

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 25, 26 and 27, 2016</p> <p>Facility number: 004168 Provider number: 004168 AIM number: N/A</p> <p>Residential census: 49</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 14454 on June 5, 2016.</p>	R 0000		
R 0092 Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(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:</p> <p>(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</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.

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>the building is not required. Drills shall be conducted quarterly on each shift to 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 conduct or attempt to conduct a fire and disaster drill every 6 months with the local fire department.</p> <p>Finding includes:</p> <p>A review of all fire drills for the past year was conducted on 5/26/16. There was one occurrence, on 5/15/16, when the fire department was on scene to assist with resetting the fire alarm system.</p> <p>During an interview, on 5/27/16 at 10:20 A.M., the Executive Director (ED) indicated, on 5/15/16, the local fire department was in the building due to a broken toilet flooding a resident's room and the fire alarm went off. The ED indicated the fire department evaluated the situation and assisted the staff with resetting the fire alarm system. The ED</p>	R 0092	<p>No residents were impacted by the lack of the fire department's presence at the monthly drills or actual alarm events. While fire department responders were present in the building at least once during the past year, they were not there for the purpose of observing a fire drill.</p> <p>All residents have potential to be impacted by the lack of coordinated rescue efforts between community emergency responders and our staff. The Goshen Fire Department was contacted on 6/13/16 for their involvement in the earliest drill they could participate in. This is now scheduled for July 13, 2016, at 10:00 a.m.</p> <p>The Plant Operations Director will contact the Goshen Fire Department every six months to schedule their involvement in a planned fire drill. The Plant Operations Director will document attempts to schedule a coordinated drill as well as the</p>	06/30/2016

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R 0118 Bldg. 00	<p>indicated no other fire and or disaster drills were completed in conjunction with the local fire department.</p> <p>On 5/27/16 at 1:55 P.M., the Director of Nursing provided a policy titled "Drills," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...4. As a minimum, one (1) drill annually, on each shift, will be conducted with the assistance of our fire department's fire prevention bureau and/or such agencies having jurisdiction over such matters...."</p> <p>410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) had a current Indiana certification.</p> <p>Finding includes:</p>			R 0118	<p>occurrence of such coordinated drills.</p> <p>The fire drill schedule as well as the effectiveness of fire and evacuation drills will be reviewed and documented on a monthly basis for six months, then on a quarterly basis, at the monthly Quality Assurance Committee meeting. The Executive Director will ensure that contact with the Fire Department for coordinated drills has been attempted and documented.</p> <p>CNA #17 was taken off the schedule for any future shifts in the CNA role on May 28, 2016, and worked no additional shifts since then. Her employment was terminated on June 10, 2016, due to her infrequent PRN shift availability per company</p>		06/30/2016

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>On 5/26/15 a review of the employee records was conducted of all licensed/certified employees currently employed by the facility. The record indicated CNA #17 was hired on 7/25/15. A CNA certification for CNA #17 was not included in the facility's license binder.</p> <p>During an interview, on 5/27/16 at 9:50 A.M., the Executive Director indicated CNA #17 had a CNA certification in the State of Illinois and the business office never followed up to make sure she had an Indiana CNA certification. He provided a copy of her Illinois CNA certification, dated 6/21/13.</p> <p>During an interview, on 5/27/16 at 1:45 P.M., the Director of Nursing (DON) indicated the CNA had worked 51.67 hours after her 120 days (days allowed to obtain the Indiana CNA certification). The DON indicated CNA #17 was hired as an as needed CNA because she was currently working on her RN (Registered Nurse) license. The DON indicated after she passed her basic nursing classes she was qualified to work as a CNA.</p> <p>According to the Administrative Standards for the Indiana State Department of Health Nurse Aide</p>		<p>policy and her recent move back to Illinois.</p> <p>All Current CNAs certifications have been audited by the Director of Assisted Living or a designee to assure every employee is currently certified in the State of Indiana. Upon hire the Director of Assisted Living will print off from the ISDH website a copy of the certificate from the State of Indiana for each new CNA and file it in the license book.</p> <p>A monthly audit will be conducted by the Director or a designee of the CNAs newly hired for the month and reported in the Quality Assurance Committee meeting. An action plan will be put into place to address any finding other than 100 % compliance. We will perform this for compliance through September 30,2016.</p>	

