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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155103 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/09/2016 |
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| F 0000<br><br>Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00194127.</p> <p>Complaint #IN00194127 – Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 2, 3, 4, 7, 8 &amp; 9, 2016</p> <p>Facility number: 000042<br/>Provider number: 155103<br/>AIM number: 100291540</p> <p>Census bed type:<br/>SNF/NF: 98<br/>Total: 98</p> <p>Census payor type:<br/>Medicare: 15<br/>Medicaid: 76<br/>Other: 7<br/>Total: 98</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2–3.1.</p> <p>Quality Review completed by 14454</p> | F 0000        | <p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Trailpoint Village desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective on March 28, 2016.</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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| F 0272<br>SS=D<br>Bldg. 00                             | <p>on March 10, 2016.</p> <p>483.20(b)(1)<br/>COMPREHENSIVE ASSESSMENTS<br/>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br/>                     Identification and demographic information;<br/>                     Customary routine;<br/>                     Cognitive patterns;<br/>                     Communication;<br/>                     Vision;<br/>                     Mood and behavior patterns;<br/>                     Psychosocial well-being;<br/>                     Physical functioning and structural problems;<br/>                     Continence;<br/>                     Disease diagnosis and health conditions;<br/>                     Dental and nutritional status;<br/>                     Skin conditions;<br/>                     Activity pursuit;<br/>                     Medications;<br/>                     Special treatments and procedures;<br/>                     Discharge potential;<br/>                     Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br/>                     Documentation of participation in assessment.</p> <p>Based on interview and record review,</p> | F 0272  | F272 COMPREHENSIVE  | 03/28/2016   |  |   |  |

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|  | <p>the facility failed to ensure the MDS (Minimum Data Set) was accurate for a continence decline since admission for 1 of 3 residents reviewed for incontinence. (Resident #10)</p> <p>Finding includes:</p> <p>On 3-8-2016 at 3:20 P.M., Resident #10's clinical records were reviewed. The diagnoses included, but were not limited, to Diabetes Mellitus, cerebral vascular accident, hemiplegia, seizure disorder, depression, coronary artery disease and history of stroke.</p> <p>The admission assessment, titled Resident Assessment, dated 9-9-2015, indicated the resident was not continent of bowel or bladder on admission.</p> <p>The document titled, Comprehensive Admission, dated 9-11-2015, indicated Resident #10 was not continent of bladder prior to admission.</p> <p>The document entitled, 3-Day Voiding Pattern, dated 9-12-2015 through 9-14-2015, indicated on day one, 9-12-2015, Resident #10 was incontinent 5 times. On day two, 9-13-2015, the resident was incontinent 8 times. On day three, 9-14-2016, the resident was incontinent 7 times.</p> |   | <p>ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?-</b></p> <ul style="list-style-type: none"> <li>·The facility reviewed resident #10's current MDS to ensure it accurately reflected the residents current functional capacity.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All incontinent residents have the potential to be affected by the alleged deficient practice.</li> <li>·All residents will be reviewed by MDS Coordinator or designee to ensure their comprehensive assessment is accurate for continence and incontinence.</li> <li>·All new admissions and comprehensive assessments will be reviewed for accuracy on continence and incontinence by the IDT team.</li> </ul> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·The IDT team and MDS Coordinator or designee will review all comprehensive assessments for continence and</li> </ul> |  |  |   |  |

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|                    | <p>The Admission Assessment form, completed on 9-22-2015, indicated the urinary/bowel assessment was done on 9-14-2015, and indicated, "...question if always aware of need to void. Goal 1 incontinent episode per shift...."</p> <p>The MDS (Minimum Data Set) Admission Assessment, dated 9-18-2015, indicated the resident was always continent of bladder and bowel.</p> <p>The 90 day MDS assessment, dated 12-7-2015, for significant change, indicated the resident was always incontinent of bladder and bowel.</p> <p>Resident #10's care plans included but were not limited to: "Resident is incontinent of bowel and bladder due to: CVA [Cerebral Vascular Accident], decreased awareness of urge," dated 9-22-2015.</p> <p>On 3-9-2016 at 11:22 A.M., the Administrator provided the policy titled, "American Senior Communities, RESIDENT ASSESSMENT (RAI) [Resident Assessment Instrument] OBRA [Omnibus Budget Reconciliation Act] Required Assessments," dated 1-2016, and indicated this was the policy currently used by the facility. The policy</p> |               | <p>incontinence to ensure they are accurate.</p> <ul style="list-style-type: none"> <li>·The IDT team and MDS coordinator or designee will review assessments of continence and incontinence of all new residents to ensure accuracy.</li> <li>·MDS Coordinator and MDS Assistant have been inserviced on ensuring accuracy of the MDS and comprehensive assessment by the MDS Consultant.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Attached CQI tool (labeled "A") will be used to audit assessments daily for 30 days, then weekly X4, then monthly X3, and quarterly X2. If a threshold of 95% or greater is not achieved on the audit tool an action plan will be developed by the IDT team.</li> <li>·The IDT team will audit assessments monthly to ensure accuracy.</li> </ul> |                      |

