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 07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00177165. Complaint IN00177165 - Substantiated. State deficiencies related to the allegations are cited at R0041, R0090, R0149, R0270 and R0406. Unrelated State tags cited. Survey Dates: July 8, 9 & 13, 2015 Facility number: 009894 Provider number: 009894 AIM number: NA Census bed type: Residential: 108 Total: 108 Census payor type: Other: 108 Total: 108 Sample: 6 These State findings are cited in accordance with 410 IAC 16.2-5	R 0000	The 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 the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based record review and interview the facility failed to implement their policy for the investigation to an abuse allegation, in that when a resident voiced a concern to nursing staff related to the actions of a specific certified nurse aide (#9) the facility failed to follow the established policy which included additional staff and resident interviews for 1 of 1 allegation of abuse reviewed. (Resident "B"). Findings include: During an interview on 07-08-15 at 8:20 a.m., License Nurse #5 indicated there had been an allegation from Resident "B" regarding CNA (Certified Nurse Aide) #9. The Licensed Nurse indicated the resident said "someone hit her in the face. She's pretty with it. She said someone slapped her across the face. That's all I know about it."	R 0041	1. Corrective Action for Affected resident: There was no negative outcome for Resident "B" from failure to comply with state and community regulation of reporting alleged abuse. The Abuse policy of the community was followed with the exception of reporting the allegation, even though the incident could not be substantiated. 2. How to identify other Residents with potential for similar events: Failure to report the abuse allegation may have had the impact to affect other residents, however no other residents made an allegation of abuse during this timeframe. As part of the initial investigation, other residents were interviewed regarding their treatment, and no other residents	07/31/2015

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	A review of the facility "Investigation - [Resident name]," dated 06-30-15 indicated the following: "[Name of Assistant Health and Wellness Director] informed me via phone that resident [name of resident "B"] had accused [name of CNA #9] has hit her in the face with paper menu. I spoke with [name of CNA #9] via phone and told her an allegation of abuse had been given towards to [sic] and to clock out and she was to be suspended pending investigation." "Statement [name of resident] - ...can you tell me what occurred between you and [name of CNA #9] this morning. [Resident name] replied that [name of CNA #9] was reading the menu to her and she was going so fast she couldn't understand her and she ask [sic] her to slow down and she never did. She then told [name of CNA #9] to get someone else to read it to her and on the way out of her room she swatted her in the face with paper menu." During an interview on 07-08-15 at 10:20 a.m., CNA #9 indicated she was told there was an allegation of abuse regarding Resident "B." They sent me home around 9:30 a.m., and then [name of Assistant Health and Wellness		alleged abuse or mistreatment. 3. Systemic Changes: The Executive Director was instructed by District Supervisor on proper reporting requirements for the state of Indiana. The Executive Director will monitor incident reports during stand-up meetings. In the event allegations are reported the ED / Designee will be responsible for reported the event to the ISDH within 24 hours of allegation to staff. 4. Monitoring Q.A. plan All reportable events will be reviewed by the District Director of Operations and/or the District Director of Clinical Services for compliance with notification requirements.	

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	Director] called me around 6:30 p.m. that night and she said I could come back to work because they already did the investigation. They told me I couldn't work with [name of Resident "B"] anymore. A review of the staffing "as worked" schedule for 06-30-15, indicated CNA #9 worked with License Nurse #5 and CNA #11. Further review of the "investigation" lacked interviews with the staff members who worked directly with CNA #9 on 06-30-15. In addition, the investigation lacked resident interviews regarding any concerns related to abusive actions by the facility staff. A review of the facility policy on 07-08-15 at 8:30 a.m., titled "Abuse, Neglect and Exploitation Policy," dated 10-01-2001, indicated the following: "Policy Overview: Brookdale is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up... 5. Investigation: a. Upon receipt of an allegation of abuse, neglect or exploitation, the Administrator and or			

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	Executive Director, or their designee, should conduct a confidential internal investigation of the incident. b. The investigation should be conducted confidentially and in a manner that is least disruptive to the on-going delivery of services and daily routine of the community. (1) The investigation should include interviews with potential witnesses, which may include the alleged perpetrator, the alleged victim, associates, other residents and visitors to the community." During the Daily Exit conference on 07-08-15 at 3:30 p.m., the Administrator indicated she had not interviewed the staff who worked on 06-30-15 nor had she interviewed any other residents. This State tag relates to Complaint IN00177165.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or			

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	by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based record review and interview the facility failed to implement their policy for the investigation to an abuse	R 0090	1. Corrective Action for Affected resident:	07/31/2015

