

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/31/2015
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NAME OF PROVIDER OR SUPPLIER  STRATFORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032
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F 000  Bldg. 00	<p>This visit was for Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00170123.</p> <p>Complaint IN00170123 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 23, 24, 25, 26, 27, 30, &amp; 31, 2015.</p> <p>Facility number: 011151 Provider number: 155794 AIM number: N/A</p> <p>Census bed type: SNF: 14 Residential: 32 Total: 46</p> <p>Census payor type: Medicare: 8 Other: 38 Total: 46</p> <p>Residential Sample: 9</p> <p>These deficiencies reflect state findings</p>	F 000		
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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 157 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review,</p>	F 157	<u>What corrective action will be</u>	04/30/2015			

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	<p>the facility failed to notify a resident's family member/legal representative of a change in health condition and/or medication/treatment changes for 1 of 20 residents reviewed for family notification. (Resident #25)</p> <p>Findings include:</p> <p>During an interview on 3/24/15 at 5:19 p.m., a family member indicated the resident had a change in condition within the past several months, which was a wound on his leg. She indicated she was the responsible person who should have been notified when there was a change in the resident's condition and/or a medication/treatment change. She indicated she had not been notified about the wound on the resident's leg. She indicated she had found out about the wound on his leg when she noticed his right leg had a dressing on it and she asked the nurse about the dressing on his leg. The family member indicated she had not been notified regarding medications being changed. She indicated she had not been informed of all changes in Resident #25's Depakote dosages.</p> <p>During an interview on 3/27/15 at 2:45 p.m., the Director of Nursing (DON) indicated when a family member was</p>		<p><b><u>taken by the facility?</u></b>Healthcare nursing staff immediately educated on Notification of Changes pertaining to the resident's health condition on 3/30/15. DON met with POA of resident #25 to discuss acute condition changes that have occurred with this resident (total chart review) on 4/17/15. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b>All Charts have been reviewed to ensure that notification was given to the resident's legal representative for residents that have experienced acute condition changes. Audits (attachment #1) were completed by 4/20/15 and no other active resident was missing notification documentation on acute condition changes. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b>The DON will audit physician orders and the 24 hour book orders for any acute condition changes 5 days per week. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. Staff educated to the 24 hour acute documentation requirements by 4/20/15. <b><u>How will the corrective action be monitored to ensure the deficient practice does not</u></b></p>				

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	<p>notified of a new physician order, the nurses documented the notification on the order sheet or the nurses' progress notes.</p> <p>During an interview on 3/30/15 at 10:48 a.m., the DON indicated a family member was to be notified as soon as there was a change in the condition of a resident.</p> <p>Resident #25's record was reviewed on 3/26/15 at 9:37 a.m. Diagnoses included, but were not limited to, diabetes, difficulty in walking, muscle weakness, and Alzheimer's disease.</p> <p>A physician progress note, dated 3/2/15, indicated Resident #25 had a new open area on his right lower extremity, which was a skin tear. The note indicated the area was reddened and slightly warm to the touch. The resident had 2+ edema of the lower extremities.</p> <p>Resident #25's record did not indicate family notification of the following physician's orders: a. 3/2/15--Right lower extremity skin tear-Cleanse with Normal Saline, then apply Bacitracin (an antibiotic ointment) twice daily to affected area, then cover with non-adherent dressing, then an ABD</p>		<p><b><u>recur and what QA will be put into place?</u></b>The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		

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F 282 SS=D Bldg. 00	<p>(abdominal) pad and secure with kerlix wrap.</p> <p>b. 3/19/15--Decrease Depakote (An anticonvulsant medication) to 250 mg (milligrams) by mouth twice daily.</p> <p>c. 3/19/15--Apply tubigrips (tubular shaped compression stocking used to reduce swelling) medium pressure to bilateral lower extremities foot to knee. On in the a.m. and off in the p.m. for edema.</p> <p>d. 3/26/15--Discontinue Depakote sprinkles, Depakote ED 250 mg by mouth twice daily for dementia with behaviors.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow physician orders for 1 of 20 residents reviewed for following physician orders. (Resident #25)</p> <p>Findings include:  On 3/26/15 at 9:38 a.m., the resident was</p>	F 282	<p><b><u>What corrective action will be taken by the facility?</u></b> Resident #25 - CNA sheet stated that bilateral legs were to be elevated along with the application of tubigrips in the am and removal in the pm. The CNAs did not follow their respective assignment sheets. Immediate education was conducted with the healthcare staff on 3/30/15. <b><u>How will the</u></b></p>	04/30/2015

