

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 06/29/2016
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NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY CIR HOBART, IN 46342
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 27 and 28, 2016.</p> <p>Facility number: 002627 Provider number: 002627 AIM number: N/A</p> <p>Residential Census: 89</p> <p>Sample: 11</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 32883 on 6/30/16.</p>	R 0000	<p>This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. This plan of correction is being submitted as required by the regulation. On or before August 17, 2016 the Administrator will ensure all corrective action in the following POC has been completed.</p>	
R 0029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation and interview, the facility failed to ensure a resident was treated in a dignified manner related to the way he was spoken to by a staff member for 1 of 11 sampled residents. (Resident #11)</p>	R 0029	<p>-Housekeeper #1 no longer is employed at the community. -All staff will be required to attend training reviewing resident rights and treating residents in a dignified manner. The training will also include the community's procedure for reporting any allegations of residents being</p>	08/17/2016

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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R 0041 Bldg. 00	<p>Finding includes:</p> <p>On 6/27/16 at 2:03 p.m., Housekeeper #1 was overheard in the Main Dining Room speaking to Resident #11 in a loud, harsh tone. The Housekeeper said, "(Resident's name twice), I have told you before to stay out of there, you can't be in there messing around. You need to go to your room."</p> <p>The Administrator was observed to come out of her office at this time. The Administrator proceeded to walk past the staff member and the resident without intervening as the conversation was taking place. Interview with the Administrator at the time, indicated that she didn't hear the conversation since she was in her office. She indicated the resident had a habit of "messaging" with the carts and tables in the dining room to get a napkin to place over his walker. The Administrator indicated she would talk to the Housekeeper.</p> <p>410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident;</p>				<p>treated in an undignified manner. -All residents and their responsible party will be notified by the Administrator and/or Designee regarding residents being treated in a dignified manner. Any subsequent reported concerns will be addressed immediately by the Administrator and/or Designee. -Weekly, the Administrator will report any concerns utilizing the Weekly Report Form to the Regional Director of Operations for oversight. -Quarterly and ongoing, the Quality Assurance committee will review any concerns regarding residents being treated in an undignified manner to ensure compliance.</p>		

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	<p>(B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals.</p> <p>Based on record review and interview, the facility failed to investigate and respond to a grievance related to a missing necklace for 1 of 3 residents interviewed in a sample of 11. (Resident #4)</p> <p>Finding includes:</p> <p>On 6/28/16 at 9:48 a.m., interview with Resident #4 indicated she had a missing necklace just after Christmas 2015. She reported the missing item to the Business Office Director and CNA #1.</p> <p>Review of the Grievance logs with the Administrator indicated there was no documentation indicating a formal grievance had been made.</p> <p>Interview with CNA #1 on 6/28/16 at 10:30 a.m., indicated the resident reported to her she had a missing necklace just after Christmas and had reported the missing item to the Business Office. The CNA further indicated, after the conversation with the resident, she did not follow-up with the resident or report the allegation to the Administrator.</p>	R 0041	<p>-Administrator and/or Designee will meet with resident #4 regarding the report of a missing necklace and complete the Complaint/Issue Report. -All staff will be required to attend training reviewing the policy and procedure for reporting violations of resident rights including but not limited to missing items. -All residents and their responsible party will be educated on the community's policy and procedure on investigating missing items by the Administrator and/or Designee. Any subsequent reported missing items will be addressed immediately by the Administrator and/or Designee using the community's policy and procedure. -Weekly, the Administrator will report any concerns regarding missing items utilizing the Weekly Report Form to the Regional Director of Operations for oversight. -Quarterly & ongoing, the Quality Assurance committee will review any concerns regarding resident right violations including but not limited to missing items to ensure compliance with policy and procedures.</p>	08/17/2016			

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R 0092 Bldg. 00	<p>Interview with the Business Office Director on 6/28/16 at 10:53 a.m., indicated she did not have any documentation to indicate she had investigated the allegation. She further indicated she would have reported the allegation to the Administrator.</p> <p>Interview with the Administrator on 6/28/16 at 11:02 a.m., indicated she was aware of the missing necklace allegation and she believed she interviewed a housekeeper regarding the incident, however, she did not have any documentation regarding the allegation, and the facility did not have a policy regarding investigating grievances or concerns.</p> <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to</p>						

