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| 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 10/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER DIGBY PLACE | STREET ADDRESS, CITY, STATE, ZIP CODE 167 CR W 240 S LAFAYETTE, IN 47905 |
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| R 0000 Bldg. 00 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: October 13 & 14, 2015</p> <p>Facility number: 004392 Provider number: 004392 AIM number: N/A</p> <p>Census bed type: Residential: 41 Total: 41</p> <p>Sample: 8</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 21662 on October 16, 2015.</p> | R 0000 | Please accept the enclosed plan of correction as our credible allegation of compliance. | |
| R 0144 Bldg. 00 | <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure a clean, sanitary, and home like environment related to</p> | R 0144 | Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of | 11/30/2015 |

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>hallways, dining area, laundry room and furniture. This deficient practice had the potential to affect 41 of 41 residents.</p> <p>Findings include;</p> <p>1. During the initial tour on 10/13/2015 at 10:00 a.m., the following were observed:</p> <p>a.) The laundry room walls were chipped, marred, gouged, and peeling.</p> <p>b.) The emergency call bell light system was not working for the common areas which included all hallways, the dining room area, the spa and toilet area, the laundry room, the library and the activity room.</p> <p>c.) The dining room chairs (33) and tables (3) were gouged, marred, chipped and peeling.</p> <p>d.) The hallway window ledges and venetian blinds (3) across from rooms 121, 120, and 119 were dirty with debris and dead insects.</p> <p>e.) The dining room window ledges and Venetian blinds (8) were dirty with debris and dead insects.</p> <p>f.) The hallway between rooms 135 and</p> | | <p>Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. The laundry room walls will be repaired to remove all chipping, mars, gouges and peeling by the maintenance technician or designee. The emergency call bell light system was immediately restored to full functionality by the Maintenance Technician on 10/13/2015. The affected dining room chairs and tables will be touched up with a furniture stain in areas where gouging, mars chips and peeling exist by the maintenance technician or designee. The hallway window ledges across from rooms 121, 120 and 119 will be cleaned and all dirt, debris and insects removed by the housekeeper or designee. The venetian blinds across from rooms 121, 120 and 119 will be cleaned or replaced as necessary in order to remove all dirt, debris, and dead insects by the housekeeper or designee. The dining room</p> | |

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| | <p>137 had a curio case. The curio case had a glass which was broken with sharp and jagged edges exposed.</p> <p>During the environmental tour on 10/14/2015 at 10:55 a.m., with the Executive Director, he indicated the common call bell light should have been working, the curio case glass should have been repaired and the window ledges and Venetian blinds should have been cleaned.</p> <p>During an interview on 10/14/2015 at 2:30 p.m., the Executive Director indicated the facility did not have a procedure for detecting when common area call bell lights were not in working order.</p> | | <p>window ledges will be cleaned and all dirt, debris and dead insects removed by the housekeeper or designee. The venetian blinds in the dining room will be cleaned or replaced as necessary in order to remove all dirt, debris and insects by the housekeeper or designee. The curio case glass was immediately taped over with packing tape such that no sharp or jagged edges existed by the maintenance technician on 10/13/15. Current residents have the potential to be affected by the alleged deficient practice. All staff will be educated to the cleaning procedures for the common areas as well as testing the call bell system. The maintenance tech or designee will monthly perform the following preventative maintenance tasks:</p> <p>a) Repair chips, mars, gouges and mars on furniture and walls b) Making note of hazards such as jagged or sharp edges in the hallways The maintenance tech or designee will at least weekly test the functionality of the call system by pulling a station and ensuring the system properly alerts staff that the station has been pulled. Weekly rounds will be conducted by the ED or designee, to inspect the following:</p> <p>a) Chips, mars, gouges and peeling on walls b) Testing the functionality of the call light system by pulling stations in the common area and resident rooms</p> | |

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| R 0273 Bldg. 00 | <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was labeled and dated in the refrigerator, freezer, open kitchen area, and dry storage area, and food was served app by staff wearing appropriate head covers. This deficiency had the potential to affect 41 of 41 residents.</p> <p>Findings include:</p> <p>During the tour of the kitchen on 10/13/15 at 9:40 a.m., the following</p> | R 0273 | <p>at random and ensuring the call light system is properly alerting staff of the fact that the station has been pulled. c) Check furniture for mars, chips, gouge and peeling. d) Ensuring window ledges and venetian blinds throughout the facility are free of dirt, debris and insects. e) Ensuring that hallways are free of hazards such as sharp or jagged edges. . The Administrator of designee will make random weekly rounds to assure compliance. The results of the rounds will be reviewed monthly in the QA committee for a period not to exceed 6 months.</p> <p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the</p> | 11/30/2015 |