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	<p>observed sitting in his room in a straight back chair. His bilateral legs were not elevated at that time and he had edema (swelling) to his bilateral ankles and lower extremities. The resident did not have his tubigrips (tubular shaped compression stockings used to reduce swelling) on at that time.</p> <p>On 3/26/15 at 12:58 p.m., the resident was observed sitting in his room in a straight back chair. His bilateral legs were not elevated at that time and he had edema to his bilateral ankles and lower extremities. He did not have his tubigrips on his bilateral legs.</p> <p>On 3/26/15 at 4:03 p.m., the resident was observed sitting in a straight back chair without his tubigrips on his bilateral legs. His legs were not elevated at that time and he had edema to his bilateral ankles and lower extremities.</p> <p>On 3/30/15 at 10:20 a.m., the resident was observed sitting in his recliner with his feet down and he had edema to his ankles and lower extremities. He did not have his tubigrips on his bilateral legs. A family member was visiting at that time and indicated the resident had not had his tubigrips on his bilateral legs on 3/29/15 or today. She indicated she had to tell the staff to place the tubigrips on the resident</p>		<p><b><u>facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b></p> <p>Charts have been reviewed to ensure that physician orders and therapy communication correlate with the CNA assignment sheets. Audits (attachment #2) completed by 4/20/15. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b>The DON will audit the physician orders and therapy communication documentation to ensure that the CNA assignment sheets are up-to-date 5 days per week. The DON will observe 3 residents daily 5 times per week to ensure the CNAs are following the CNA assignment sheets. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and follow-up. Re-education completed with all healthcare staff on the utilization of the C.N.A assignment sheets by 4/20/15. New hires will continue to be educated during on floor orientation on an ongoing basis. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b>The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any</p>		

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	<p>and he did not have his tubigrips applied until 1 p.m. on 3/29/15.</p> <p>Resident #25's record was reviewed on 3/26/15 at 9:27 a.m. A physician's order dated 3/19/15, indicated tubigrips (medium pressure support stockings) to his bilateral lower extremities applied in the a.m. and removed in the p.m., for edema.</p> <p>During an interview on 3/24/15 at 4:46 p.m., a family member of Resident #25's indicated staff identified the extremity edema (swelling) at the beginning of March and support hose were ordered. She indicated the support hose had not been placed on the resident as of 3/24/15.</p> <p>During an interview on 3/27/15 at 11:15 a.m., the Director of Nursing (DON) indicated the tubigrips ordered on 3/19/15 were not delivered to the facility until the evening of 3/26/15.</p> <p>During an interview on 3/30/15 at 5:18 p.m., the DON indicated the night shift staff was assigned to get the resident out of bed every morning. He indicated the resident required assistance from the staff to get dressed and place his tubigrips on his bilateral lower extremities every morning.</p>		<p>recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		

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F 323 SS=D Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the safety of a resident during a transfer for 1 of 1 resident reviewed for safe transfers (Resident #38).</p> <p>Findings include:</p> <p>During an observation on 03/24/2015 12:35 p.m., CNA #1 transferred Resident #38 from her wheelchair to a straight back dining chair in the dining room by holding the resident's right arm. The resident indicated to CNA #1 she needed to transfer her from the left side.</p> <p>During an interview on 3/24/2015 12:46 p.m., CNA #1 indicated she should not have used the resident's right arm to assist her to stand and indicated she had a gait belt she could have used for transferring the resident.</p> <p>During an interview with Occupational Therapist (OT) #2 on 03/26/2015 at 11:03 a.m., she indicated Resident #38</p>	F 323	<p><b><u>What corrective action will be taken by the facility?</u></b>All healthcare staff educated immediately on appropriate resident transfers. Education completed on 3/26/15 and 3/27/15. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b>The DON will audit all CNA assignment sheets to ensure that appropriate transfer information is documented. Audit (attachment #3) completed by 4/20/15. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b>The DON will observe 3 resident transfers per day 5 times per week to ensure the use of gait belts and proper transfer techniques. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. All healthcare staff educated to the use of gait belts and proper resident transfer</p>	04/30/2015

