

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2013	
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 3025 W SYCAMORE ST KOKOMO, IN 46901			
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R000000	<p>This visit was for a State Residential Licensure Survey</p> <p>Survey dates: August 27 and 28, 2013</p> <p>Facility number: 011075 Provider number: 011075 AIM number: N/A</p> <p>Survey team: Bobette Messman RN TC Rita Mullen RN Maria Pantaleo RN</p> <p>Census bed type: Residential: 47 Total: 47</p> <p>Census payor type: Medicaid: 5 Other: 42 Total: 47</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley, RN on September 4, 2013.</p>			R000000	<p>The following is the Plan of Correction for Sterling House of Kokomo in regards to the Statement of Deficiencies for the annual survey completed on August 28th, 2013. 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, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.</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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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff on duty met requirements of first aid and CPR (cardiopulmonary resuscitation) for 2 of 14 night shift schedules reviewed.</p> <p>Findings include:</p> <p>A review of night shift schedule was completed on 8/27/13. The schedule indicated on 8/24/13 and 8/25/13,</p>	R000117	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Affected associate will be recertified in CPR and First Aid as required by state regulation. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? An audit of associate files will be completed by the Business Office</p>	09/25/2013			

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	<p>there were not staff on duty who had first aid and CPR training.</p> <p>During and interview with Health and Wellness Director on 8/28/13 at 10:30 a.m., she acknowledged the night shift on 8/24/13 and 8/25/13, did not include a staff member certified in first aid and CPR.</p>		<p>Manager to verify expiration dates for CPR and First Aid certifications and a tickler file will be initiated to track such due dates in an on-going manner. In the event other associates are found to be due for recertification, the Business Office Manager (BOM) is to notify the Health and Wellness Director (HWD) in order for the HWD to schedule required training. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? The BOM has been re-educated on the use of an audit tool by the E.D. The results of the audits are to be routinely provided by the BOM to the HWD and the ED. The HWD will utilize this information when scheduling associates. Nurses will be required to have current CPR and First Aid Certifications in order to be scheduled for their shift. In the event of non-compliance with scheduled CPR/First Aid training, the associate may be removed from the schedule until such time as certification is current. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? The Executive Director (E.D.) will be provided a copy of the BOM's audit of current associates and the expiration dates of their current CPR and First Aid certifications.</p>				

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			This process will continue monthly and on-going to audit for continued compliance with the state requirement. Additional action will be taken by the E.D. as warranted, based on results of audits.		

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R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>						

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	<p>Based on record review and interview, the facility failed to ensure new employees were given second step TB (tuberculin) skin test effected 3 of 5 employee records reviewed for pre-employment TB testing. (CNA's #1,2,3)</p> <p>Findings include:</p> <p>Employee records were reviewed on 8/27/13 at 1:30 p.m. The following items were not found:</p> <p>The second step TB skin test for CNA #1, hired on 4/8/13.</p> <p>The second step TB skin test for CNA #2, hired on 6/24/13.</p> <p>The second step TB skin test for CNA #3, hired on 1/12/13.</p> <p>During an interview with the Health and Wellness Director on 8/27/13 at 2:30 p.m., she indicated the second step TB skin tests were not completed for the three CNA's.</p>	R000121	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Indicated associates will have TB (tuberculin) skin tests readministered with 2 step process followed. How will the facility identify other associates with the potential to be affected by the same alleged non-compliant practice and what corrective action will be taken? An audit of associate files will be completed by the Business Office Manager to verify expiration dates TB (tuberculin) skin tests, and a tickler file will be initiated to track such due dates in an on-going manner. In the event other associates are found to be due for annual TB (tuberculin) testing, the Business Office Manager (BOM) is to notify the Health and Wellness Director (HWD) in order for the HWD to schedule required testing be administered. What measures will be put in place or what systemic changes will the facility make to ensure the alleged non-compliant practice does not recur? The BOM has been re-educated on the use of an audit tool by the E.D. The results of the audits are to be routinely provided by the BOM to the HWD and the ED. The HWD will utilize this information when scheduling associates. All associates will be required to have current TB (tuberculin) skin tests in order to be scheduled for</p>	09/25/2013			

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			<p>their shift. In the event of non-compliance with scheduled TB testing, the associate may be removed from the schedule until such time as TB shots are current. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? The Executive Director (E.D.) will be provided a copy of the BOM's audit of current associates and the expiration dates of their current TB (tuberculin) skin tests. This process will continue monthly and on-going to audit for continued compliance with the state requirement. Additional action will be taken by the E.D. as warranted, based on results of audits.</p>	