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	allegation and reporting to the State Agency, in that when a resident voiced a concern to nursing staff related to the actions of a specific certified nurse aide (#9) the facility failed to immediately notify the State Agency and failed to follow the established policy which included reporting obligations for 1 of 1 allegation of abuse reviewed. (Resident "B") Findings include: During an interview on 07-08-15 at 8:20 a.m., License Nurse #5 indicated there had been an allegation from Resident "B" regarding CNA (Certified Nurse Aide) #9. The Licensed Nurse indicated the resident said "someone hit her in the face. She's pretty with it. She said someone slapped her across the face. That's all I know about it." A review of the facility "Investigation - [Resident name]," dated 06-30-15 indicated the following: "[Name of Assistant Health and Wellness Director] informed me via phone that resident [name of resident "B"] had accused [name of CNA #9] has hit her in the face with paper menu. I spoke with [name of CNA #9] via phone and told her an allegation of abuse had been given towards to [sic] and to clock out and she		There was no negative outcome for Resident "B" from failure to comply with state and community regulation of reporting alleged abuse. The Abuse policy of the community was followed with the exception of reporting the allegation, even though the incident could not be substantiated. 2. How to identify other Residents with potential for similar events: Failure to report the abuse allegation may have had the impact to affect other residents, however no other residents made an allegation of abuse during this timeframe. As part of the initial investigation, other residents were interviewed regarding their treatment, and no other residents alleged abuse or mistreatment. 3. Systemic Changes: The Executive Director was instructed by District Director of Operations on proper reporting requirements for the state of Indiana. The Executive Director will monitor incident reports during stand-up meetings. In the event allegations are reported the ED / Designee will be responsible for reported the event to the ISDH within 24 hours of allegation to staff. 4. Monitoring Q.A. plan	

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	was to be suspended pending investigation." "Statement [name of resident] - ...can you tell me what occurred between you and [name of CNA #9] this morning. [Resident name] replied that [name of CNA #9] was reading the menu to her and she was going so fast she couldn't understand her and she ask [sic] her to slow down and she never did. She then told [name of CNA #9] to get someone else to read it to her and on the way out of her room she swatted her in the face with paper menu." A review of the facility policy on 07-08-15 at 8:30 a.m., titled "Abuse, Neglect and Exploitation Policy," dated 10-01-2001, indicated the following: "Policy Overview: Brookdale is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow-up...External Reporting/Notification and Indiana State Department of Health Policy and Procedure re [regarding]: Reportable Unusual Occurrences. c. Report to		All reportable events will be reviewed by the District Director of Operations and/or the District Director of Clinical Services for compliance with notification requirements.	

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	Indiana State Department of Health and Other Agencies. (1) The Administrator and or Executive Director or designee should contact the ISDH [Indiana State Department of Health] ... within 24 hours of determining a situation exists, or existed, that is reasonable believed to constitute abuse, neglect or exploitation." During an interview on 07-08-15 at 9:30 a.m., the Administrator indicated she had not reported the allegation of Abuse to the Indiana State Department of Health. "I asked my boss if I should report it and I was told no." This State tag relates to Complaint IN00177165.			
R 0121 Bldg. 00	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: (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			

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	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. (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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (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.			
	Based on record review and interview the facility failed to ensure a health record that included reports of all employment health screenings for 3 of 8 employee records reviewed. (Employees #14, #15 and #16). Findings include: Employee #14 was hired on 05-28-15 as a Certified Nurses Aide. The employee file contained an undated physical examination.	R 0121	1. Corrective action for the cited associates: The alleged deficient practice had no adverse effect on associates who were seen by physician for their physicals, but the physician failed to enter the date of the physical. 2. How to identify other Associates with potential for similar events:	07/31/2015

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	Employee #15 was hired on 05-28-15 as an Licensed Practical Nurse. The employee file contained an undated physical examination. Employee #16 was hired on 06-25-15 as a Certified Nurses Aide. The employee file contained an undated and unsigned physical examination and incomplete description as to what position the employee had been hired. During the daily Exit Conference on 07-08-15 at 3:30 p.m., the omissions in the employee files were discussed with the Administrator. During employee record review on 07-09-15 at 10:30 a.m., the physical examination for Employee #14 had been dated as "05-20-15," the physical examination for Employee #15 had been dated as "05-20-15," and the physical examination for Employee #16 had been dated as "06-23-15" and "initialed." During interview on 07-09-15 at 11;15 a.m., the Business Office Manager indicated, "I took the employee files back to the nurses and they said [name of physician] doesn't date his physicals. The nurses put the dates on the physicals of when they thought the exam was done."		The Business Office Manager/Designee conducted an audit of other associate files. No other physicals were noted to be lacking a date on the form. 3. Systemic Changes you will make: The Medical Director who completes the physicals was notified of the need to enter the date of the exam on the form. This notification was completed by the Medical Director on 7/16/15. The Health and Wellness Director/Nurse Designee will be responsible for auditing new physicals for completion. 4. Monitoring Q.A. plan: Business Office Manager/Designee is to be in charge of all Associates employment files. She will be monitoring for continued compliance at each new hire. In the event incomplete forms are notes, the Executive Director is to be notified, and the appropriate manager will be assigned to obtain the missing information.	