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| F 0371<br>SS=E<br>Bldg. 00 | <p>indicated, "It is the policy of American Senior Communities to conduct an initial and periodic comprehensive...accurate, standardized reproducible assessment of each resident's functional capacity..."</p> <p>During an interview on 3-8-2016 at 10:38 A.M., the Assistant MDS Coordinator indicated when she assessed the resident, she noted that he was not always continent on his admission assessment, but she incorrectly entered the resident was always continent in Resident #10's MDS admission assessment.</p> <p>During an interview on 3-8-2016 at 2:13 P.M., the Director of Nursing indicated the assessment information should always be correct when entered into the MDS system.</p> <p>3.1-31(c)(4)</p> <p>483.35(i)<br/>FOOD PROCURE,<br/>STORE/PREPARE/SERVE - SANITARY<br/>The facility must -</p> |               |   |                      |

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|                    | <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>A. Based on observation, interview and record review, the facility failed to monitor the freezer temperatures in 3 of 3 nourishment refrigerators and failed to label the thickened liquids with an open date and discard date in 3 of 3 nourishment refrigerators. (Hall 200, 300 and 400)</p> <p>B. Based on observation and interview, the facility failed to maintain an area in the kitchen in good repair for 1 of 1 kitchens.</p> <p>Findings include:</p> <p>A. 1. On 3-8-2016 at 9:58 A.M., an observation of the nourishment refrigerator on Hall 200 was conducted. Two (2) opened and undated thickened liquid containers and no thermometer in the freezer section of the refrigerator were observed.</p> <p>On 3-8-2016 at 10:03 A.M., a record review of the refrigerator logs for Hall 200 indicated no temperature logs for the freezer. The freezer contained 7 individual ice cream containers. An</p> | F 0371        | <p>F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>The facility must-</p> <p>1.Procure food from sources approved or consideredsatisfactory by Federal, State or local authorities; and</p> <p>2.Store, prepare, distribute and serve food undersanitary conditions</p> <p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?-</b></p> <p>·Thermometers have been added to 3 of 3nourishment pantry refrigerators(all nourishment pantry refrigerators beingused). Temperature logs for 3 of 3 nourishment pantry refrigerators have beenupdated (please see attachment labeled "B") to reflect an area for freezertemperatures as well as refrigerator temperatures. (Hall 200,300 and 400)</p> <p>·The dietary staff will begin distributingalready poured thickened liquids in glasses every morning. The glasses will becoved and come labeled with the date poured and resident name. The containersused to pour the thickened liquids will be labeled after opening and checkeddaily to ensure there will</p> | 03/28/2016           |

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|                    | <p>interview, at this time, with the Social Service Director for Hall 200 indicated, "The over night nurse is responsible to get a reading from the refrigerator and record in the log book. We should be getting a reading from the freezer too."</p> <p>On 3-9-2016 at 9:59 A.M., an observation of the nourishment refrigerator on Hall 300 indicated 1 opened honey thickened orange juice container, dated 2-28-2016, and no discard date. An interview with the Dietary Manager, at this time, indicated, "...I check the refrigerators on the hall every morning and make sure the open containers have an open date...this container [honey thickened orange juice] should have been thrown out...I don't know where this came from...we go by the manufacturer's recommendations for discard...I think this should be discarded by day 7...."</p> <p>On 3-9-2016 at 10:37 A.M., a record review of a posting on the nourishment refrigerator on Hall 200 and 400 labeled "Labeling and Dating" indicated, "All opened and leftover items need to be labeled with the date of opening/date stored and a discard/use by date."<br/>"Thickened Liquids...Thickened liquids can be kept refrigerated after opening according to the manufacturer's</p> |               | <p>be no expired or unlabeled containers.</p> <ul style="list-style-type: none"> <li>·All nursing and dietary staff will be inserviced on new procedure by 3/28/16 by Dietary Manager and CEC.</li> <li>·Wall near dishwasher in disrepair is scheduled to be replaced on June/July. Please see attached quote which has been approved (labeled F-1, F-2, and F-3)</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents in facility have potential to be affected by the alleged deficient practice.</li> <li>·All thickened liquid containers were checked by Dietary Manager to ensure the thickened liquid containers were labeled and dated properly.</li> <li>·DNS or designee will monitor nourishment pantry refrigerators daily to ensure there are no expired thickened liquids in the nourishment pantry refrigerators.</li> <li>·Kitchen Manager or designee will monitor to ensure successful process of labeling and dating thickened liquids every morning. Kitchen manager or designee will monitor successful process of distributing labeled and dated glasses to nourishment pantry refrigerator every morning. Kitchen manager or designee will monitor successful process</li> </ul> |                      |