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| | <p>observations were made:</p> <p>1.) The refrigerator was observed to have open and not dated items: a.) salad dressing open and not dated b.) mayonnaise open and not dated c.) sour cream open and not dated d.) 10 bowls of pudding uncovered and not dated</p> <p>2.) The freezer was observed to have a package of cookies open and not dated.</p> <p>3.) The dry storage was observed to have: a.) 1 package of noodles open and not dated b.) 1 package of graham crackers open and not dated</p> <p>4.) The food preparation area had: a.) 1 package of potato chips open and not dated b.) 1 container of brown sugar not labeled and not dated c.) 1 package of raisins opened and not dated.</p> <p>5.) CNA #1 and CNA #2 were observed to be working in the refrigerator and were not wearing a hairnet.</p> <p>During an interview on 10/13/15 at 11:19 a.m., the Dining Services Coordinator indicated all open food should be dated.</p> | | <p>facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. No residents were found to be affected. All resident have the potential to be affected. 1) a) The salad dressing was immediately disposed of by the cook on 10/13/15. b) The mayonnaise was immediately disposed of by the cook on 10/13/15. a) The sour cream was immediately disposed of by the cook on 10/13/15. b) The 10 bowls of pudding were immediately disposed of by the cook on 10/13/15. 2) The package of cookies in the freezer was immediately disposed of by the cook on 10/13/15 3) a) The package of noodles was immediately disposed of by the cook on 10/13/15. b) the package of graham crackers was immediately disposed of by the cook on 10/13/15. 4) a) The 1 package of potato chips was immediately disposed of by the cook on 10/13/15. b) The 1 package of brown sugar was immediately disposed of by the cook on 10/13/15. c) The 1 package of raisins was immediately disposed of by the cook on 10/13/15. 5) CNA#1 and CNA#2 will be educated to the proper usage of hairnet All dietary staff will be re-educated to the facility "Storage of Products" policy. All Staff will be instructed to the proper wearing of hairnets</p> | |

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| R 0408 Bldg. 00 | <p>A policy titled "Storage of Products" dated 07/01/2014 received from the Executive Director on 10/14/15 at 10:30 a.m., indicated "...III. Items should be dated before being stored and should be place behind similar items already on the shelf to ensure that older items are used first. IV. once opened, items should be dated and sealed...."</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to screen a new resident for Tuberculosis (TB) by administering a Chest X-ray within the required time frame. This affected 1 of 8 resident reviewed for Chest X-ray's in a sample of 8 (Resident #3).</p> <p>Findings include: The clinical record of Resident #3 was reviewed on 10/13/2015 at 2:00 p.m. Diagnoses included, but were not limited to, Parkinson's, hypertension, hyperlipidemia, benign prostatic hypertrophy, urinary retention, history of prostate cancer, anemia, chronic pain and</p> | | | R 0408 | <p>in a dietary setting per facility policy. The Executive Director or designee will conduct a weekly dietary sanitation audit which will include the inspection of the proper labeling and dating of food and the proper wearing of hairnets by facility staff. The results of the weekly dietary sanitation audit will be reviewed in the monthly QA committee for a period not to exceed 6 months.</p> <p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition,</p> | | 11/30/2015 |

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| | <p>dementia.</p> <p>The admission chest x-ray was completed on 10/16/14. Admission date for this resident was 5/16/15. The chest x-ray was outside the six month time frame.</p> <p>During an interview with the Care Services Manager, on 10/13/2015 at 2:35 p.m., she indicated the chest x-ray was not completed in the 6 month time frame.</p> <p>A facility Policy for "TB Testing and Vaccine Consent Record", dated 7/1/2014 received from the Executive Director on 10/13/2015 at 2:56 p.m., indicated "...State regulations will be followed "</p> | | <p>preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p>A new chest x-ray has been ordered and will be done for Resident #3.</p> <p>An audit of all current resident records will be conducted to determine that a diagnostic Chest X-ray or TB (where appropriate) has been administered within the required time frame prior to admission.</p> <p>Any deficient findings will</p> | |

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| | | | <p>result in a new chest x ray or TB test (where appropriate) being conducted as soon as possible.</p> <p>The findings of the record audit will be reviewed in the next scheduled QA meeting.</p> <p>Any new admissions will be reviewed for diagnostic chest x-rays no more than 6 months old and reviewed in the monthly QA meeting for a period not to exceed 6 months.</p> | |