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	During the daily exit conference on 07-09-15 at 11:45 a.m., the Administrator indicated she was not aware the nurses back dated the employee files.			
R 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency (f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24. Based on record review and interview the facility failed to implement an effective pest control policy, in that when a resident was determined to have bed bugs, the nursing staff failed to isolate the resident for 1 of 2 incidents of bed bug infestation on 1 of 1 nursing units. [Resident "B"]. Findings include: During an interview on 07-08-15 at 10:20 a.m., CNA (Certified Nurses Aide) #9 indicated Resident "B" was found with bed bugs by the "CNA on the night shift. There were quite a few bed bugs and they moved her from [resident room number] to room [number documented]. Before that she went to the Beautician and returned her to the unit. They threw away her mattress, but they didn't give her a shower until that night and the aide found more bed bugs on her. I think the beautician also found one in the sink when she was doing her hair."	R 0149	1. Corrective Action for resident "B" identified during the survey process. The resident is currently free of bedbugs as verified by skin observation and Eccolab checks. 2. How to identify other Residents with the potential for similar events. Other residents who were in neighboring apartments had the potential to be affected. Head – to-toes skin Observations were completed on each resident that resides on the Terrace wing. These checks were completed by the Health and Wellness Director/Nurse designee, and documented in the clinical record. No further signs of bed bugs or bites were noted. No other resident was affected. 3. Systemic changes you will make.	07/31/2015

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	During an interview on 07-08-15 at 3:15 p.m., the Beautician indicated she brushed out the resident's hair. "After that and I was sweeping up the hair I saw a little bitty bug on the floor. I didn't know what it was." During an interview on 07-09-15 at 8:50 a.m., the representative from the local pest control company indicated he received a call about the bed bugs around 10:20 a.m., on 07-01-15. "I think I arrived at the facility around 12:30 p.m., and completed my work around 2:20 p.m. They had already moved her to the room across the hall." A review of the "Pest Control Inspection and Treatment Documentation," dated 07-01-15, indicated "Bed bugs noted during treatment. Bed bugs found bed frame area and reported coming off guest [Resident "B"]. Resident moved to room before showering or changing clothes." A review of the 07-02-15 "Pest Control Inspection and Treatment Documentation," indicated "No bed bug activity noted during inspection. Dead Bugs left over. Staff member told me that patient/guest was not changed from clothes or showered till 6:45 p.m. last evening. I departed at 2:00 p.m. with		In the event that any resident has been identified as having bed bugs, they will not be removed from their apartment until a shower has been provided, a skin observation completed and fresh clothes placed to replace existing. Mattresses and Box springs will be encased in plastic before removing from unit and placed in dumpster. 4. Monitoring Q.A.plan Maintenance Director will partner with the pest control company to be observing and treating for any pest found	

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	instructions to isolate her, her clothes and bathe ASAP [as soon as possible], she was moved to another room before this happened. Will discuss with management." During an interview on 07-08-15 at 3:10 p.m., CNA #12 indicated, "I haven't seen any bed bugs recently but not long ago [name of Resident "B"] had bed bugs. They told us to keep her [in reference to Resident "B"] isolated and bag things up. I gave her [Resident "B"] a shower between 3:00 and 3:30 p.m. and when I did 2 bed bugs fell of of her in the shower and on to her foot." A review of the facility policy on 07-08-15 at 10:00 a.m., titled "Bed Bugs," dated July 2011, indicated the following: "Resident & Belongings Treatment: The resident should receive an evaluation of their skin from signs of infestation and treatment by their health care provider. The resident should be removed from their surroundings and placed in another apartment when possible. Belongings and furniture should remain in the room so pest control treatment can begin. Encasing the mattress and box spring is recommended since it may take up to 1 year to starve the bed bugs. Dragging or moving mattresses's/box springs through			