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R 0241 Bldg. 00	<p>Training Program, dated January 15, 2014, Standard 7 indicated ..." Out of state nurse aides who are current and in good standing on another states's Nurse Aide Registry may be permitted to challenge the ISDH nurse aide training program through reciprocity. These individual will be required to take the 100 question written examination, and the optional skills final examination, at the discretion of the hiring facility...."</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. Based on record review and interviews, the facility failed to ensure there was documentation in the medical record to ensure there was nurse approval, for as needed (PRN) medications administered by QMAs (Qualified Medication Aides) for 1 of 7 residents reviewed. (Resident #3) The facility also failed to ensure</p>	R 0241	<p>A. QMA PRN medication administration without nurse documentation R resident (#3) was identified who received a PRN medication administered from a facility QMA (Qualified Medication Aide) without having the documentation in the medical record to ensure</p>	06/30/2016

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>physician orders were obtained for administering medications upon admission to the facility for 1 of 7 residents reviewed medication orders. (Resident #2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 05/25/16 at 2:00 P.M. Resident #3 was admitted to the facility on 05/13/16 with diagnosis, including but not limited to: arthritis.</p> <p>The physician's orders for medication upon admission, included an order for Tylenol 325 mg (milligrams) four times a day, as needed for pain.</p> <p>The Medication Administration Record for May 2016 for Resident #3 indicated she received 325 mg of Tylenol for pain, administered by a Qualified Medication Aide (QMA) on 05/16/16 at 7:42 P.M., 05/21/16 at 11:30 P.M., and 05/22/16 at 6:30 P.M. There was no documentation regarding which licensed nurse had been contacted regarding the need for medication and had granted permission for the QMA to administer the medication.</p> <p>During an interview, on 05/25/16 at 2:45 P.M., QMA/Medical Records Staff</p>		<p>there was a Nurse's approval. Residents may receive PRN medications from a QMA but require documentation on the part of the Nurse and the QMA that the QMA has talked to the Nurse, reviewed why the medication should be given and that the Nurse has advised the QMA to administer the PRN medication. QMAs and Nurses were in-serviced (Addendum E) on June 15, 2016 by the Director of Assisted Living (RN) of the PRN medication procedure, "QMA Protocol for Administration of PRN Medications": 1. PRN medications may be administered by a QMA only upon authorization by a Nurse. 2. Authorization from a Nurse is required for each administration of a PRN medication. 3. All contacts with a Nurse not on the premises shall be documented in the progress notes of the electronic record for that resident indicating the time and date of the contact. 4. The contacted Nurse will also enter in a progress note for the resident verification of permission being given for the administration of the PRN medication, the name of the QMA and why the medication is being given. 5. Follow-up QMA documentation in a timely manner of the administration of a PRN medication is required to assess effectiveness of the PRN medication upon the resident. The procedural compliance will be monitored as part of the monthly</p>				

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>Member #10 indicated the nurse authorization for PRN medications was to be documented in the nursing progress notes of the electronic record. QMA #10 looked at all of the nursing progress notes since the resident had been admitted and indicated there was no documentation regarding nurse authorization on the days</p> <p>During an interview on 05/26/16 at 10:00 A.M., the Director of Nursing (DON) indicated she could not locate documentation regarding nurse authorization for any of the Tylenol's given by the QMAs.</p> <p>On 05/12/16 at 3:12 P.M., the Administrator provided the facility policy and procedure, titled "Assisted Living Guidelines Medication Administration," dated December 2010, and indicated this was the policy and procedure currently used by the facility. The policy and procedure indicated "...g. PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication...i. All contacts with a nurse or physician not on the premises for authorization to administer PRN's shall be documented in the nursing notes, indicating the time and</p>		<p>QA audit conducted by the Director of Assisted Living and will be continued for 90 days. The Matrix computer system report, "PRN Administration History Report" will be used for this audit with results recorded on the QA Compliance Report Tool (Addendum A)with an additional action plan put into place by the Director of Assisted Living for any audit that is not at 100%.</p> <p>B. Lack of Admitting Orders for Medications</p> <p>A physician order for Resident #2 was obtained on June 14, 2016 for the medications that the resident was receiving without a documented physician order. The facility with each new admission will obtain Physician orders for medications and treatments prior to or at admission for all non-independent residents who receive nursing assistance. All non-independent residents will have a monthly medication record sent to their physician to assure they have a signed, current, and verified list of medications they are to be receiving on record.</p> <p>The Director of Assisted Living or a designee will conduct an audit of newly admitted residents' charts to verify current medication and treatment orders have been received on admission. All audits will be reviewed monthly at our Quality Assurance Committee meeting for the next 90 days with results recorded on the QA</p>				