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	<p>familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure the local fire department was invited to attend a fire and disaster drill every six months. The facility also failed to ensure fire drills were performed on a consecutive monthly basis throughout the year. This had the potential to affect the 89 residents who resided in the facility.</p> <p>Finding includes:</p> <p>Review of the Fire Drill log on 6/27/16 at 9:15 a.m., indicated the local Fire Department was called to the facility on 1/8/15 for a fire drill. There were fire drills held on 2/11/15, 3/12/15, 8/31/15, 9/10/15, 10/1/15, 11/30/15 and 12/18/15. The facility had missed fire drills for the months of April, May, June, and July 2015. There was no documentation to indicate that the local fire department participated in any of the drills.</p>	R 0092	<p>1. A search was conducted for the missing fire drills. The Fire Department has been called and invited to attend the facility's next fire drill. 2. Fire drills will be completed per regulations for the remainder of 2016. All drills will be documented and stored in the Fire Drill Book. The Maintenance Director will report monthly to the Administrator and/or Designee during the Safety Committee Meeting when the drill has been completed. 3. The Administrator and/or Designee will assign the months for notifying the Fire Department semi -annually on the Fire Drill schedule and monitor for compliance. 4. The Fire Drill book will be reviewed monthly during Safety Committee Meeting by the Administrator and/or Designee. 5. Quarterly, the Fire Drill book will be reviewed at the Quality Assurance meeting to validate ongoing compliance.</p>	08/17/2016			

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R 0144 Bldg. 00	<p>Interview with the Maintenance Director on 6/28/15 at 11:42 a.m., indicated the local Fire Department had not been contacted or attended a fire drill since his employment in August 2015. He further indicated the facility did not have a Maintenance Director for several months prior to his employment. He had searched for the missing fire drills in the prior months, and did not find any documentation indicating the fire drills had been conducted.</p> <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 the facility was clean and in a state of good repair related to dryer vent filters filled with lint, dried food substances on railings, an accumulation of spider webs, dirty and</p>	R 0144	1) The Maintenance Director immediately checked and cleared all lint from dryer vents throughout each community laundry area. The Maintenance Director also immediately ensured that the dried food	08/17/2016			

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	<p>stained hallway and bedroom carpeting, dusty bathroom ceiling vents, chipped door frames, and marred walls and doors on 2 of 2 floors, stained chair upholstery, and marred chair arms and legs for 1 of 1 sitting areas and 2 of 3 dining rooms. (The First and Second Floors, The Memory Care Sitting Area, and the Main and Memory Care Dining rooms)</p> <p>Findings include:</p> <p>During the Environmental Tour with the Maintenance Supervisor on 6/28/16 at 1:30 p.m., the following was observed:</p> <ol style="list-style-type: none"> 1. First Floor <ol style="list-style-type: none"> a. The East laundry room had 3 of 3 dryer vents filled with lint. b. The wall outside of Room 118 was gouged and the door was marred. c. The hallway carpet of the entire first floor was dirty and stained. d. The door of Room 304 was marred. e. The door frame outside of Room 308 was chipped and marred. 2. Second Floor 		<p>substances were cleaned from railings. The Maintenance Director or designee will clean ceiling vents immediately. A management team cleaning day was scheduled immediately (and occurred on July 15, 2016) to clean common areas of dust and spider webs, (specifically the areas indicated of the SOD). The Administrator made arrangements for Stanley Steamer to professionally clean common area upholstered furniture, common area carpeting and resident apartment carpeting, as needed. 2) Magnetic reminder signs that state "Check dryer vents" will be placed on the door of each dryer in the community. The Administrator will in-service all staff regarding expectations for common area and resident apartment cleaning. The Maintenance Director will utilize a monthly cleaning schedule for ceiling vents to ensure ongoing compliance. The Administrator or designee will perform a daily walk through of the community on an ongoing basis to ensure continued compliance with cleanliness standards; reporting any findings to the Maintenance Director and/or Housekeeping staff for immediate correction. Bids to replace common area carpet will be processed with a plan to complete new carpet installation as soon as is practical. Bids to replace marred &soiled furniture</p>				

