapine (an antipsychotic medication used to treat delusions) 25 mg (milligrams) at bedtime. Quetiapine may cause abnormal involuntary movements.</p> <p>The resident had a current plan of care with a start date of 10/21/14, indicating the resident had a history of delusions and received an antipsychotic medication. The interventions included completing a routine AIMS (Abnormal Involuntary Movement Scale) on the first Wednesday of every third month.</p> <p>An AIMS assessment was completed on 7/25/14 and on 9/17/14. The next AIMS assessment was completed on 1/8/15, four months after the last assessment.</p>		<p>PLAN</p> <p>Resident #130 has had an updated AIMS assessment completed.</p> <p>All residents receiving antipsychotics have been identified and will be reviewed to verify that current AIMS assessment have been completed. Any concerns will be addressed.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> · Care plan template has been updated to complete AIMS assessments every 6 months, per facility policy. · Social Services Director will monitor AIMS assessment schedules on all residents who have an order for an antipsychotic medication. · All new admissions will be reviewed within 48 hours of admission to verify that any resident on an antipsychotic medication has an AIMS assessment completed and a care plan in place. <p>Licensed nurses will be offered education regarding AIMS assessments and appropriate care plans for residents on an antipsychotic as per facility policy.</p> <p>In addition, the Social Services Director has been provided education regarding the systemic change.</p>	

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F 329 SS=D Bldg. 00	<p>During an interview with Registered Nurse (RN) #1 on 3/23/15 at 4:45 p.m., RN #1 indicated the AIMS assessments were not completed as indicated by the plan of care.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate</p>		<p>The Director of Nursing or designee will complete a QA audit tool to audit for appropriate care plans and current AIMS assessments for residents who receive an antipsychotic medication. The audit tool will be completed daily on new residents and any new orders for an antipsychotic medication (including weekends) for 30 days, then weekly for 60 days, then every other week for a total of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once completion is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.</p> <p>Compliance date: 4/24/2015. The Administrator at Aspen Trace Health and Living Community is responsible in ensuring compliance in this plan of correction.</p>	

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	<p>monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to assess 2 residents receiving antipsychotic medications for abnormal involuntary movements for 2 of 5 residents reviewed for unnecessary medication use. (Resident #127 and Resident #130)</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #127, completed on 3/19/15 at 11:26 a.m., indicated the resident had diagnoses including, but not limited to, dementia with behavioral disturbances and abnormal involuntary movements.</p> <p>Resident #127 was admitted to the facility on 1/19/15, and then admitted to a</p>	F 329	<p>F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Resident #127 and #130 have a current AIMS assessment. The care plans have been updated to state that AIMS assessments will be completed every 6 month, as per facility policy.</p> <p>All residents receiving an antipsychotic have been identified and reviewed for current AIMS assessments.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> Care plan template has been updated to complete AIMS assessments every 6 months, per facility policy. 	04/24/2015

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	<p>geripsychiatric behavioral unit on 1/20/15. Upon return to the facility on 1/28/15, the resident had a physician's order for risperidone (an antipsychotic medication) 0.5 mg (milligrams) 3 times a day for the treatment of dementia with behavioral disturbances and trihexyphenidyl (a medication used to treat tremors, spasms, and side effects of antipsychotic medications) 2 mg twice a day for the treatment of abnormal involuntary movements.</p> <p>A current plan of care dated 1/30/15, indicated the resident had a diagnosis of dementia with behavior disturbance and required the use of antipsychotic medications. Interventions included completing an AIMS (Abnormal Involuntary Movement Scale) once a day on the first Wednesday of every third month.</p> <p>The clinical record review indicated an AIMS assessment had been completed on 1/20/15.</p> <p>On 4/19/15 at 2:15 p.m., the Regional Clinical Specialist provided the Behavior Management Program dated October 2013, and indicated the policy was the one currently used by the facility. The policy indicated, "...AIMS monitoring will be performed within 48 hours of a</p>		<ul style="list-style-type: none"> · Social Services Director will monitor AIMS assessment schedules on all residents who have an order for an antipsychotic medication. · All new admissions will be reviewed within 48 hours of admission to verify that any resident on an antipsychotic medication has an AIMS assessment completed and a care plan in place. <p>Licensed nurses will be offered education regarding AIMS assessments and appropriate care plans for residents on an antipsychotic as per facility policy.</p> <p>The Social Services Director has been provided education regarding the systemic change.</p> <p>The Director of Nursing or designee will complete a QA audit tool to audit for appropriate care plans and current AIMS assessments for residents who receive an antipsychotic medication. The audit tool will be completed daily on new residents (including weekends), and any resident with a new order for an antipsychotic medication for 30 days, then weekly for 60 days, then every other week for a total of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then</p>	