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R000144	<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 maintain the cleanliness of the building and grounds and failed to repair damaged walls and ceilings, loose hand rails, and worn and stained carpet for 1 of 1 environmental tour.</p> <p>Findings include:</p> <p>During the Environmental tour with the Dietary/Maintenance Manager on 8/27/13 10:10 a.m., the following observations were made:</p> <ol style="list-style-type: none"> 1. Dead flies and gnats were in the window frames through out the facility. 2. The carpet through out the building was worn and stained. 3. Water stains on the ceiling around the return air vent. 4. The resident laundry room had dirt and debris under the two washing machine lids, a dusty wall mounted fan, a personal floor scale with a broken plastic cover and metal 	R000144	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 1. The window frames throughout the community were cleaned on 8/28. 2. Carpet throughout the common areas in the entire building was just installed in April of 2013. Therefore, it is not "worn" as was stated in the deficiencies. It was also professionally cleaned by McCools on 6/22/13. There are ongoing discussions by our Regional Director of Maintenance with the manufacturer, regarding faulty carpeting being installed. Despite their recommendations for cleaning and equipment, carpet remains looking dirty and stained. The Regional Director of Maintenance is meeting with a representative of the manufacturer on 9/13/13. 3. Water stains on the ceiling around return air vents have been cleaned and painted. 4. Resident laundry room was cleaned on 8/28 and has been added to the regular cleaning schedule. Furniture is being replaced on 9/17, and metal scale and wall mounted fan have been disposed of. 5. Hand rails were tightened and secured on 8/28. 6. The</p>	09/25/2013			

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	corrosion, and two chairs with soiled and stained seat cushions.		dumpster and surrounding areas were cleaned up and staff has been inserviced on proper trash removal procedure. 7. The two ovens and refridgerator in the country kitchen were cleaned on 8/29 and have been added to the regular cleaning schedule. 8. Dining room walls have been patched and painted. Dining room vent covers and ceiling tiles were cleaned and have been added to the regular maintenance schedule. Entire dining room will be repainted as part of our refresh of the community. New furniture being delivered 9/17. 9. Return air vents in the Executive Dining room and entry way were cleaned on 8/29, and have been added to the regular cleaning schedule. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? The Maintenance Tech has observed the condition of carpeting and is developing a cleaning schedule to best maintain the carpet. 1-9.The community will continue to adhere to the cleaning schedule(s), having common carpeting areas professionally cleaned on a regular schedule, every 6 months (or more, as needed.) What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? Windows throughout				

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			<p>the community are on a weekly cleaning schedule and window sills and ledges will be kept free of debris and dead insects. As previously noted, our Regional Director of Property Management is meeting with the carpet manufacturer on 9/13/13 to find a resolution to correct the deficient carpeting and/or replace as needed. Weekly carpeting cleaning, as needed, will help until a resolution is found with the carpeting manufacturer. Ceilings will be inspected monthly and touch ups and cleaning will be done as needed. Laundry room is now on a weekly cleaning schedule. The laundry room will have new paint and furniture before year end. Handrails will be inspected regularly and tightened or adjusted as needed. The dumpster area will be inspected at least weekly. The Country Kitchen will be inspected weekly cleaned as necessary to ensure that the ovens and refrigerator remain free of spills and dirty surfaces. Walls throughout the community will be regularly inspected and repairs made wherever damaged areas are noted. Return air vents throughout the community will be regularly inspected and repairs and cleaning done wherever needed. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?</p>	

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			<p>Windows throughout the community are on a weekly cleaning schedule and window sills and ledges will be kept free of debris and dead insects. The HWD and ED will monitor and ensure that staff are adhering to the schedule. As previously noted, our Regional Director of Property Management is meeting with the carpet manufacturer on 9/13/13 to find a resolution to correct the deficient carpeting and/or replace as needed. Weekly carpeting cleaning, as needed, by our Maintenance Tech will help until a resolution is found with the carpeting manufacturer. Ceilings will be inspected monthly by the new Maintenance Tech and touch ups and cleaning will be done as needed. Laundry room is now on a weekly cleaning schedule and the HWD and ED will monitor and ensure that staff are adhering to the schedule. The laundry room will have new paint and furniture before year end. Handrails will be inspected by the Maintenance Tech for security on a regular basis and tightened or adjusted as needed. The dumpster area will be inspected at least weekly by the Maintenance Tech and new staff will be inserviced on proper trash removal procedure. The Country Kitchen will be inspected weekly by the Resident Programs Coordinator and cleaned as necessary to ensure that the ovens and refrigerator</p>	

