STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey Dates: May 1, 2, and 3, 2012 Facility number: 004352 Provider number: 004352 AIM number: NA Survey team: Cheryl Fielden RN, TC Diana Sidell, RN Census bed type: Residential: 30 Total: 30 Census payor type: Other: 30 Total: 30 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 7, 2012 by Bev Faulkner, R.N.	R0000	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 facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (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: (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. (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 effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the	R0120	**Citation #1** **R 120** **410 IAC 16.2-5-1.4(e)(1-3)**	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensure resident rights and abuse in-service education was provided and attended annually. This affected 2 of 5 employees reviewed for annual resident rights and abuse in-service education. LPN #1 and the Dining Service Coordinator. Findings included: 1. On 5/3/2012 at 2:00 p.m., review of in-service records for LPN #1 indicated the last in-service attended for resident rights and abuse was 3/1/2011. No other documentation was provided for annual in-service training for resident rights and abuse. 2. On 5/3/2012 at 2:00 p.m., review of in-service records for the Dining Service Coordinator (DSC) indicated no attendance for the resident rights and abuse training on 3/1/2011. No other documentation was provided for annual in-service training for resident rights and abuse. On 5/3/2012 at 2:55 p.m., an interview with the Wellness Director (WD) provided the most recent resident rights and abuse training was on 3/1/2011. The WD interpreted, annually as every calendar year and not every 12 months.		**Personnel- Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. LPN #1, Dining Service Coordinator, and staff at Jewel House were reeducated regarding resident rights and abuse education by the Wellness Director. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. The Wellness Director conducted employee file audit and reeducated staff as to organized in-services that needed to be completed annually. The Wellness Director developed a calendar of in-services to be completed on a monthly basis in effort to satisfy Indiana state residential regulation 410 IAC 16.2-5-1.4(e)(1-3) Personnel-Noncompliance. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Regional Director of Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The WD indicated that LPN #1 and DSC did not have resident rights and abuse training in the past 12 months.		and Care Management reeducated the Wellness Director as to the Indiana State regulation 410 IAC 16.2-5-1.4(e)(1.3). The Wellness Director and/or Designee will be responsible to ensure an organized in-service education and training program planned in advance for all personnel in all departments at least annually. The Wellness Director developed a calendar of in-services to be completed on a monthly basis in effort to satisfy Indiana state residential regulation 410 IAC 16.2-5-1.4(e) (1-3). **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform a random monthly audit of employee files to ensure organized in-service education is completed for Jewel House personnel for a period of 6 months to ensure continued compliance. Audits will be reviewed through our Jewel House QA process and reviewed after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			June 20, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0144	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. Based on observation and interview the facility failed to ensure the facility was in a state of good repair in that: 1. Two railings at the entrance to the facility were not attached firmly to prevent movement. 2. Two round holes in the surface of the sidewalk, located at rear of the facility, were missing covers. Finding included: 1. On 5/3/2012 at 1:00 p.m., an observation during the environmental tour with Regional Maintenance (RM) revealed two railings at the entrance to the facility were not attached firmly to prevent movement. Upon further observation, the front post of the right side railing was not attached to the concrete walkway. The back post was attached to the concrete. The left	R0144	**Citation #2** **R 144** **410 IAC 16.2-5-1.5(a)** **Sanitation and Safety Standards- Deficiency** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The Maintenance Director removed the two railings at the entrance of the facility. The Maintenance Director replaced the covers on the two round holes in the surface of the sidewalk. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director educated Jewel House staff and	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	railing posts were attached to the concrete but were loose. On 5/3/2012 at 2:30 p.m., during an interview with RM, it was indicated that the railings would be removed immediately and be replaced at a later date. 2. On 5/3/2012 at 1:00 p.m., an observation during the environmental tour with RM, two round holes were found in the surface of the concrete walkway without covers. These holes were located in the rear sidewalk of the facility. Both holes previously had covers, as the broken fragments were located within or near the holes. On 5/3/2012 at 1:00 p.m., during an interview with RM, it was indicated the covers would be replaced.		Maintenance Director as to communicating physical plant issues via the morning stand up and maintenance log upon findings to ensure continued compliance with Indiana state residential regulation R144 410 IAC 16.2-5-1.5(a). The Maintenance Director will be responsible for ensuring 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. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform a random weekly round of residence for a period of 6 months to ensure continued compliance. Audits will be reviewed through our Jewel House QA process and reviewed after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** June 20, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, record review and interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in that cabinet shelves had soiled areas that were marred and pitted, and cabinet doors had soiled areas during 1 of 3 kitchen observations. This deficient practice had the potential to affect all 30 residents in the facility. Findings included: During a kitchen observation and interview on 5/3/12 at 10:47 a.m., with Cook #1, the following was observed: - A base cabinet across from the handwashing sink had grooves and scratches on the shelf surface which exposed board underneath the white veneer surface in an 8" by 8" area. A 'Hamilton Beach Stay or Go Crock Pot' sat on the top shelf and had a handle that dangled on the left side due to a missing screw. The top inner corners of both cabinet doors, where the doors met in the middle, had yellow and brown drips. Cook #1 indicated the outside of the	R0154	**Citation #3** **R 154** **410 IAC 16.2-5-1.5(k)** **Sanitation and Safety Standards- Deficiency** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The Wellness Director and staff cleaned the cabinets located in the kitchen. The cleaning schedule of the dietary department was revised to include cleaning the cabinets nightly. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?**	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cabinet doors are cleaned every time she works, but didn't know about the inside of the cabinets. - A base cabinet, on the far right side, under the windows, had yellow and gray smudges on the top inner corners of both doors where the inside of the handles were located. - The second base cabinet from the right, under the windows, had a top shelf that was pitted and marred gray and black over two thirds of the shelf surface, upon which sat a set of steel mixing bowls. The bottom shelf was pitted and had black marks over half the surface area and had 3 colanders and a large baking pan stored on the shelf. The top left inside cabinet door was soiled with tan and gray smudges in a 10" by 10" by 3" area, and the inside top of the right door was soiled on an area that measured 5" by 5" by 3." - The third base cabinet from the right had marred areas on the inside of the doors with tan and yellow smudges, and the shelves and sides of the cabinet had numerous gray marred areas. - In the corner base cabinet, both shelves were scraped through the veneer and the board was exposed underneath. Two square plastic containers had cereal stored		The Wellness Director reeducated staff as to residence cleaning expectations and the revised cleaning schedule to ensure continued compliance with Indiana state regulation 410 IAC 16.2-5-1.5(k). The Wellness Director and/or Designee will be responsible for ensuring the facility will keep all kitchens, kitchen areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform a random weekly round of residence for a period of 6 months to ensure continued compliance with the assigned cleaning schedule. Audits will be reviewed through our Jewel House QA process and reviewed after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** June 20, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in them, and sat on the top shelf. - In a base cabinet on the right side of the gas range, the top shelf was stained with a yellow substance and had pitted areas that covered half the surface area of the shelf. The bottom shelf had a dishcloth laying flat on the shelf that was coated with a yellow and gray substance, and covered two thirds of the shelf. The yellow substance had a tacky, gummy texture. The top left inside of the door had yellow and tan smudges across the top and down the door in several drips. Cook #1 removed a round plastic dispenser with a pointed lid that contained two thirds of an inch of a liquid yellow substance. Cook #1 indicated she thought there had been containers of oil stored on the shelf at one time. - Across from the gas range, large soup pots were stored in an island base cabinet that had 2 shelves. Both shelves had gray and black marred areas and rust colored areas that covered most of the shelf surface. Both doors had yellow smudges on the top inner door surfaces and across the top of the door. - The center base cabinet of the island had a top shelf that was pitted over most of the right side, and a bottom shelf that was marred. Plates were stored on the top			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shelf, and trays were stored on the bottom shelf. Inside both doors was a yellow substance along the inner top surface of the door. - The island base cabinet on the far right, across from the range, had two shelves, the top shelf had black marred areas on the right side of the shelf with stacks of bowls stored on the shelf. The bottom shelf had a black marred streak down the center of the shelf approximately 5" wide and had stacks of plates stored on it. On 5/3/12 at 1:00 p.m., the Director of Wellness Services provided a cleaning schedule for the dietary department for review. The list failed to include cleaning the cabinets.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to maintain current emergency information on each resident in that 2 residents failed to have a hospital preference listed, (Residents #6 and 8), 3 residents failed to have allergies listed, (Residents #8, 22, and 25) and 1 resident failed to have a medical or financial power of attorney in their emergency file. (Resident #26) This affected 5 of 5 residents reviewed for emergency files in a sample of 7. Findings include:	R0356	**Citation #4** **R 356** **410 IAC 16.2-5-8.1(i)(1-8)** **Clinical Records-Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The emergency files for residents # 6, 8, 22, 25,and 26 were updated with the correct information. **How the facility will identify other residents having the**	06/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the emergency files provided by the Director of Wellness Services on 5/3/12 at 1:00 p.m., indicated the following residents lacked information in their emergency file: 1. Resident #6 did not have a hospital preference. 2. Resident #8 did not have allergies or hospital preference. 3. Resident #22 did not have allergies listed. 4. Resident #25 did not have allergies listed. 5. Resident #26 did not have a medical power of attorney or financial power of attorney listed. During an interview on 5/3/12 at 2:55 p.m., the Director of Wellness Services indicated they had no policy for emergency files.		**potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. The Wellness Director performed an audit of resident emergency information files and updated the files with the information needed to satisfy Indiana state regulation 410 IAC 16.2-5-8.1(i)(1-8). **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Regional Director of Quality and Care Management reeducated the Wellness Director to Indiana state regulation 410 IAC 16.2-5-8.1(i)(1-8). The Wellness Director and/or Designee will be responsible for ensuring that a current emergency information file shall be immediately accessible for each resident containing the information referenced in the above regulation. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform a random monthly audit of the resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			emergency information files for completion and accuracy. Audits will be reviewed through our Jewel House QA process and reviewed after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** June 20, 2012	