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	a hallway could result in a more wide spread infestation. All items removed from rooms/apartments should be completely wrapped in plastic before removal." A review of the pest control "Special Instruction and Service Protocol," for this date of service (07-01-15) included the following instructions: "...If bed bug activity is suspected in a room, then customer must immediately place that room 'out of service' until after that room is inspected by [name of pest control company]. All bedding, linens, curtains, mattresses, box springs, and other furnishings must be left in the room by customer for inspection... If during the preliminary inspection [company] finds one or more live bed bugs, or evidence of live bed bugs, in the inspected room, then that room will be considered an 'Infested Room.'" Further interview with the representative from the local pest control company on 07-09-15 at 9:15 a.m., indicated, "I told them to isolate her and that she needed to have a shower. I was pretty upset that they moved her and didn't shower her until later that day. I had to have a talk with them." During interview on 07-08-15 at 3:30			

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	p.m., the Administrator indicated the resident originally refused a shower "that's her right." When further interviewed the Administrator indicated the resident had not been isolated after it was first determined she had bed bugs. This State tag relates to Complaint IN00177165.			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review the facility failed to ensure the kitchen was clean and maintained in good repair for 1 of 1 kitchens observed. This deficient practice had the potential to affect 108 of 108 residents receiving meals from the kitchen. Findings include: During the observation of the kitchen on 07-09-15 at 10:00 a.m., with the Administrator and the representative from the local pest control company in attendance the following was observed:	R 0154	. Corrective Action for affected resident: No resident was adversely affected by these structural damages to kitchen area. 2. How to identify other Residents with potential for similar events. Since the alleged deficient practice	07/31/2015

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	A portion of the wall adjacent to the cooler had holes in the wall which were too numerous to count. The representative from the pest control company indicated the integrity of the wall allowed pests to enter through the holes into the kitchen area. The ceramic cove base, beneath and behind the cooler had two tiles which were broken with jagged edges. The area behind the tiles had been broken and lacked a wall behind the pieces. Ice machine - water from the ice machine was draining onto the floor and not siphoned into a drain to prevent backflow. A section of flooring which measured approximately 30 inches by 15 inches was covered with a piece of wooden board. The Administrator indicated the area of the floor had been missing "for a while." The Chemical Supply closet also had an area of the floor missing and had been covered with a wooden board. The area measured approximately 2 feet by 1 foot. The wooden surfaces could not be sanitized. Three compartment sink area - This area was described by the local pest control		had the potential to affect residents, the kitchen was closed for a 12 hour period, to enable deep cleaning and repairs to the structural areas to be implemented. The residents were served meals in an alternate area of the community during the closure. 3. Systemic Changes:. Areas in dietary that had structural damage including floors and walls will be repaired or replaced. Drains in kitchen floor will be checked on a monthly basis to ensure proper drainage. Floor has been steamed cleaned and will be cleaned on a daily basis. Vents will be checked on a monthly basis and cleaned as needed. 4, Monitoring Q.A. Plan: Dietary Director, Maintenance Director, Administrator and Registered Dietician will be visually be monitoring the kitchen on a daily basis for compliance. A written report will be completed upon finding any further areas of concern.	

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	representative as "structural damage" which could allow the access of pests into the kitchen. The area of the floor which was missing measured approximately 4 feet by 1 1/2 feet. The ceiling square air vent had blackish streaks which spanned approximately 6 inches and extended out from the edge of the vent. This vent was situated in the ceiling midway between the food preparation area and the wall. The flooring throughout the kitchen was heavily soiled on the tiled surface and grout joints. A drain which was situated near the food prep area had standing water visible in the drain. Garbage Disposal - An area of the wall had "structural damage." The area of the wall which was missing measured approximately 2 feet by 3 feet A review of the contracted "Pest Control Service Reports" on 07-09-15 at 11:00 a.m., indicated the following: "Original date of concern - 06-24-14 Floor tiles or baseboards loose missing. Hole/gap noted behind dishmachine. Hole/gap noted behind cook line. 03-02-15 'condition unchanged.' Seal to prevent pest entry or harborage."			

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	"Original date of concern - 07-24-14 Hole/gap noted behind prep [preparation] sink. 03-02-15 Still needs attention - seal to prevent pest entry or harborage." "Original date of concern 07-28-14 Floor drains in need of cleaning Please clean in and around drains frequently to help prevent pest breeding site. 03-02-15 Still needs attention." During an interview on 07-09-15 at 10:30 a.m., the Administrator indicated she was aware of the conditions noted in the kitchen. "It's been like that for quite awhile."			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on observation, record review and interview the facility failed to ensure resident's received the physician ordered diet, in that when residents had specific needs related to chewing and swallowing difficulties, the dietary staff failed to provide the altered diet for 3 of 3 resident's reviewed with special diets in a	R 0270	Diet Orders 1. Corrective Action In service training for the kitchen staff was completed on 7/16/15 related to the Brookdale policy and procedure for provision of appropriate diet orders, Brookdale	07/31/2015