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|  | <p>directions. Label with the date the container is opened and the discard date...."</p> <p>On 3-9-2016 at 10:45 A.M., a record review of the manufacturer's directions for "Orange Juice Honey Thickened Beverage" indicated, "...Shelf Life...once opened refrigerate and use within 5 days...."</p> <p>On 3-8-2016 at 11:40 A.M., the Director of Nursing provided the policy titled, "Food Storage," with a revised date of 07/15, and indicated this was the policy currently used by the facility. The policy indicated, "...Procedure...13. Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors, shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded...14. Thickened liquids must be dated with the date opened and consumed or discarded per the manufacturer's directions for the specific product...15. Refrigeration: d) Each nursing unit with a refrigerator/freezer unit will be monitored daily for appropriate temperatures...."</p> <p>B.1. On 3-2-2016 at 11:05 A.M. a tour of the kitchen was conducted. The walls under the dishwasher area were bowed</p> |   | <p>oflabeling and dating containers used to pour the thickened liquids to ensurethere are no expired or unlabeled containers being used.</p> <p>·Maintenance Director will be responsible tomaintain structural integrity of kitchen areas and will report to the ExecutiveDirector any areas in need of repair. Area behind the dish machine scheduledfor repair on June/July. In addition a humidity gauge has been added to monitorideal humidity in the dry storage area.</p> <p><b>What measures will beput into place or what systemic changes will you make to ensure that thedeficient practice does not recur?</b></p> <p>·All areas in kitchen were inspected byMaintenance Director to ensure no other areas were in need of repair.</p> <p>·Temperature logs have been updated to add anarea for freezer temperatures. Night shift nurses will continue to monitortemperatures and the DNS or designee checking daily to ensure completion.</p> <p>·All Nurses and Dietary Staff have beeninserviced by Dietary Manager and DNS or designee on new procedure withdistributing thickened liquids.</p> <p>· DNS ordesignee will monitor nourishment pantry refrigerators daily to ensure properlabeling and dating provided on thickened liquids. Kitchen manager will monitorproper procedure being followed to ensure glasses are</p> |  |  |   |  |

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|  | <p>and in disrepair. The walls had a black substance on them and were wet from the dishwashing counters to the floor. An interview with the Dietary Manager indicated, "...they [corporate] had talked about fixing those when they installed the new dishwasher but then they [corporate] didn't do it...yes, they are wet and the water runs under the floor...when I sweep out the dry storage area, the metal door plate on the floor is loose and when I put it back in place, it is wet there also..."</p> <p>On 3-8-16 at 11:40 A.M., the Director of Nursing provided the policy titled, "Food Storage," with a revision date of 07/15, and indicated this was the policy currently used by the facility. The policy indicated, "...Procedure...1...Dry storage rooms must be well ventilated...Ideal humidity is between 50-60%...." No humidity readings were available.</p> <p>3.1-21(i)(2)</p> |   | <p>labeled and dated properly and containers used to pour thickened liquids are properly labeled with open date and discarded appropriately according to manufacturer's guidelines and facility policy.</p> <ul style="list-style-type: none"> <li>·Kitchen will be monitored by Maintenance Director and Dietary Manager to ensure it remains in good repair and will report any deficiencies to the Executive Director.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Dietary and nursing staff have been inserviced by Dietary Manager and DNS or designee on the new distribution of thickened liquid procedure, proper labeling and dating procedures for food and thickened liquids, and discarding expired thickened liquids or food.</li> <li>·Nursing staff have been inserviced by DNS or designee on taking freezer and refrigerator temperatures and facility policy. Attached is new temperature log to include freezer temperatures.</li> <li>·Dietary staff have been inserviced on properly labeling and dating thickened liquids and distributing them daily.</li> <li>·DNS or designee will monitor nourishment pantry refrigerators for expired thickened liquids daily X4 weeks, weekly X4,</li> </ul> |                      |   |