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	<p>a. The door frame outside of Room 210 was chipped.</p> <p>b. The door of Room 212 was marred.</p> <p>c. There was an accumulation of spider webs at the bottom of the window outside of Room 406, and there was a dried red food substance smeared on the handrail.</p> <p>d. The door of Room 407 was marred.</p> <p>e. The carpet in Room 414 was stained and dirty. The bathroom ceiling vent was dusty and the closet doors were marred.</p> <p>f. The carpet in Room 421 was stained and dirty. The bathroom ceiling vent was dusty.</p> <p>g. The door frame outside of Room 427 was marred.</p> <p>h. The door of Room 430 was marred.</p> <p>i. The door of Room 432 was marred.</p> <p>j. The carpet in Room 433 was dirty.</p> <p>3. The Memory Care Dining Room</p> <p>a. There were multiple chairs with marred legs and arms.</p>		<p>will be obtained with a plan to systematically replace marred& soiled furniture. The Administrator will send out a letter to residents/families reminding them that professional carpet cleaning is offered annually as part of their residency agreement at the time of their move in anniversary. Administrator or designee will visit 5% of resident apartments monthly on an ongoing basis to monitor for continued compliance. 3) The Maintenance Director or designee will monitor compliance by checking dryer vents in each laundry area twice per week for one month, then weekly for the following two months and bi-weekly thereafter. Maintenance Director or designee will correct marred walls, doors and door frames by cleaning, sanding and painting, as appropriate, (specifically the areas and apartments indicated on the SOD). Administrator or designee will visit 5% of resident apartments daily for one month to monitor for spots and stains, addressing findings with Maintenance Director of housekeeping staff for immediate correction, with a full house round completed by month's end. 4) During quarterly QA Meetings the Maintenance Director will bring audit sheets for review to ensure ongoing compliance. Quarterly the Quality Assurance Committee will review all audits and</p>				

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R 0148 Bldg. 00	<p>4. The Memory Care Sitting Area</p> <p>b. There were multiple chairs with stained upholstery and marred legs and arms.</p> <p>5. The Main Dining Room</p> <p>a. There were multiple chairs with marred legs and arms.</p> <p>There were 27 residents who resided on the Memory Care Unit (400's) and 72 residents who resided and used common areas throughout the remainder of the facility.</p> <p>Interview at the time with the Maintenance Supervisor indicated the above was in need of cleaning and/or repair.</p> <p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as</p>		monitoring forms to ensure ongoing compliance.				

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	<p>follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview the facility failed to maintain a safe and functional call system for 1 of 3 units throughout the facility. (The Memory Care Unit)</p> <p>Finding includes:</p> <p>On 6/28/16 at 1:35 p.m., the bedroom call cord was pulled in Room 412. The light illuminated on the wall panel at the bedside. At 1:45 p.m., the light remained illuminated on the panel, at this time no staff had entered the room to respond to the alert.</p> <p>At 1:47 p.m., the bedroom call cord was pulled in Room 414. The light illuminated on the bedside wall panel.</p> <p>At 1:49 p.m., the bedroom call cord was pulled in Room 433. The light</p>	R 0148	<p>1. The Maintenance Director was instructed to assess the function of the facility call system and it was found to be in working order.</p> <p>2. The Staff nurse/QMA for the Memory Care Unit (MCU) will be responsible for carrying the pager at all times when on duty. It will be the responsibility of the person carrying the pager to answer any bedroom pull cords activated on the unit.</p> <p>3. All MCU staff will be in-serviced on the protocol for answering bedroom pull cords.</p> <p>4. The MCU director or designee will monitor for compliance regarding the carrying of the pager by utilizing an audit tool on all three shifts. Three times weekly on rotating shifts the MCU director or designee will pull a bedroom pull cord to check on response times by the MCU staff and document utilizing the audit tool.</p> <p>5. Quarterly & ongoing, the audits of pull cord response times will be reviewed during the Quality</p>	08/17/2016			

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	<p>illuminated on the bedside wall panel. At this time the alerts for Room 412 and 414 remained unanswered.</p> <p>At 2:00 p.m., the alerts for the above rooms remained unanswered. Interview at the time with the Unit Manager indicated she was unaware the call system had been initiated. Continued interview indicated the facility used a paging system which alerted the nursing staff when the residents needed assistance. The page included the resident's name and room number. She further indicated the Memory Care Unit had one pager for the entire unit and the pager was located in the Nursing Station which was located behind two locked and secured doors. There was no nursing staff in the nursing station at this time. Once the nurse received the page it was her responsibility to communicate the alert to the remaining staff via walkie talkie. The pager was observed with the Unit Manager at this time, she indicated the alert for Room 421 had come through the pager, however, the alert for Rooms 414 and 433 had not come through the paging system.</p> <p>At 2:06 p.m., observation with the Unit Manager and the Maintenance Supervisor the call cord in Room 401 was pulled. At this time the pager alerted indicating</p>		Assurance meetings to ensure compliance.	