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	sample of 6. (Resident's "D", "E", and "F") Findings include: 1. The record for Resident "D" was reviewed on 07-08-15 at 10:00 a.m. Diagnoses included, but were not limited to, seizure disorder, dementia, hypertension, and dysphagia. These diagnoses remained current at the time of the record review. The record indicated the resident originally had physician orders for a mechanical soft diet and honey thickened liquids. A review of the resident's Personal Service Plan, dated 02-05-15 alerted the nursing staff to provide textured modified foods and thickened liquids - honey consistency. "Be alert to coughing or choking while eating." The resident had current physician orders dated 06-17-15 for pureed diet with honey thickened liquids. The record indicated the resident had a recent hospitalization and a review of the hospital discharge summary, dated 07-02-15, indicated the resident had dysphagia, and aspiration pneumonia.		approved diets, and food modification. 2. How to Identify Through audit of diet orders, and review of the Nutrition Tracker, no other residents were identified as being affected by the alleged deficient practice. 3. Systematic Changes Kitchen staff was re-educated on the existing process, and gave return demonstration of the proper technique for diet modifications, specifically texture modified, and pureed diets 4. Monitoring Dining services management will ensure each resident is receiving the proper diet as posted in the kitchen and updated per physician order	

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	A review of the resident's "Room Service - pre-order sheet, for lunch on 07-08-15 indicated the resident required a pureed diet but the resident was not provided the physician ordered diet. During an observation on 07-08-15 at 11:15 a.m., during the lunch meal the resident's meal tray contained beef manhattan with green peas. The plate had a whole slice of bread and whole pieces of beef. The green peas appeared chopped with pieces of peelings from outside of the peas. During this observation, some peas remained whole. During this observation, CNA (Certified Nurse Aide) #9 indicated, "This doesn't look like pureed to me. I'll have to send it back to the kitchen." 2. The record for Resident "E" was reviewed on 07-08-15 at 1:00 p.m. Diagnoses included, but were not limited to, cerebral vascular accident, dysphagia and hypertension. These diagnoses remained current at the time of review. A current physician order, originally dated 10-16-13 indicated, "Aspiration precautions should be followed." A review of the resident's Personal			

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	Service Plan, dated 04-22-15 indicated the resident received a Regular diet "meats must be cut small." During an observation on 07-08-15 at 11:45 a.m., during the lunch meal, the resident's meal tray contained beef manhattan with green peas. The meat was not cut up for the resident. 3. The record for Resident "F" was reviewed on 07-08-15 at 1:15 p.m. Diagnoses included, but were not limited to, dysphagia, dementia and depression. These diagnoses remained current at the time of the record review. A review of the resident's Personal Service Plan, dated 01-06-15 indicated "Provide texture modified foods. Be alert to coughing or choking while eating - regular portions." A current physician order, originally dated 07-17-13 indicated "all meat except fish should be mechanically altered - chopped. Provide extra sauce, gravy, sour cream etc. - give cottage cheese or apple sauce with meals." During observations on 07-08-15 during the lunch meal service and breakfast on 07-09-15 the resident was not provided with cottage cheese or applesauce, and			

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	did not receive extra sauce or gravy when served the beef manhattan on 07-08-15 during the lunch meal service. This State tag relates to Complaint IN00177165.			
R 0273 Bldg. 00	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. Based on observation, record review and interview the facility failed to ensure the kitchen prepared and stored foods under sanitary conditions for 1 of 1 kitchens observed. This Deficient practice had the potential to affect 108 of 108 residents receiving meals from the kitchen. Findings include: During an observation on 07-08-15 at 11:30 a.m., a dietary staff member was observed placing 4 cups in the freezer. During this observation, the dietary staff member indicated the contents of the cups was "sherbet." The sherbet was placed into the freezer, uncovered and undated. During the observation of the kitchen on	R 0273	1. Corrective Action The kitchen was closed for a period of 12 hours in order to complete the necessary cleaning and to initiate repairs. 2. How to Identify other areas: An audit was completed by the Dietary Manager/Executive Director/Designee on 7/15/15 to determine additional areas in need of cleaning or repair. Schedules were put in place and posted for the cleaning staff. 3. Systematic Changes An In-service was provided by the dietary manager/designee for the dietary associates to review the standards and expectations for	07/31/2015