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	<p>new antipsychotic medication...within 48 hours of an increased dosage...within 48 hours of a new admission with an antipsychotic medication...every 6 months after the initial AIMS assessment...."</p> <p>During an interview with the Administrator and the Director of Nursing (DON) on 3/20/15 at 5:00 p.m., the DON indicated an AIMS assessment had not been completed since the resident had returned to the facility on 1/28/15, with an order for a new antipsychotic medication.</p> <p>2. The clinical record review of Resident #130, completed on 3/20/15 at 11:43 a.m., indicated the resident had diagnoses including, but not limited to, dementia with behavioral disturbances.</p> <p>The current, March 2015, recapitulation of physician's orders indicated Resident #130 was receiving quetiapine (an antipsychotic medication used to treat delusions) 25 mg (milligrams) at bedtime. Quetiapine may cause abnormal involuntary movements.</p> <p>The resident had a current plan of care with a start date of 10/21/14, indicating the resident had a history of delusions and received an antipsychotic medication.</p>		<p>quarterly thereafter once completion is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.</p> <p>Compliance date: 4/24/2015. The Administrator at Aspen Trace Health and Living Community is responsible in ensuring compliance in this plan of correction.</p>	

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F 371 SS=E Bldg. 00	<p>The interventions included completing a routine AIMS (Abnormal Involuntary Movement Scale) on the first Wednesday of every third month.</p> <p>An AIMS assessment was completed on 7/25/14 and on 9/17/14. The next AIMS assessment was completed on 1/8/15, four months after the last assessment.</p> <p>During an interview with Registered Nurse (RN) #1 on 3/23/15 at 4:45 p.m., RN #1 indicated the AIMS assessments were not completed as indicated by the plan of care.</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to cover, label, and date food and juices stored in the kitchen areas in 4 of 4 nursing units. (Renaissance Way, Heritage Court, Cherished Memories, and Ambassador Square)</p>	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>Food and juices that were not covered, labeled, or dated in the kitchen areas of Renaissance Way,</p>	04/24/2015

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	<p>Findings include:</p> <p>1. During the initial tour of the Ambassador Square unit on 3/16/15 at 10:40 a.m., the refrigerator in the kitchen area of the nursing unit contained:</p> <p>a. An opened container of tomato juice with a date opened of 12/14/14.</p> <p>b. Thickened cranberry juice with date opened of 2/25/15. Instructions on the back of the label indicated to discard within 10 days of opening.</p> <p>c. Thickened water with lemon with a date opened of 3/3/15. Instructions on the back of the label indicated to discard within 10 days of opening.</p> <p>d. A pitcher of dark red colored liquid with a date of 7/15 (sic) as the prepared by date and use by date of 7/18 (sic) in a plastic gallon pitcher.</p> <p>e. An uncovered, unlabeled, and undated carafe of dark brown liquid.</p> <p>f. Undated and unlabeled carafes of dark brown liquid, yellow liquid, dark reddish brown liquid, and clear liquid.</p> <p>g. Three unlabeled steel trays containing</p>		<p>Heritage Court, Cherished Memories, and Ambassador were immediately removed and disposed of during the survey process.</p> <p>All kitchen areas on the nursing units were audited for any food or juices not covered, labeled or dated and any concerns were addressed.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> · Food products in all dining areas and nourishment pantries will be audited for expiration, dating and labeling of foods weekly by the Dietary Manager, or designee. This auditing will be ongoing. · Refrigerators in the activity areas will be monitored and maintained by the activity staff storage weekly. They will be audited for expiration, dating and labeling of foods. This audit will be ongoing. <p>Education will be provided to dietary, activity, and nursing staff regarding systemic changes. This education will include the recommended storage times and temperature and covering, labeling and dating of all items placed in the refrigerator or cabinets or in an opened container. New dietary, nursing and activity staff will be provided education regarding the systemic change.</p>	