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	<p>the resident in Room 401 needed assistance, the pager also displayed an alert for Room 433. The alert for Room 414 still had not reached the pager at this time according to the Unit Manager, she indicated the paging system was not functioning properly and she would have to call downstairs to have the computer system restored, this sometimes happens when multiple alerts are sent at the same time.</p> <p>There were 27 residents who resided on the Memory Care Unit.</p> <p>Interview with the Administrator on 6/28/16 at 3:30 p.m., indicated the facility's paging system was equipped to receive multiple alerts at the same time and the pagers should receive multiple alerts sequentially.</p>			

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R 0187 Bldg. 00	<p>410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation and interview the facility failed to ensure the hot water temperatures in the resident's rooms were maintained between 100 and 120 degrees Fahrenheit for 2 of 2 Floors. (The First and Second Floors)</p> <p>Findings include:</p> <p>On 6/28/16 at 1:30 p.m., during the Environmental tour with the Maintenance Supervisor the following was observed:</p> <p>First Floor:</p> <p>a. The water temperature in Room 311 was hot to the touch. The digital thermometer provided by the Maintenance Supervisor read 125 degrees Fahrenheit.</p> <p>Second Floor:</p> <p>a. The water temperature in Room 211 was hot to the touch. The digital</p>	R 0187	<p>1. The Maintenance Director adjusted the maximum water temperature on the mixing valve the day of the survey observation. 2. The Maintenance Director will obtain water temperatures of all resident apartments within the facility, making adjustments as needed. 3. All water temperatures will be documented on the facility's temperature control log sheet. The Maintenance Director will be instructed that all apartment water temperatures must be checked and documented monthly. If the temperature is above 120 degree Fahrenheit, the temperature will be adjusted and checked again within 24 hours for compliance. 4. The temperature logs will be reviewed monthly at the Safety Committee Meeting by the Administrator and/or designee on an ongoing basis. 5. Quarterly, the temperature logs will be reviewed at the Quality Assurance meeting to ensure compliance on an ongoing basis.</p>	08/17/2016			

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R 0241 Bldg. 00	<p>thermometer provided by the Maintenance Supervisor read 129 degrees Fahrenheit.</p> <p>b. The water temperature in Room 214 was hot to the touch. The digital thermometer provided by the Maintenance Supervisor read 129 degrees Fahrenheit.</p> <p>Interview with the Maintenance Supervisor at the time indicated he was not aware of the safe temperature ranges and he did not keep a temperature log. There was no facility policy available.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure prescriptions were obtained in a timely manner to obtain refill medication for 1 of 7 records reviewed in the sample of 11. This resulted in the resident missing multiple doses of medications. (Resident #2)</p> <p>Finding includes:</p>	R 0241	<p>1. During the annual survey, the Health Services Director reviewed both resident's current medication list and medication supply to confirm that all medications were available for administration. 2. The Health Services Director queried her nursing staff regarding any resident's currently missing medications during the annual survey. No resident was</p>	08/17/2016

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	<p>The record for Resident #2 was reviewed on 6/27/16 at 10:35 a.m. The resident's diagnoses included, but were not limited to, dementia, anxiety, insomnia, and coronary artery disease.</p> <p>The June 2016 Physician's Order Summary (POS), indicated the resident had a current order for Ritalin (a medication used to treat attention deficit disorder) 10 milligrams (mg) by mouth twice a day.</p> <p>An entry in the Nursing Progress notes dated 5/15/16 at 11:00 a.m., indicated the resident's Physician was faxed because the resident's 12:00 p.m. dose of Ritalin was not available. The Physician was informed the Pharmacy needed an actual prescription for the controlled substance.</p> <p>On 5/16/16 at 9:00 a.m., the Physician was again faxed in regards to the Ritalin prescription and the resident's 8:00 a.m. dose of medication not being available.</p> <p>An entry in the Nursing Progress notes dated 5/17/16 at 11:05 a.m., indicated the Physician had called the facility and was notified of lab results for the resident. There was no documentation to indicate the Physician had been asked for a prescription for the Ritalin.</p>		<p>identified as missing medications at that time. 3. The Health Services Director will in-service all nursing staff responsible for reordering resident medication within the facility. The staff will be instructed to call on the phone, along with faxing a physician when a medication is missing, refused, or in need of a new script, until the medication is available. The resident's responsible party will also be notified. 4. The Health Services Director and/or Designee will audit the Medication Administration Records (MAR) weekly for compliance. 5. Quarterly & ongoing, the MAR audit will be reviewed at the Quality Assurance meeting to ensure continued compliance.</p>				