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	<p>5. During tour of facility on 8/27/13 at 10:15 a.m., hand rails were observed to be loose at junction points throughout facility.</p> <p>During interview with the Maintance Director on 8/27/13 at 11:00 a.m., he indicated the railings had been removed during remodeling and not replaced correctly by contractors.</p> <p>6. The dumpster door was observed to be open, trash and debris was observed around the dumpster enclosure with 3 large filled trash bags on ground around dumpster. Observed behind the dumpster enclosure was a broken recliner.</p> <p>7. In the country kitchen, two ovens and refrigerator were observed to be</p>		<p>remain free of spills and dirty surfaces. Walls throughout the community will be regularly inspected by the Maintenance Tech and repairs made wherever damaged areas are noted. Return air vents throughout the community will be regularly inspected by the Maintenance Tech and repairs and cleaning done wherever needed. By what date will these systemic changes be implemented? 9-25-13 (Replacement of carpeting may require more time, but we can inform the State of replacement date if needed.)</p>	

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	<p>dirty with food spilled on surfaces.</p> <p>8. The dining room walls were observed to marred with gauges into the plaster.</p> <p>9. The return air vents in the Executive Dining room and entry way were observed to have dirt and dust on vent covers and ceiling tiles that surround the vent.</p> <p>During an interview with Maintance Director on 8/27/13 at 11:00 a.m., he indicated that the facility had been without a maintance technician for approximately 45 days.</p>			

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R000151	<p>410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.</p> <p>Based on record review and interview the facility failed to ensure a resident's pet was current with regular examinations and vaccinations by a licensed veterinarian in 1 of 3 resident pet records reviewed. (Resident #10)</p> <p>Findings include:</p> <p>Resident #10's record was reviewed on 08/27/13 at 11:00 a.m.</p> <p>The record indicated the resident's pet vaccination record had expired on 3/26/13.</p> <p>During an interview on 08/27/13 11:15 a.m., the Wellness Director indicated the current vaccination record could not be located.</p>	R000151	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident had pet vaccinated and had verbally informed us of the update. Vet office was contacted on 8/28 and we received the paper verification the same day. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? All pets within the community are on a monitored audit tool with reminders placed on the calendar for updates as required. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? An audit tool for pet vaccinations is now being kept and monitored by the Resident Programs Coordinator and she will keep a binder with updated information/vaccination certificates in the front office for easy access to entire staff. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? Executive Director will check with Resident</p>	09/25/2013

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(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
			Programs coordinator every 4 months to ensure vaccination updates are being done and current records are up to date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2013	
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 3025 W SYCAMORE ST KOKOMO, IN 46901			
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R000217	<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:</p> <p>(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.</p> <p>(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 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 have a signed and dated Service Plan for 1 of 7 residents reviewed for Service Plan acknowledgement by the resident or the resident's representative in a sample of 7. (Resident #1).</p>	R000217	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #1: Personal Service Plan was printed, signed and a copy has been placed in the chart. How will the facility identify other residents with the potential to be affected by the same</p>	09/25/2013			

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	<p>Findings include:</p> <p>The clinical record of Resident #1 was reviewed on 8/28/13 at 10 a.m. The Resident was admitted to the facility on 7/29/13.</p> <p>No signed and dated Service Plan was found in the clinical record.</p> <p>During an interview with the Wellness Director, on 8/28/13 at 10:45 a.m., she indicated the Service Plan was done on the computer but there was no signed and dated form in the clinical record.</p>		<p>alleged deficient practice and what corrective action will be taken? Health and Wellness Director and/or Designee will audit other resident clinical records to ensure a copy of the most current Personal Service Plan is printed for the clinical record. If a responsible party is not immediately available to review and sign the document, a care conference will be requested, at which time signatures may be obtained. This notification will occur by the HWD or designee. In the event the responsible party requests, the document will be mailed for signature, faxed for signature, or e-mailed for signature. Documentation of notifications will be placed in the clinical record. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? The Health and Wellness Director has been re-educated on the PSP signature process by the Executive Director and audits will be performed on a weekly basis by reviewing the "Personal Service Plan Due and Error report" available to all Brookdale Executive Directors and Health and Wellness Nurses. The ED will be notified by the HWD of any scheduled reassessments and/or changes of condition assessments completed on a routine basis during morning meetings. How will the</p>				

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			corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? The Health and Wellness Director / Designee will audit placement of the Personal Service Plan utilizing a checklist and the PSP Due and Error report to audit that a copy of the PSP is present for each resident in the clinical record. Results of audits will be reviewed by the Executive Director on a weekly basis to monitor for continued compliance. In the event a non-compliance is noted, the ED will designate next steps and monitor results.	