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	<p>a thick red colored substance, a thick white substance, and a tan colored substance containing multicolored ingredients.</p> <p>h. A carafe marked prune juice with a prepared date of 3/13/15, and a use by date of 3/15/15.</p> <p>i. Uncovered and undated dishes of ice cream in the freezer.</p> <p>The cabinet in the kitchen area contained:</p> <p>j. A plastic bag marked raisin bran with a date of 2/11/15.</p> <p>k. Undated and unlabeled plastic bags of dry cereal.</p> <p>l. A plastic bag marked corn flakes dated 2/11/15.</p> <p>m. Unlabeled and undated plastic bags of multigrain bread and dinner rolls.</p> <p>n. An unmarked package of hamburger buns with an expiration date of 3/12/15.</p> <p>During an interview with the Dietary Manager (DM) on 3/16/15 at 11:36 a.m., the DM indicated the dry cereal should be used with in 30 days of opening and the juices should be discarded 3 days after</p>		<p>The Dietary Manager or designee will audit food products in all kitchen areas on the nursing units for proper covering, labeling and dating of items, daily for 30 days (including weekends), then twice weekly for 30 days. This auditing will be on-going for weekly monitoring.</p> <p>The Activity Director or designee will monitor refrigerators in the activity areas for proper covering, labeling and dating of item, daily for 30 days (including weekends), then twice weekly for 30 days. This auditing will be on-going for weekly monitoring.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 2 months and then quarterly thereafter once compliance is at 100%. Frequency and duration will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 4/24/15. The Administrator at Aspen Trace Health and Living Community is responsible for this plan of correction.</p>	

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	<p>preparation or opening. The DM indicated the staff should be dating the items when opened or prepared with the date opened as well as the date to be discarded.</p> <p>2. During the initial tour of the Cherished Memories unit at 11:40 a.m., the refrigerator in the kitchen area of the nursing unit contained:</p> <p>a. Unfrozen and undated Mighty Shakes. The label on the Mighty Shakes indicated to discard within 14 days of thawing.</p> <p>The cabinet in the unit contained:</p> <p>b. Unlabeled and undated partial loaves of white bread.</p> <p>c. An undated and unlabeled partial loaf of multigrain bread.</p> <p>d. An undated and unlabeled loaf of white bread.</p> <p>e. Twelve hamburger buns with an expiration date of 3/5/15.</p> <p>f. Five hamburger buns with an expiration date of 3/12/15.</p> <p>g. An undated and unlabeled bag of dinner rolls.</p>			

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	<p>h. An undated bag of bran flakes wrapped in plastic wrap.</p> <p>3. During an initial tour of the Heritage Courts unit on 3/16/15 at 12:30 p.m., the refrigerator in the kitchen area of the nursing unit contained:</p> <p>a. A carafe of lemonade dated 3/13/15, with a use by date of 3/15/15.</p> <p>b. Thickened cranberry juice opened and undated. The label on the back indicated to discard within 10 days of opening.</p> <p>c. Thickened orange juice opened and undated. The label on the back indicated to discard within 10 days of opening.</p> <p>4. During an initial tour of the Renaissance Way unit on 3/16/15 at 1:00 p.m., the refrigerator in the kitchen area of the nursing area contained:</p> <p>a. Strawberry yogurt with an expiration date of 2/25/15.</p> <p>b. Peach yogurt with an expiration date of 2/27/15.</p> <p>c. A container of prune juice with a prepared date of 3/12/15.</p>			

