

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 06/16/2016
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NAME OF PROVIDER OR SUPPLIER  JEWEL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 607 VIRGINIA AVE MADISON, IN 47250
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 15, and 16, 2016</p> <p>Facility number: 004352 Provider number: 004352</p> <p>Census bed type: Residential: 26 Total: 26</p> <p>Sample: 7</p> <p>These state finding are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 34233 on June 21, 2016.</p>	R 0000	<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 residents, or any employees, or agents involved in the conclusions set forth in these allegations by the survey agency. The Jewel House respectfully requests paper compliance for this survey.</p>	
R 0215  Bldg. 00	<p>410 IAC 16.2-5-2(b) Evaluation - Deficiency</p> <p>(b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>requires is within the range of personal care and supervision provided by a residential care facility.</p> <p>Based on record review and interview, the facility failed to ensure subsequent assessments after the initial admission assessment were completed in a timely manner. This deficient practice affected 1 of 7 residents reviewed for semi-annual assessments. (Resident R#4)</p> <p>Finding included:</p> <p>Review of the clinical record for Resident R#4 on 6/15/16 at 11:00 a.m., indicated the resident had diagnoses which included, but were not limited to: atrial fibrillation, diabetes, hypertension, anemia, renal failure and a pacemaker.</p> <p>The last Level of Care Assessment completed for Resident R#4 was dated 5/6/15 with the next review to be completed on 11/1/15. A new problem to the assessment was added on 10/27/15 after a resident had experienced a fall. The 11/1/15 and the 5/1/16 Semi-Annual Assessments were noted to be missing. The next assessment was not completed until 6/1/16 when the resident experienced a change in condition.</p> <p>During the final exit conference on 6/16/16 at 12:15 p.m., the Wellness</p>	R 0215	<p>Citation #1 R215 410 IAC 162-5-2(b) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 100% audit of all assessments have been completed to ensure the assessments for all resident's are up to date. 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; An Assessment Due Date report was executed to ensure no assessments will be missed and policy is followed. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The assessment report will be updated and reviewed on admission and discharge of all residents. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Daily x 10 days weekly x 2 weeks Assessment due dates will be reviewed each day in morning meeting and monthly at Quality Assurance meeting The Health &amp; Wellness Director is responsible or designee if they are unavailable.</p>	06/17/2016

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R 0217 Bldg. 00	<p>Director indicated that when she took over the position in February 2016, she noticed several residents were missing in the computer and never had their semi-annual assessments completed when they were due.</p> <p>On 6/16/16 at 10:38 a.m., the Administrator presented a copy of the facility's current policy titled "Level of Care Fee Charges and Reconciliation". Review of this policy at this time included, but was not limited to: "...1) Unless specified by state regulations, all residents are assessed/evaluated a minimum:...D) No greater than every 6 months..."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident</p>						

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	<p>may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure a Resident Service Plan on a newly admitted resident was developed and discussed with the resident with signature by the resident after review. The facility also failed to ensure the Service Plan was readily accessible to the staff responsible for caring for the resident. This deficient practice affected 1 of 7 residents reviewed for Service Plans (Resident R#1).</p> <p>Finding included:</p> <p>Review of the clinical record for Resident R#1 on 6/15/16 at 9:40 a.m., indicated the resident was admitted to the facility on 5/21/16 and had diagnoses which included, but were not limited to: hypertension, osteoporosis, coronary artery disease, and history of a back fracture due to a fall.</p>	R 0217	R0217, Citation #2 410 IAC 162-5-2(e)(1-5) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Health & Wellness Director completed 100% audit of resident agreements to assure all agreements were signed and dated by resident and/or responsible party. 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 Health & Wellness Director implemented a system to ensure all assessments are reviewed and signed by the resident and responsible party if applicable per policy and procedure Residents were reviewed with no other findings. In the event the responsible party is required to sign the assessment it will be reviewed via a phone conversation and	06/17/2016			