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	07-09-15 at 10:00 a.m., with the Chef in attendance, the following was observed: Walk in Refrigerator - The floor to this refrigerator had food debris and spillage throughout. A large box noted as German Chocolate cake was observed with the lid of the box open allowing the cake to be exposed to refrigerator air. During this observation the Chef indicated the lid on the box was a "cover." "We don't have to do anymore. It meets food code." Multiple containers which the Chef described the contents as "eggs, ham, lettuce. pecans and cheese," were observed undated. A large block of cheese had been opened, but was undated. The Chef moved to the food prep area and arranged pieces of chicken onto a baking pan. Within 2 feet of this prep area was an uncovered trash can, filled with trash, garbage and food leftovers. True Refrigerate - Lemon slices were covered but undated. A plastic container identified by dietary staff as Cole Slaw was not completely covered and was undated.		cleaning and reporting of concerns. This was completed on 7/16/15. New Dietary staff will be trained upon hire during the orientation process. 4. Monitoring Each kitchen staff member will initial each item when it is completed and dining service management will review the cleaning schedule to be certain that the cleaning is completed as scheduled. The Dietary Manager will be responsible for reviewing audits weekly for compliance. The Dietary Manager will be responsible for corrective action, based on findings. The Executive Director/Designee will be responsible for directing additional actions when necessary. 1. Corrective Action In service training for the kitchen staff was provided by the dietary manager / designee on 7/16/15 The Brookdale policy for labeling and dating was reviewed and illustrated with an example of a properly labeled item 2. How to Identify others An audit was completed by the	

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	The freezer located on the Terrace Unit contained plastic cups of ice cream. The ice cream was not covered or dated. The inside of this freezer had multiple areas of dried/frozen brown spillage across the bottom surface. Three tray stands, with 2 sets of webbing across the top two bars were observed for each tray stand with a heavy build up of food debris and dried liquid stains. A review of the "Daily cleaning schedule" on 07-08-15 at 10:45 a.m., included the following tasks for the Dietary staff to perform: Walkin [sic] cleaned and organized, items wrapped and labeled, wall behind machine and rack wiped down and clean, floors clean, swept and mopped, all products wrapped and properly labeled/dated." A review of the "Weekly cleaning schedule" on 07-08-15 at 10:45 a.m. included the following tasks for the Dietary staff to perform: Walk in floor swept, scrubbed and mopped, stainless steel and walls scrubbed and cleaned." A review of the facility policy on 07-13-15 at 9:00 a.m., titled "Labeling: Safety and Sanitation," and dated as "revised 5/10, indicated the following:		Dietary Manager/Executive Director/Designee on 7/15/15 to determine if other items were in need of proper labeling or dating. If no date was noted, the item was disposed of. 3. Systematic Changes Dining services staff has been re-trained on proper labeling and dating procedures. This training was provided by the dietary manager/designee and completed by 7-16-15. New dietary staff will be trained upon hire during the orientation process. 4. Monitoring The Dietary Services Manager / Designee will be responsible for completion of audits on a weekly basis to determine if each item is properly labeled, dated, and discarded when necessary. Results of audits will be available to the Executive Director for monthly review. The ED will be responsible for directing additional action, based on findings.	

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	"Policy Overview - All food items must be labeled and dated before storing." "Policy Detail - 1. All food items upon receipt from food vendors must have a date marked before putting in any storage (dry, refrigerator, freezer, pantry). This should be done even if the food item has a 'use by' or 'sell by' date marked by the manufacturer. 2. All prepared items (i.e. leftovers or prepared for next meal) must have a label with the name of item, date prepared, by whom, and date of discard."			
R 0326 Bldg. 00	410 IAC 16.2-5-7.1(a) Activities Programs - Deficiency (a) The facility shall provide activities programs appropriate to the abilities and interests of the residents being served. Based on observation, record review and interview the facility failed to provide an activity program for the residents who resided on the Terrace Unit for 2 of 2 residents observed for activities (Resident D and G). This deficient practice had the potential to effect 15 of 15 resident's who currently resided on this Unit. Findings include: During observation on 07-08-15 at 2:00 p.m., the bulletin board had the Activity Calendar for June 2015.	R 0326	1. Corrective action for affected/citied resident/ The Life Enrichment Coordinator will review the Life Story for Resident # "C" and Resident "D" in order to develop a Life Enrichment Service Plan, complete with suggestions for associates to interact when the Life Enrichment Coordinator is not available. This information will be utilized in development of the Life Enrichment calendar. 2. How to identify other Residents with potential for similar	07/31/2015