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	<p>d. Nine lemon slices in an uncovered steel container dated 3/2/15.</p> <p>e. Thickened apple juice, thickened water with lemon, thickened cranberry juice, and thickened orange juice open and undated. The labels on the back indicated to discard within 10 days of opening.</p> <p>f. An uncovered, unlabeled, and undated carafe of pale orange colored liquid.</p> <p>g. Two undated and unlabeled carafes of reddish brown liquid.</p> <p>The cabinet in the kitchen area contained:</p> <p>h. Two slices of multigrain bread in a plastic bag with an open date of 3/13/15.</p> <p>i. An undated partial loaf of white bread.</p> <p>j. An undated full bag of dinner rolls.</p> <p>k. Six hamburger buns with an expiration date of 3/2/15.</p> <p>l. Ten dinner rolls in a plastic bag with an open date of 3/9/15.</p> <p>m. One and 1/2 hamburger buns with an expiration date of 3/12/15, and an opened date of 3/13/15.</p>			

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	<p>n. During an observation on 3/19/15 at 3:15 p.m., the refrigerator contained a carafe marked peach tea dated 3/16 - 3/18, (prepared and use by dates) 1 carafe marked prune juice dated 3/15 - 3/17, (prepared and use by dates) and 1 carafe with an unreadable label. Dietary Supervisor #3 was present and indicated the carafes were expired and should have been discarded.</p> <p>5. During the initial tour of the facility on 3/16/15 at 10:40 a.m., the refrigerator in the activity area of Renaissance Way contained:</p> <p>a. An orange cream yogurt with a sell by date of 12/1/14.</p> <p>b. A bun size frank with an expiration date of 1/23/15.</p> <p>c. A strawberry yogurt with an expiration date of 1/25/15.</p> <p>d. A blackberry pomegranate yogurt with an expiration date of 2/5/15.</p> <p>e. A keylime yogurt with an expiration date of 2/9/15.</p> <p>f. A plastic bag of undated and unlabeled hotdogs.</p>			

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	<p>g. Three undated and unlabeled hot dog buns in an unsealed plastic bag.</p> <p>h. Two undated and unlabeled bowls containing a reddish brown substance.</p> <p>i. A bag of undated and unlabeled baked cookies in the freezer.</p> <p>During an interview with the Administrator (Admin), the Environmental Services Director, and the Regional Director of Dietary Services (RDDS) on 3/23/15 at 2:05 p.m., the Admin indicated the refrigerators in the kitchen areas of the nursing units were monitored and managed by dietary staff. The Administrator indicated the refrigerators in the activity areas were not used on a regular basis, and were not monitored nor maintained by a specific department.</p> <p>On 3/23/15 at 2:05 p.m., the RDDS provided the policy Food and Non Food Storage dated 5/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...Recommended Storage Times and Temperatures...Opened canned fruits and juices...3 days. Store in covered containers with name and use by date...Thickened Beverages...3 days after</p>			

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F 441 SS=E Bldg. 00	<p>opening, label with use by date...."</p> <p>On 3/23/15 at 2:05 p.m., the RDDS also provided the policy Environmental Sanitation/Infection Control dated 2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...Daily: 1. Spills and odors are avoided by covering, labeling, and dating all items placed in the refrigerators...."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program</p>			

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	<p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, interview, and record review, the facility failed to isolate 2 of 2 residents suspected of having clostridium difficile (c-diff, a multi-drug resistant organism characterized by severe diarrhea). (Resident #130 and Resident #168)</p> <p>B. Based on record review and interview, the facility failed to ensure the 2nd step of the tuberculin skin testing process was administered to 5 recently hired employees prior to starting work, for 5 of 13 employees reviewed for receiving the tuberculin skin test in a timely manner. (Licensed Practical Nurse [LPN] #2, Certified Nursing Assistant [CNA] #3, CNA #4, CNA #5, and CNA #6)</p>	F 441	<p>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>Resident #130 is no longer infectious with clostridium difficile. #168 stool culture was negative for c-diff.</p> <p>All residents' bowel patterns have been reviewed with no other residents having signs and symptoms of c-diff.</p> <p>All staff identified on the 2567 that had not completed their 2nd step PPDs will restart the PPD process, and will receive 1st and 2nd step according to facility protocol.</p> <p>Current employees have been reviewed to verify that 1st and 2nd step PPDs have been given timely, according to facility protocol.</p>	04/24/2015