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	<p>On 6/16/16 at 9:15 a.m., a request to the Wellness Director was made for the resident's Service Plan for review. At 9:30 a.m., the Wellness Director indicated she did have it completed and printed out the resident's Service Plan with a date of 6/13/16. The Service Plan was lacking a signature and date by the person who completed it, as well as a signature and date as to when it was discussed with the resident.</p> <p>On 6/16/16 at 10:38 a.m., the Administrator presented a copy of the facility's current policy titled "Level of Care Fee Charges and Reconciliation". She indicated this was what the facility used as a policy for Service Plans.</p> <p>Review of this policy at this time included, but was not limited to: "...1) Unless specified by state regulations, all residents are assessed/evaluated a minimum:...B) Initial after move in....5) Post Assessment/evaluation the ED along with the ALD (Assistant Living Director)/Designee are to meet with the resident/RP/POA (Responsible Party/Power of Attorney) to discuss the current corresponding assessment/evaluation/LOC (Level of Care) charge. 6) This meeting/discussion MUST BE completed no more than 5</p>		<p>documented as to the date of the conversation. A copy will be placed within the chart for reference with the original sent to the responsible party for signature and a self addressed envelope for return to the community. The signed copy will then be placed in the resident record. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Health &amp; Wellness Director was re-educated to the policy and procedure regarding the assessments and ensuring the Service Plan is readily accessible to the staff responsible for caring for the resident How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; The Health &amp; Wellness Director or designee will be responsible to perform a random ongoing monthly review of the resident Assessments and Service Plans as to accuracy and completion of the assessment, reviewed with the resident and/or responsible party with appropriate signatures from the resident and/or responsible party indicated within our policy and procedure.</p>				

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R 0356 Bldg. 00	<p>(five) days post assessment/evaluation. The Cost of Care Communication form should be signed by all parties..."</p> <p>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 ensure the files contained a resident photo; hospital preference; name and phone number of physician; code status; and/or had the signed code status form. This deficient practice affected 7 of 26 Resident Emergency files reviewed. (Resident R#1, R#2, R#6, R#8, R#9, R#10, and R#11).</p>	R 0356	R0356, 410 IAC 16.2-5-81 (1-8) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Administrator and/or designee completed 100% audit of the emergency binder. All missing information was added and is 100% updated as of 6/20/2016. How the facility will identify other residents having the potential to be affected by the	06/20/2016

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	<p>Findings include:</p> <p>Review of the Emergency Resident Files binder on 6/15/16 at 10:30 a.m. indicated the following items were missing:</p> <ol style="list-style-type: none"> <li>1. Resident R#1 was admitted to Apartment 114 on 5/21/16. A picture, hospital preference, or the name and phone number of the primary physician could not be located on the sheet.</li> <li>2. Resident R#2 was admitted to Apartment 118 on 10/19/15. On 9/30/15, the family made a DNR (Do Not Resuscitate) Declaration prior to admission to the facility. A copy of this declaration was in the sleeve with a note which indicated "Original out for signature." The original form had never been returned, nor had the physician signed the copy either.</li> <li>3. Resident R#6 was admitted to Apartment 105 on 7/31/14. No hospital preference was listed on the emergency sheet.</li> <li>4. Resident R#8 was admitted to Apartment 104. No hospital preference was designated.</li> <li>5. Resident R#9 was admitted to Apartment 106 on 2/21/16. A picture and the DNR form were missing.</li> </ol>		<p>same deficient practice and what corrective action will be taken; The Executive Director and/or designee will be responsible for updating the emergency binder upon admission, move out and any time there is a change in resident preferences. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; The Executive Director educated the management team on when to update the emergency binder and what must be documented within the binder. How will the corrective action(s) will be monitored? This will be reviewed at each morning meeting and monthly at QA meeting to ensure updates have occurred. The Executive Director/or designee will be responsible for updating the emergency binder.</p>	