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	During an observation on 07-08-15 at 1:15 p.m., Resident "D" was seated at a dining room table. No other residents were in this dining area. CNA #6 was standing at the other end of the dining area looking out the window. The resident moved himself from the table to the other end of the dining area in the direction of the wall. The resident stopped in front of the wall and began to talk in a mumbling manner. There was no staff re-direction or involvement to engage the resident in an Activity. During an observation on 07-08-15 at 1:30 p.m. Licensed Nurse #5 approached the resident and said, "[Name of resident] do you want to go and watch TV ?" The resident mumbled and then the Licensed Nurse moved the resident from the dining area to the lounge. The resident was left alone in this room without staff involvement. During an observation on 07-09-15 at 8:00 a.m., the bulletin board remained with the June 2015 Activity Calendar. 2. During an observation on 07-09-15 at 9:30 a.m., Resident "G" was seated at the		events. Other residents have the potential to be affected from a perceived lack of activity on the unit. Residents who so desire may continue to be taken to activities on the Manor side of community at any time. In addition, an assistant and/or volunteers will be responsible for reviewing resident histories and interviewing residents in order to provide life enrichment opportunities when formal Life Enrichment activities may not be available. 3. Systemic Changes you will make: An Activity Assistant has been hired and will be in charge of all planned activities on the Terrace. This area of the community will have a separate activity calendar based on Resident's interests. Nursing staff that works on that unit will receive in-service of appropriate activities and interaction with the residents. Activity Assistant will have the responsibility to ensure the calendar is changed and updated on a monthly basis. 4. Monitoring Q.A. plan:	

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	table in the dining area on the Terrace Unit. The resident was observed clapping her hands and pointing to the floor. There was no activity provided, nor staff in attendance to engage the resident in any meaningful activity. During an interview on 07-09-15 at 10:15 a.m., the Administrator indicated the Terrace Unit was currently without any Activity Staff.		Activity Assistant will monitor for activity attendance and staff interaction and give a verbal report on a daily basis to Activity Director.	
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview and record review the facility failed to ensure infection control measures were maintained to help prevent the transmission of bed bugs and the possibility of transmission of infection related to the use of disposable gloves and lack of handwashing. (Resident B Findings include: 1. During an interview on 07-08-15 at 10:20 a.m., CNA (Certified Nurse Aide) #9 indicated Resident "B" was found with bed bugs by the, "CNA on the night	R 0406	1. Corrective Action for resident "B" identified during the survey process. Resident B appears currently free of bed bugs, but Skin Observations by a licensed nurse will continue weekly x 8 weeks to determine that eradication is complete. 2. How to identify other Residents with the potential for similar events. Head-to-toe Skin Observations skin have been completed on each resident that resides on the Terrace	07/31/2015

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	shift. There were quite a few bed bugs and they moved her from [resident room number] to room [number documented]. Before that she went to the Beautician and returned her to the unit. They threw away her mattress, but they didn't give her a shower until that night and the aide found more bed bugs on her. I think the beautician also found one in the sink when she was doing her hair." During an interview on 07-08-15 at 3:15 p.m., the Beautician indicated she brushed out the resident's hair. "After that and I was sweeping up the hair I saw a little bitty bug on the floor. I didn't know what it was." During an interview on 07-09-15 at 8:50 a.m., the representative from the local pest control company indicated he received a call about the bed bugs around 10:20 a.m. on 07-01-15. "I think I arrived at the facility around 12:30 p.m. and completed my work around 2:20 p.m. They had already moved her to the room across the hall." A review of the "Pest Control Inspection and Treatment Documentation," dated 07-01-15, indicated "Bed bugs noted during treatment. Bed bugs found bed frame area and reported coming off guest [Resident "B"]. Resident moved to room		wing. These observations were completed and documented by the Health and Wellness Director/Nurse Designee. No further signs of bed bugs or bites were noted. No other resident was found to be affected. 3. Systemic changes you will make. Nursing staff was re-educated on the existing Bed Bug "Clinical Guideline". This clinical guideline is currently posted in the Nurse Communication Binder for ongoing reference and review. Monthly Skin Observations will be completed by a licensed nurse on Terrace residents. If any resident is later identified as having bed bugs, the directions on the clinical guideline are to be followed. An In-service for all nursing staff on Brookdale's clinical guidelines for hand washing and use of disposable gloves was completed by Health and Wellness Director. Maintenance Director will in-service all staff regarding Brookdale's bed bug guidelines. 4. Monitoring Q.A.plan Maintenance Director will partner with the pest control company to be observing and treating for any pest found. Health and Wellness director will be	

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	before showering or changing clothes." A review of the 07-02-15 "Pest Control Inspection and Treatment Documentation," indicated "No bed bug activity noted during inspection. Dead Bugs left over. Staff member told me that patient/guest was not changed from clothes or showered till 6:45 p.m. last evening. I departed at 2:00 p.m. with instructions to isolate her, her clothes and bathe ASAP [as soon as possible], she was moved to another room before this happened. Will discuss with management." During an interview on 07-08-15 at 3:10 p.m., CNA #12 indicated, "I haven't seen any bed bugs recently but not long ago [name of Resident "C"] had bed bugs. They told us to keep her [in reference to Resident "B"] isolated and bag things up. I gave her [Resident "B"] a shower between 3:00 and 3:30 p.m. and when I did 2 bed bugs fell of of her in the shower and on to her foot." A review of the facility policy on 07-08-15 at 10:00 a.m., titled "Bed Bugs," dated July 2011, indicated the following: "Resident & Belongings Treatment: The resident should receive an evaluation of their skin from signs of infestation and		monitoring nursing staff on a weekly basis to assure continued compliance	