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	<p>Findings include:</p> <p>A. 1. The clinical record review of Resident #130, completed on 3/20/15 at 11:43 a.m., indicated the resident had diagnoses including, but not limited to, dementia with behavioral disturbances and a history of c-diff.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed on 1/29/15, assessed the resident as moderately cognitively impaired and had poor decision making abilities.</p> <p>The nursing progress notes on 3/6/15, indicated the resident's husband thought the resident had a urinary tract infection (UTI). At 11:06 a.m., the physician was notified and an order was given to obtain a urine specimen. At 4:46 p.m., the physician was contacted and an order was received for Rocephin (an antibiotic) 1 gm (gram) intramuscularly for the treatment of UTI.</p> <p>On 3/8/15, the resident had a large amount of diarrhea stool. The physician was notified and an order was received to obtain a stool specimen for c-diff culture. The clinical record lacked documentation of implementation of contact isolation for a suspected c-diff infection.</p>		<p>The systemic change includes:</p> <ul style="list-style-type: none"> · The c-diff protocol has been updated to include initiating contact isolation once c-diff is suspected. · All new orders and progress notes will be reviewed at the morning clinical meeting (5 days a week) and any resident symptomatic of C-Dif or a physician order to obtain a stool specimen for c-dif culture will have contact isolation initiated. · All new employees will receive a 1st and 2nd step PPD according to facility protocol. · The HR Director or designee will maintain a log of employee PPDs and dates for the 1st and 2nd step PPD and monitor for compliance weekly. <p>Education will be offered to licensed nurses on the updated c-diff policy and will also include the signs and symptoms of c-diff, immediate placing on contact isolation when c-diff is suspected, and appropriate documentation.</p> <p>Education will be provided to the HR Director regarding the facility policy on employee PPDs, including when the 1st and 2nd step PPD is due, as well as the systemic change.</p>	

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	<p>On 3/9/15 at 12:13 a.m., the physician was notified of the culture results indicating the resident had an active c-diff infection. New orders were received to start Flagyl (an antibiotic used to treat c-diff infections) 500 mg (milligrams) 3 times a day and to place the resident into contact isolation.</p> <p>During an interview with Registered Nurse (RN) #1 on 3/24/15 at 3:30 p.m., RN #1 indicated the facility had followed the current policy for c-diff infections and had not placed the resident into isolation until the culture confirmed the resident had an active c-diff infection.</p> <p>2. On 3/17/15 at 2:00 p.m., Resident #168 indicated, in a brief interview, she was too ill to have a conversation. She indicated she was having, "terrible diarrhea."</p> <p>A brief review of the resident's record, on 3/17/15, at 4:00 p.m., indicated an order had been obtained from the physician that day to get a stool specimen. A nurse's note, dated 3/18/15, at 3:47 p.m., indicated, "received labs back, c.diff negative..."</p> <p>On 3/17/15 at 3:30 p.m., RN #1 indicated Resident #168 was not placed in isolation</p>		<p>The Director of Nursing or designee and Human Resources will both monitor that 1st and 2nd step PPDs have been given according to protocol. This will be audited after each new employee is hired, and before starting work. The employee PPD log will be audited weekly on-going.</p> <p>The results of these reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once completion is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.</p> <p>Compliance date: 4/24/2015. The Administrator at Aspen Trace Health and Living Community is responsible in ensuring compliance in this plan of correction.</p>	