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>date of contact..."</p> <p>2. On 5/27/16 at 9:00 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 1/12/16. The resident's diagnoses included, but were not limited to: Alzheimer's disease, hypertension and memory loss.</p> <p>The clinical record contained no orders for the resident's medications.</p> <p>The clinical record indicated the resident was not self-administering her medications upon admission and received the following medications: *aspirin 81 milligrams (mg) daily (Nonsteroidal Anti-inflammatory drug), *bystolic 10 mg daily (Antihypertensive), *calcium +vitamin D 1250 mg/200 units daily (dietary supplement), *donepezil 10 mg daily (Anti-Alzheimers drug), *fluoxetine 10 mg daily (Antidepressant), *losartan 50 mg daily (Antihypertensive), *vitamin D3 5,000 units daily (dietary supplement).</p> <p>During an interview, on 5/27/16 at 11:10 A.M., QMA #10 indicated there were no medication orders for Resident #2 upon admission. QMA #10 indicated she used a medication list from an office visit the Resident had at a (name of a medical</p>		Compliance Report Tool (Addendum A). Additional action plan will be put into place to address any audit that is not at 100% and be followed up in the QA Committee meetings.	

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R 0273 Bldg. 00	<p>facility), dated 10/27/16.</p> <p>On 5/27/16 at 1:46 P.M., the Director of Nursing provided a policy titled, "Assisted Living Guidelines - Physician's Orders", dated December 2010 and indicated the policy was the one currently used by the facility. The policy indicated "...1. Physician orders for medications and treatments shall be obtained prior to or at admission...."</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 standards, including 410 IAC 7-24.</p> <p>Based on observation, record review, and interviews the facility failed to ensure food was prepared and served in a sanitary manner in 1 of 1 kitchens. This potentially affected 49 of 49 residents who consumed food in the facility.</p> <p>Findings include:</p> <p>During the kitchen sanitation tour, conducted on 05/25/16 between 1:35 P.M. to 1:50 P.M. with the Food Service Supervisor (FSS), Employee #11, the</p>	R 0273	<p>A. Kitchen Sanitation</p> <p>Corrective actions to sanitize soiled equipment included scheduled contract cleaning of the vent fire hood on 6/20/16, deep cleaning of the inside and outside of the convection ovens, and cleaning of the grill surface and stove-top burners on 6/15/16. Uncovered dishes on the dessert cart in the walk-in refrigerator were covered and the open bag of frozen broccoli in the freezer was placed in a zip-lock bag on 5/27/16.</p> <p>While no residents were adversely</p>	06/30/2016

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>following was noted:</p> <ul style="list-style-type: none"> -Two small wheeled metal carts with trays of cakes and donuts on small dishes were observed uncovered in the walk in refrigerator. There were shelving and food items stored on shelves above and adjacent to the carts. -A heavy build up of a yellow brown greasy substance was observed on the inside doors of both convection ovens and a build up of burnt food spills were observed on the bottom of both ovens on foil covered drip pans. -The outside top of the convection oven, used to store mitt type pot holders, was observed to have a large build up of a dusty/greasy substance. -The vent hood (located above the convection ovens, open grill and regular stove and burners) was observed to have two large yellowish/brown colored drips and greasy looking material and dust visible on the sides and back of the hood. The FSS, Employee #11 indicated the deep cleaning should have been done by 05/16/16. -The charbroil grill, located between the convection oven and regular oven had a large build up of food debris on the grates. There were large greasy black 		<p>impacted by the less than sanitary equipment, preparing food in sanitary conditions is necessary at all times for the wellbeing of all our residents, guests and staff. The cleaning schedule for kitchen equipment was reviewed and assignments clarified with kitchen staff on June 16, 2016.</p> <p>The Director of Food Service will monitor cleaning of kitchen equipment on a weekly basis as well as spot checks throughout the week utilizing the "Dietary 2016 Annual Survey Audit Sheet" (Addendum B). Extra cleaning will be scheduled off-shift if unable to maintain during normal operating hours.</p> <p>The Executive Director will audit kitchen equipment cleanliness on a weekly basis for four weeks, then monthly, to ensure that cleaning of equipment is occurring as needed to ensure a sanitary food preparation environment. These audits will be reviewed at the monthly Quality Assurance Committee on a monthly basis for 6 months and then on a quarterly basis thereafter, with results recorded on the QA Compliance Report Tool (Addendum A).</p> <p>Completion date: June 30, 2016</p> <p>B. Unsanitary use of Gloved Hands Cooks #12, #13 & #14 were observed touching various objects and then handling food or clean dishes without changing gloves when there was potential for contamination due to what had</p>				