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R 0414	<p>6. Resident R#10 was admitted to Apartment 123 on 4/23/16. A picture was missing as well as a Code Status designation.</p> <p>7. Resident R#11 was admitted to Apartment 113 on 5/16/16. A hospital preference was not designated, nor was the DNR form in the emergency file.</p> <p>At 11:25 a.m., the facility concierge was observed to add the missing pictures for Residents R#1, R#9 and R#10. The code status form was also added for R#10.</p> <p>In an interview with the Business Office Manager at 12:55 p.m., she indicated the Emergency files were updated upon admission, move out and any time there was a change. She also indicated there was no specific time frame or on a regular basis when updating the emergency files.</p> <p>During the final exit conference on 6/16/16 at 12:20 p.m., the Administrator indicated that if no hospital preference was listed, then the facility would just send the resident to the local hospital.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency</p>				

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Bldg. 00	<p>(k) 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>Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were maintained related to food and drink service to 2 of 22 residents (Residents R #1 and R #12) observed in the Main Dining Room.</p> <p>Findings include:</p> <p>During the lunch meal service on 06/15/16 between 11:55 a.m., and 12:25 p.m., 22 resident were observed sitting in the Main Dining Room. CNA (Certified Nursing Assistant) # 1 was observed serving a lunch plate to Resident R #13. The CNA patted the shoulder of Resident R #13 in an attempt to wake her. The CNA then walked over to the kitchen door, where LPN (Licensed Practical Nurse) # 1 handed her two plates of food. The CNA walked over to Resident R #12 and Resident R #1, and placed the plates of food on the table in front of the residents, who began eating from the plates. The CNA did not use hand sanitizer or perform handwashing before handling the resident's plates.</p> <p>The Concierge (Receptionist) and the Business Office Manager attempted to</p>	R 0414	<p>R414, 410 IAC 16.2-5-12(k) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; An in-service for all staff was instituted immediately. Some staff were on vacation so in-service was completed on remainder of staff on 6/24/16. 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; Two managers will be required to be in the dining room during meal times to ensure employees are understanding the importance of hand washing. This will occur daily x 2 weeks, weekly x3 and monthly x 5 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; All staff demonstrated hand washing to Administrator and/or designee and indicated understanding when and how often hand washing should occur. Staff members also voiced understanding of policy and procedure for hand washing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; Random hand washing will be</p>	06/24/2016

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	<p>ask CNA # 1 to leave the dining room area, but LPN # 1 indicated the CNA could not leave the dining room once the meal service had begun. The Concierge was given hand sanitizer by the Business Office Manager and she brought it into the dining room and handed it to CNA # 1. The CNA applied the hand sanitizer, and continued to serve the lunch meal.</p> <p>On 06/16/16 at 10:10 a.m., during an interview with the Concierge, she indicated during the lunch meal service on 06/15/16 she observed the CNA handling plates and she needed to use hand sanitizer.</p> <p>On 06/16/16 at 10:12 am., during an interview with the Business Office Manager, she indicated during the lunch meal service on 06/15/16, CNA # 1 needed to use hand sanitizer because she touched the back of the chair of a resident.</p> <p>During an interview on 06/16/16 at 10:20 a.m., the DON (Director of Nursing), indicated on 06/15/16, CNA # 1 was observed to touch the shoulders of a resident and pass plates, without using hand sanitizer. The DON also indicated staff need to use hand sanitizer at least when passing plates and wash their hands after 3 residents are served.</p>		<p>conducted daily x 2 per day for two weeks. Weekly x3 per week for three weeks. Monthly x 5 months thereafter, upon hire and PRN as indicated. Hand washing will also be reviewed monthly in Q &amp; A meeting.</p>	

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	<p>On 06/16/16 at 11:32 a.m., the Business Office Manager provided a copy of CNA # 1's Certificate of Completion Infection Control, dated 06/01/16, with one hour of online training.</p> <p>The DON provided a copy of the facility's Hand Washing policy on 06/16/16 at 10:24 a.m., which indicated, but was not limited to, the following: "All staff and residents are instructed on hand washing technique and asked to perform a return demonstration during the outbreak...9. Hand washing is done as follows: After...Handling soiled clothing or linens...Before...Eating, Preparing food, Serving food, Providing care to the resident...Procedure...Hand washing is the most important method of infection control...Hands must be washed between direct contact with any residents..."</p>			