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	<p>that day, despite the resident's complaints of diarrhea., and the physician's order for a stool specimen.</p> <p>On 3/20/15 at 4:20 p.m., the Clinical Consultant provided a policy titled, "Clostridium Difficile [C-Diff] Policy," dated 10/10/14, and indicated it was the policy currently used by the facility. The policy indicated a resident must be placed in isolation after a confirmed diagnosis of C-diff.</p> <p>"Frequently Asked Questions about Clostridium Difficile for Healthcare Providers," March, 2012, was retrieved on 3/24/15 from the Centers of Disease Control (CDC) website. The guidance included the need to use contact isolation precautions (wearing gowns and gloves) when entering the room of a resident with known or suspected C-diff.</p> <p>B. A review of employee records on 3/19/15 at 10:00 a.m. indicated the following:</p> <p>1. LPN #2 started working at the facility on 1/20/15. The 1st step tuberculin skin test was administered to this employee on 1/14/15. No information was found in the employee's record which indicated a 2nd step had been administered.</p>			

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	<p>2. CNA #3 started working at the facility on 11/13/14. The 1st step tuberculin skin test was administered to this employee on 1/7/14. No information was found in the employee's record which indicated a 2nd step had been administered.</p> <p>3. CNA #4 started working at the facility on 1/20/15. The 1st step tuberculin skin test was administered to this employee on 1/14/15. No information was found in the employee's record which indicated a 2nd step had been administered.</p> <p>4. CNA #5 started working at the facility on 1/15/15. The 1st step tuberculin skin test was administered to this employee on 1/12/15. No information was found in the employee's record which indicated a 2nd step had been administered.</p> <p>5. CNA #6 started working at the facility on 11/13/14. The 1st step tuberculin skin test was administered to this employee on 11/8/14. No information was found in the employee's record which indicated a 2nd step had been administered.</p> <p>On 3/19/15 at 3:30 p.m., the Human Resources Director indicated she was not able to locate a 2nd step tuberculin skin test for the above employees.</p>			

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F 456 SS=B Bldg. 00	<p>On 3/24/15 at 11:30 a.m. the Human Resources Director provided a policy titled, Employee Health Screening, and indicated it was the policy currently used by the facility. The policy indicated, "Testing for active tuberculosis is accomplished using the two-step Mantoux tuberculin test method recommended by the Centers for Disease Control..."</p> <p>3.1-18(j) 3.1-14(t)(1)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure the refrigerators in the resident rooms were maintained in a safe operating condition.</p> <p>Findings include: During the initial tour of the facility on 3/16/15 at 10:40 a.m., and during Stage 1</p>	F 456	<p>F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The housekeeping staff initiated monitoring of refrigerators in resident rooms and cleaning daily during the survey process.</p> <p>All refrigerator temperatures and</p>	04/24/2015
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	<p>interviews of residents in their rooms, facility refrigerators were seen in each of the resident rooms on all 4 units of the facility.</p> <p>The Environmental Services Director (ESD) indicated the environmental services staff checked the refrigerators in the resident rooms on a daily basis for cleaning, but the temperatures were not monitored. The EDS indicated the refrigerators were new and were not on a schedule for preventative maintenance.</p> <p>During an interview with the Environmental Services Director, the Administrator, and the Regional Director of Dietary Services on 3/23/15 at 2:05 p.m., the Administrator indicated the facility did not have a policy regarding the monitoring or maintenance of the refrigerators in the resident rooms and in the activity areas.</p> <p>3.1-19(bb)</p>		<p>cleaning in the activity areas began being monitored by the activity staff during the survey process.</p> <p>All refrigerators were audited by housekeeping staff to verify thermometers are in place in each.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> The refrigerators in all resident room will be monitored by housekeeping daily and as needed. Housekeeping will also monitor and record temperatures daily and report any abnormal temperatures to the Environmental Service Director. The refrigerators in all activity areas will be monitored by activity staff daily and as needed. Activity staff will also monitor and record temperatures daily and report any abnormal temperatures to the Environmental Service Director. <p>Education will be offered to housekeeping and activity staff on recording temperatures, appropriate temperature range for the refrigerators and when to notify the Environmental Service Director, as well as cleaning of designated refrigerators. In addition, education will be provided to any new employees hired into the housekeeping or activity departments.</p>	