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>areas observed on the side of the convection oven.</p> <p>-The burners on the gas stove top had a large build up of food debris on them. There were also food crumbs and a greasy dusty substance observed on the metal shelf above the stove top.</p> <p>-A shiny black substance approximately 1/2 inch wide and 1 foot long was observed on the wall behind the dirty side of the dishwasher. During an interview, on 05/26/16 at 11:30 A.M., the FFS indicated the black substance was right along a strip of caulking which had been placed between the dishwasher shelving and the back wall to prevent water from running down the wall.</p> <p>-An open bag of frozen broccoli was in the deep freezer. The FSS, Employee #11, indicated most of the opened food items were to be placed inside a Ziploc plastic bag.</p> <p>2. During the observation of the serving of the noon meal, conducted on 05/26/16 between 11:30 A.M. 12:00 P.M. the following was noted:</p> <p>-Cook #12 was serving goulash in bowls. She donned gloves, then touched paper menus with both gloved hands, touched the handles of a ladle and then reached to</p>		<p>been touched. While there is no evidence of any negative resident outcomes associated with this finding, proper sanitary technique is critical to lessen the opportunity for contamination of any kind. All residents who eat foods prepared or served in unsanitary conditions could experience adverse outcomes. The Director of Food Services, certified in ServeSafe training, in-serviced Food Service staff on June 16, 2016, (Addendum F) to offer training on proper use of gloves and the limitations of perceived "glove safety" in accordance with 410 IAC 7-24-246 which states if used, single-use gloves shall be:</p> <ol style="list-style-type: none"> 1. Used only for one task, such as working with ready-to-eat food or with raw animal food; 2. Used for no other purpose; and 3. Discarded when damaged or soiled, or when interruptions occur in the operation <p>Compliance will be monitored by the Director of Food Service by way of random checks at both the noon and evening meal service times, utilizing the "Dietary 2016 Annual Survey Audit Tool" (Addendum B), which will be reviewed at the monthly Quality Assurance Committee on a monthly basis for 6 months and then on a quarterly basis thereafter, with results recorded on the QA Compliance Report Tool (Addendum A).</p>	

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R 0275 Bldg. 00	<p>grab bowls touching the inside of the bowls with her contaminated gloved hands.</p> <p>-Cook #13 was serving vegetables during the noon meal. She donned gloves and touched the paper menus with both hands. She was observed touching the handle of a large spoodle with her gloved hands and then reached into a plastic container and grabbed a parsley garnish with her contaminated gloved hand, she then placed the garnish on the plates of food before serving the residents.</p> <p>-Cook #14 was preparing various food items. She had donned gloves and touched the paper menus, handles of spatulas, knives, pans, the outside of containers of broth mix and then she handled lemons, baked sweet potatoes and a grilled cheese sandwich with her contaminated gloved hands.</p> <p>410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.</p>			

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>Based on observation, record review and interview, the facility failed to ensure a diet order was obtained upon admission to the facility for 1 of 7 residents reviewed for admission diet orders. (Resident #2)</p> <p>Finding includes:</p> <p>On 5/27/16 at 9:00 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 1/12/16. The resident's diagnoses included but were not limited to: Alzheimer's disease, hypertension and memory loss.</p> <p>The clinical record contained no admission orders for the resident's diet.</p> <p>During an interview, on 5/27/16 at 11:10 A.M., QMA (Qualified Medication Aide) #10 indicated there were no diet orders for Resident #2 upon admission.</p> <p>On 5/27/16 at 11:20 A.M., the Director of Nursing provided a policy titled, "Assisted Living Guidelines - Nursing/Dining Services Communication," dated December 2010, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Upon admission the admitting nurse shall obtain a diet order</p>	R 0275	<p>The clinical record of Resident #2 has been updated to include a current diet order as of June 15, 2016. While each resident considers this "their home" and has the right to choose what they will and will not eat, all residents admitted still require a diet order to be compliant with regulations. The facility has audited every resident to assure each clinical record contains a diet order, requesting a diet order for any resident who does not have one (Addendum C).The admitting nurse shall obtain a diet order from the attending physician, if not included in the original orders, for each resident upon admission. The Nursing staff was in-serviced (Addendum D) on this policy on June 15, 2016, which states:1. Upon admission the admitting nurse shall obtain a diet order from the attending physician.</p> <p>2. The admitting nurse shall provide dining services with the completed Dietary Communication Form.</p> <p>3. Dining Services shall communicate questions/concerns back to the nursing department.</p> <p>4. Diet will be provided per physician order and resident preference. 5. Nursing shall communicate any further changes in the resident's diet per</p>	06/30/2016			