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	treatment by their health care provider. The resident should be removed from their surroundings and placed in another apartment when possible. Belongings and furniture should remain in the room so pest control treatment can begin. Encasing the mattress and box spring is recommended since it may take up to 1 year to starve the bed bugs. Dragging or moving mattresses's/box springs through a hallway could result in a more wide spread infestation. All items removed from rooms/apartments should be completely wrapped in plastic before removal." A review of the pest control "Special Instruction and Service Protocol," for this date of service (07-01-15) included the following instructions: If bed bug activity is suspected in a room, then customer must immediately place that room 'out of service' until after that room is inspected by [name of pest control company]. All bedding, linens, curtains, mattresses, box springs, and other furnishings must be left in the room by customer for inspection. ... If during the preliminary inspection [company] finds one or more live bed bugs, or evidence of live bed bugs, in the inspected room, then that room will be considered an 'Infested Room.'"			

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	Further interview with the representative from the local pest control company on 07-09-15 at 9:15 a.m., indicated, "I told them to isolate her and that she needed to have a shower. I was pretty upset that they moved her and didn't shower her until later that day. I had to have a talk with them." During interview on 07-08-15 at 3:30 p.m., the Administrator indicated the resident originally refused a shower "that's her right." When further interviewed the Administrator indicated the resident had not been isolated after it was first determined she had bed bugs. 2.) During observation of the breakfast meal on 07-08-15 at 8:15 a.m., the following was observed. CNA #6 was observed with both hands gloved. Two residents requested bread. With gloved hands the CNA picked up the bagged loaf of bread, removed the closure at the end of the bag, reached into the bag and placed one slice of bread onto each resident's plate. During observation of the lunch meal on 07-08-15 at 11:30 a.m., the following was observed. CNA #9 was observed with both hands gloved. The CNA opened the door to the food cart, removed one resident plate,			

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	removed the domed cover, picked up the bowl of peas and poured the peas onto the resident's plate. The CNA's gloved hands touched the peas as she poured the contents from the bowl. This was repeated for 7 meals presented to the resident's as each time the CNA opened the door to the food cart and removed the resident's plate. The CNA failed to remove her gloves or wash her hands. During observation of the breakfast meal on 07-09-15 at 8:00 a.m., the following was observed. CNA #11 was observed with gloves donned to both hands. As the CNA opened the door to the food cart, she removed the breakfast plate for the resident, removed the domed cover, and took her gloved hand to move the bacon slices from the top of the omelet and subsequently touched the top of the omelet, and placed the bacon slices onto the plate surface. The CNA not only picked up the bacon with gloved hands, she repeated opening the door to the food cart, removing the plate, domed cover and moving the bacon from the top of the resident's for 5 additional observations. CNA #6 with hands gloved, carried the packaged loaf of bread throughout the unit. When a resident requested a slice of			

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	bread, with both hands continued to be gloved, the CNA unfastened the top of the bag, placed her gloved hand into the package and placed a slice of bread onto the resident's plate. Throughout these observations, the CNA's did not removed gloves or wash hands. A review of the facility policy on 07-09-15 at 11:10 a.m., titled "Serving Food," and dated "2005," indicated the following: "Policy Overview: The Dining Services Management should ensure foods are served using clean and sanitized utensils. When utensils are not practical, certain foods may be served by first washing hands and then wearing approved food handling gloves." "Policy Detail - 1. All foods should be served with clean, sanitized utensils such as a scoop, spoodle, tongs, ladle, etc. 2. If a food item needs to be picked up by hand, hands must be washed and an approved food handler's glove worn. (Example: If serving toast, the associate must wear a glove on the hand that is touching the toast.). 3. When gloves become soiled by touching soiled or dirty items, gloves must be removed, hands washed and new gloves put on."			

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	A review of a subsequent facility on 07-09-15, titled "Hand Washing - Associates," and dated as revised "December 2007," indicated the following: "Purpose: Handwashing is regarded as the single most important means of preventing the spread of infections. All associates should wash their hands to prevent the spread of infection and disease to other residents, other associates and visitors." "Suggested Guidelines: 1. Appropriate fifteen (15) to (20) second hand washing should be performed in situations including but not limited to: Before touching, preparing or serving food. 3. The use of gloves does not replace hand washing." This State tag relates to Complaint IN00177165.			