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NAME OF PROVIDER OR SUPPLIER ASPEN TRACE HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 S SR 135 GREENWOOD, IN 46143
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R 000 Bldg. 00	The following residential finding was cited in accordance with 410 IAC 16.2-5.	R 000	The Environmental Service Director or designee will monitor that temperatures are recorded and appropriate, and cleaning of refrigerators daily (including weekends). Audits will be completed daily for 30 days, then weekly for 60 days, and monthly thereafter for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once completion is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%. Compliance date: 4/24/2015. The Administrator at Aspen Trace Health and Living Community is responsible in ensuring compliance in this plan of correction.	
R 352 Bldg. 00	410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the			

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	<p>resident.</p> <p>(2) A record of the resident ' s evaluations.</p> <p>(3) Services provided.</p> <p>(4) Progress notes.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were documented with physician notification regarding blood sugar checks outside call parameters for 1 of 7 residents reviewed for clinical record documentation. (Resident #38)</p> <p>Findings include:</p> <p>The clinical record of Resident #38 was reviewed on 3/24/15 at 11:20 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus.</p> <p>A current physician's order, dated 1/19/15, indicated Resident #38 was to receive a finger stick blood sugar test every day in the morning and the physician was to be notified if the resident's blood sugar measured less than 60 or over 200.</p> <p>A service plan for Resident #38, dated 3/19/15, and current through 9/19/15, indicated the resident had a potential for episodes of high or low blood sugars, secondary to her diagnosis of diabetes. The goal was, "Resident's blood sugars will be maintained in call range per MD [medical doctor] order." An approach</p>	R 352	<p>R 352 410IAC 16.2-5-8.1(e)(1-4) Clinical Records – Noncompliance</p> <p>The physician for resident #38 was notified of the last 90 days of blood sugars during the survey process.</p> <p>All residents with ordered blood sugar checks will be audited for physician notification regarding blood sugar checks outside call parameters. Any concerns will be addressed and the physician notified.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> · Resident #38 Lantus orders were increased by 2 units every night · The physician will be notified of all blood sugars above 200 per physician orders · Residents' with blood sugar checks will be reviewed in the morning clinical meeting for blood sugars outside of call parameters and MD notification <p>The Director of Nursing or designee will complete a QA tool to audit resident blood sugars and documentation daily to verify that</p>	04/24/2015

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	<p>was, "Monitor blood sugars as ordered and report per call orders..."</p> <p>Review of a Diabetic Administration History indicated the following for February, 2015:</p> <p>2/1 - BS (blood sugar) = 201 2/3 - BS = 206 2/4 - BS = 240 2/6 - BS = 240 2/7 - BS = 215 2/9 - BS = 217 2/10 - BS = 202 2/11 - BS = 215 2/12 - BS = 209 2/13 - BS = 212 2/14 - BS = 215 2/15 - BS = 228 2/16 - BS = 233 2/17 - BS = 285 2/20 - BS = 258 2/23 - BS = 239 2/24 - BS = 215 2/26 - BS = 231 2/28 - BS = 222</p> <p>Review of a Diabetic Administration History indicated following for March, 2015:</p> <p>3/1 - BS = 210 3/2 - BS = 235 3/3 - BS = 240</p>		<p>any blood sugars over ordered range have been reported to the physician. Audits of blood sugars will be daily (including weekends) for 30 days, then weekly for 60 days, then monthly for a total of 12 months of monitoring. A QA audit tool will be used for</p> <p>Licensed nurses will be offered education regarding physician notification and documentation of any blood sugars outside of ordered range.</p> <p>The results of these reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Compliance date: 4/24/2015. The Administrator at Aspen Trace Health and Living Community is responsible in ensuring compliance in this plan of correction.</p>	

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	<p>3/4 - BS = 231 3/5 - BS = 233 3/6 - BS = 231 3/10 - BS = 233 3/11 - BS = 249 3/19 - BS = 202</p> <p>No information was found in Resident #38's record which indicated the physician was notified of the above blood sugars over 200.</p> <p>On 3/25/15 at 9:55 a.m., RN #10 indicated she was unable to find any documentation the staff had notified the physician of Resident #38's blood sugars over 200, per physician order.</p>			