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R 0410 Bldg. 00	<p>from the attending physician...."</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interviews, the facility failed to ensure 2 of 7 residents reviewed, had a tuberculin skin</p>			R 0410	<p>the communication form. The Director of Assisted Living or a designee will conduct a monthly audit of all new admission records to assure they contain a diet order, obtaining one if none is present. All Audits will be reviewed monthly at QA Committee meeting for the next 90 days with results recorded on the QA Compliance Report Tool (Addendum A), with an additional action plan put into place for any finding under 100%.</p> <p>The facility failed to ensure that the two identified residents received a timely skin test upon</p>		06/30/2016

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 05/27/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>test completed upon admission. (Resident #3 and #2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 05/25/16 at 2:00 P.M. Resident #3 was admitted to the facility, on 05/13/16, from a skilled nursing facility. The Corporate Nurse RN (Registered Nurse) #15 reviewed the electronic record and an incomplete Mantoux (tuberculin skin test) testing form, dated 04/29/16, was noted in the record. The Corporate Nurse indicated she would check with the facility Director of Nursing regarding the Mantoux testing for Resident #3.</p> <p>On 05/26/16 at 10:10 A.M., the Director of Nursing provided a completed Mantoux testing form for Resident #3, dated 04/29/16. The form indicated LPN (Licensed Practical Nurse) #16 had administered the Mantoux skin test to Resident #3 on 04/29/16, and read the test on 05/01/16. When asked about the dates, since the Resident was not admitted to the facility until 05/13/16, the DON indicated the resident was at the skilled nursing facility "across the street" and her staff worked at both places sometimes.</p>		<p>admission. These residents have had annual mantoux skin tests done more recently in May, 2016, and show no signs or symptoms of infection. While no residents were adversely impacted by lack of an admitting and/or two-step TB skin test, all newly admitted residents must be shown to be free of infectious disease upon admission and at least annually thereafter. All resident records were audited to determine whether there were additional residents who were not given the TB skin test within the regulatory guidelines. QMAs and Nurses were in-serviced (Addendum G) on June 15, 2016 by the Director of Assisted Living (RN) on policy and procedure for mantoux testing with new admissions. The Director of Assisted Living will conduct an audit of newly admitted residents' charts to ensure that nurses are providing the initial TB skin test and follow-up two-step test, when warranted, on a timely basis. This audit will be reviewed monthly at our Quality Assurance Committee meeting for the next 90 days with results recorded on the QA Compliance Report Tool (Addendum A). Additional action plan will be put into place to address any audit that is not at 100% and be followed up in the QA Committee meetings.</p>				

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>A Mantoux skin test, completed by the skilled nursing facility was provided. The form indicated a Mantoux test had been completed on 04/12/16. During an interview, on 05/26/16 at 1:15 P.M., the Director of Nursing indicated Resident #3 was a resident at the skilled nursing facility from 04/12/16 - 05/13/16.</p> <p>During an interview, on 05/26/16 at 1:28 P.M., LPN #16 indicated she had not ever worked at the skilled facility where Resident #3 had been on 04/29/16. She indicated she had never went to the long term care facility to administer a Mantoux test for Resident #3. LPN #16 indicated she was not aware her name had electronically been documented on the Mantoux form.</p> <p>On 05/26/16 at 3:12 P.M., the Administrator provided the facility policy and procedure, titled "Assisted Living Guidelines Chest X-ray and Mantoux Testing," dated December 2011 and revised on 10/2012, and indicated ththis was the one currently used by the facility. The policy and procedure indicated the following: "1. Residents should have a Mantoux PPD [purified protein derivative] test: ...b. Indiana - within 3 months of admission if proof of previous testing or upon admission...2. Mantoux testing should be a two step process</p>			

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 05/27/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENCE AT WATERFORD CROSSING THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>unless there has been continous annual testing following the two step process...."2. On 5/27/16 at 9:00 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 1/12/16. The resident's diagnoses included but were not limited to: Alzheimer's disease, hypertension and memory loss.</p> <p>A consent form, titled "Tuberculin Skin Test (PPD Mantoux)" indicated the resident had a TB (Tuberculin) skin test on 11/22/15 and on 1/12/16. There was no second step test documented on the form</p> <p>During an interview, on 5/27/16 at 1:35 P.M., QMA #10, indicated Resident #2 had been in respite care at the facility in November of 2015 and had a TB test then, but no second step TB test was done. QMA # 10 indicated the resident had another TB test when she was admitted into the facility on 1/12/16, but no second step TB test was completed.</p>			