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	<p>On 5/18/16 at 12:00 p.m., the Physician was faxed in regards to the resident missing his 8:00 a.m. and 12:00 p.m. doses of Ritalin due to the medication not being available. At 12:20 p.m., the Physician came to the facility and wrote a prescription for the Ritalin.</p> <p>The May 2016 Medication Administration Record (MAR) was reviewed. The resident missed seven doses of the Ritalin between the dates of 5/15/16 and 5/18/16.</p> <p>A Physician's order dated 8/23/13 and identified as current on the June 2016 POS, indicated the resident was to receive a Nitroglycerin Patch (a patch used to prevent chest pain) 0.2 mg per hour, apply 1 patch topically every morning then remove 12 hours later in the evening.</p> <p>An entry in the Nursing Progress notes dated 6/13/16 at 2:15 p.m., indicated the resident's Physician was called related to a refill for the resident's Nitroglycerin patches. The Physician indicated that she would be in with the actual prescription. There was no further documentation on 6/13/16 to indicate the Physician brought in the actual prescription.</p>						

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R 0273 Bldg. 00	<p>Documentation on 6/14/16 at 10:00 a.m. and 6:00 p.m., indicated licensed staff had spoken with the Physician related to lab results for the resident. There was no documentation related to the prescription for the Nitroglycerin patches.</p> <p>On 6/14/16 at 4:00 p.m., documentation in the Nursing Progress notes indicated the resident's Power of Attorney (POA) was called to get an emergency supply of the Nitroglycerin Patches.</p> <p>The Physician came into the facility on 6/15/16, two days later, and wrote the prescription. The June 2016 MAR, indicated the resident missed three doses of his Nitroglycerin patch.</p> <p>Interview with the Wellness Director on 6/28/16 at 11:25 a.m., indicated follow up with the Physician should have been completed in a more timely manner so the resident would not have missed as many doses of his medication.</p> <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</p>			

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	<p>standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to serve food under sanitary conditions related to a large accumulation of dirt and debris under the storage racks in 2 of 2 storage rooms, 4 boxes of food in the walk in freezer open to air, moldy hamburger buns, and a server on the food line not changing her gloves after leaving the line and returning for 1 of 1 Kitchen observed. This had the potential to affect the 89 residents who received food from the Main Kitchen. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. On 6/27/16 at 9:10 a.m., the following was observed during the Brief Kitchen Sanitation tour with the Dining Service Director:</p> <p>a. There was a large accumulation of dirt and debris under the storage racks in two dry storage rooms.</p> <p>b. Their were 4 open boxes of food (onion rings, egg patties, garden veggie patties, and beef patties) in the walk in freezer open to air.</p> <p>c. There was a bag of moldy hamburger buns.</p> <p>2. On 6/28/16 at 11:58 a.m., the</p>	R 0273	<p>1. All food service areas along with all areas pertaining to food storage and preparation will be in compliance with sanitation and safe handling practices. 2. Staff having dietary service responsibilities will be in serviced on proper sanitation and safe handling practices in all areas pertaining to food storage, preparation, and service. 3. Weekly, the Food Service Director or designee will audit for compliance with sanitation and safe handling practices. This audit will be completed on a rotating basis for each time of meal service. 4. Quarterly and ongoing, the Quality Assurance committee will review the audit findings of the food service director to validate continued compliance.</p>	08/17/2016			

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	<p>following was observed during the Full Kitchen Sanitation tour with the Dining Service Director.</p> <p>a. During the lunch service on 6/28/16 at 11:55 a.m., Dietary Aide #1 was observed on the food service line, she was handling the prepared plates for the residents. The Aide was observed leaving the service line, she walked to the stand up refrigerator, retrieved items with her gloved hands, and returned to the line without changing her gloves. At that time, the Dining Service Director indicated staff were expected to change their gloves after leaving the food service line.</p> <p>Interview with the Dining Service Director on 6/28/16 at 12:02 p.m., indicated all of the above was in need of cleaning and/or repair.</p>			