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| F 0465<br>SS=E<br>Bldg. 00 | <p>483.70(h)<br/>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure a sanitary environment was maintained in resident rooms related to discolored vinyl flooring, loose vinyl flooring, holes in doors and peeling paint on walls, in 6 of 35 rooms observed for environment. (Rooms 205, 209, 218, 311, 401, and 409).</p> <p>Findings include:</p> <p>On 3-2-16 at 1:37 P.M., observation of the bathroom in Room 409 showed the vinyl flooring, behind the toilet, around the base of the toilet and by the sink, had a black discoloration and paint peeling from the walls.</p> <p>On 3-4-16 at 9:09 A.M., observation of</p> | F 0465        | <p>F465<br/>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?-</b></p> <ul style="list-style-type: none"> <li>·All residents have potential to be affected by the alleged deficient practice.</li> <li>·The facility has a company coming to replace all of the vinyl in the bathrooms, construction to begin on the 3rd week of April, 2016.</li> <li>·The facility has painted all of the bathroom walls.</li> <li>·The facility has repaired the closet in room 218.</li> </ul> | 03/28/2016           |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155103 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____                |  | X3) DATE SURVEY COMPLETED<br><br>03/09/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>TRAILPOINT VILLAGE |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1950 RIDGEDALE RD<br>SOUTH BEND, IN 46614 |  |   |  |
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|  | <p>the bathroom in Room 311 showed the vinyl flooring, behind toilet and under sink, had a gray discoloration.</p> <p>On 3-4-16 at 9:34 A.M., observation of the bathroom in Room 209 showed the vinyl flooring, behind the toilet and under sink, had a gray discoloration and paint peeling from the walls.</p> <p>On 3-3-16 at 9:53 A.M., observation of Room 218 showed the closet doors were observed to be off the track and the vinyl flooring in the bathroom had a brown discoloration.</p> <p>On 3-4-16 at 10:11 A.M., observation of the bathroom in Room 401 showed the vinyl flooring, around the toilet and along the bathtub, had a brown discoloration.</p> <p>On 3-8-16 between 3:06 P.M. and 3:35 P.M., during an environmental tour, with the Maintenance Supervisor and the ED (Executive Director), the Maintenance Supervisor indicated " I don't know how old the vinyl flooring is but it's just shot...the door jams are rusted through...the walls have drywall missing...it all needs fixed...the closet doors are old they just don't work anymore...."</p> <p>During an interview on 3-9-16 at 8:45</p> |   | <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·All vinyl flooring in the facility is scheduled to be replaced on the 3rd week of April</li> <li>·All bathroom walls have been repainted</li> <li>·The closet in room 218 has been repaired. Closets scheduled to be replaced throughout building during renovation scheduled to start May 30th 2016.</li> </ul> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·All vinyl flooring in bathrooms is scheduled to be replaced on the 3rd week of April (See attached quote and attached email regarding quote labeled E-1, E-2, and E-3)</li> <li>·All closets are scheduled to be replaced in the renovation scheduled May 30th, 2016</li> <li>·All bathrooms have been repainted</li> <li>·Maintenance Director will continue to round rooms to ensure they are in good repair and customer care representatives are responsible to report any rooms in need of maintenance.</li> <li>·Executive Director has serviced all CustomerCare</li> </ul> |  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155103 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>03/09/2016 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>TRAILPOINT VILLAGE |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1950 RIDGEDALE RD<br>SOUTH BEND, IN 46614  |                      |   |
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|  | A.M., the ED indicated there is no policy on how rooms and floors should be maintained.<br><br>3.1-19(f)               |   | Representatives on reporting any rooms in disrepair immediately so they can be addressed.<br><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b><br>·Maintenance Director or designee will complete room rounds daily 5X weekly for 4 weeks, then weekly X4 weeks, and then monthly X4 using attached audit tool (labeled "D"). If threshold of 95% or greater is not achieved the IDT team will create an action plan to address the issues.<br><br>Systematic changes have been completed as of March 28, 2016. |                      |   |