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F 371 SS=F Bldg. 00	<p>had a rotator cuff injury on the right side. OT #2 indicated gait belts should be used for supporting the resident during transfers instead of holding the resident's arm.</p> <p>During an interview on 3/26/2015 at 1:50 p.m., the DON (Director of Nursing) indicated he provided in-services on using a gait belt and indicated CNA #1 should have had it available at all times.</p> <p>The record for Resident #38 was initially reviewed on 3/24/2015 at 10 a.m. The record indicated the resident had a history of right sided rotator cuff injury and indicated the resident needed 2 person assistance with transfers.</p> <p>A facility policy and procedure on gait belt use was provided by the DON on 3/26/2015 at 2:30 p.m. The policy and procedure dated, 12/8/2014 indicated, "...Plan transfer to patient's strong side...."</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or</p>		<p>techniques by 4/20/15. The therapy department will continue to conduct proper resident transfer education during General Orientation for all new hires.</p> <p><b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b>The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		

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	<p>local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure proper food storage, disposal of expired foods, and failed to ensure pans were stored under sanitary conditions. The deficient practice had the potential to affect 14 of 14 residents in the facility receiving food from the kitchen.</p> <p>Findings include:</p> <p>The following observations were made during a kitchen tour with the Director of Dining Services (DDS), which began on 3/23/15 at 11:46 p.m.</p> <p>1. The following items were observed in the dry storage area:</p> <p style="padding-left: 40px;">a. A plastic container of sprinkles used for ice cream topping had a two ounce black plastic cup laying inside of the container. The DDS indicated at that time the plastic cup was used to serve the sprinkles from the container and the plastic cup should not have been in the plastic container.</p> <p style="padding-left: 40px;">b. A bag with 3.5 pounds of</p>	F 371	<p><b><u>What corrective action will be taken by the facility?</u></b> The CDM educated the dietary staff on proper food storage, disposal of expired foods and storage of pans under sanitary conditions on 3/23/15. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b> All residents have the potential to be affected by the alleged practice. The CDM will continue to follow the established policy and procedure of conducting a sanitation audit (attachment # 5) of the main kitchen on a weekly basis and the RD will audit on a monthly basis. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b> The CDM will continue sanitation monitoring on a weekly basis and the RD on a monthly basis. The CDM will bring any identified issue to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The CDM will bring the results of the audits to the monthly QA Committee for</p>	04/30/2015	

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	<p>buttermilk pancake mix remaining dated 3/20/15</p> <p>was opened, but the bag was not securely closed or wrapped.</p> <p>c. A bag with 1 pound of two way Chocolate cake mix remaining dated 3/9/15, was opened, but was not securely closed or wrapped. The DDS indicated at that time the Kitchen staff should have rolled the top of the bags back down and wrapped the package in plastic wrap.</p> <p>d. A bottle with 3/4 gallon of light corn syrup remaining was open, did not have an open date. The DDS indicated at that time the light corn syrup should have had an open date and use by date on the bottle.</p> <p>2. The walk-in freezer was observed to have six 1 pound frozen egg yolk cartons with the use by date 4/27/14, stamped on the carton. The DDS indicated at that time the egg yolk cartons were expired and should have been thrown out.</p> <p>3. The following pans were observed to be wet. The DDS identified the types of pans and the liquid on the pans as water:</p> <p>a. There were four (40/210) size plastic pans observed with beads of water</p>		<p>review and recommendations. Any recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee. This practice will continue on an ongoing basis.</p>		

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	<p>between the pans and on the top of the last pan that was stacked.</p> <p>b. There were two 6 inch deep full size plastic pans observed with water between them. When the top pan was picked up the water ran off that pan onto the pan below it.</p> <p>c. There were two full quart measuring containers observed with beads of water between them.</p> <p>d. There was one sixth size metal pan used for the steam table observed with water running off of it onto another sixth size metal pan stacked underneath it.</p> <p>e. There was one third size metal pan used for the steam table observed with water onto another third size metal pan underneath it.</p> <p>f. There were two 4 inch size metal steam table pans observed with beads of water between the pans.</p> <p>g. There was one 4 inch half size metal steam table pan observed with beads of water on top of another half</p>			

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	<p>size stacked pan.</p> <p>h. There were two 4 one-half size metal steam table pans observed with beads of water in between the pans.</p> <p>During an interview on 3/23/15 at 12:00 p.m., the DDS indicated the pans had water between them and on top of them. He indicated the Kitchen staff should have made sure the pans were dry before they brought them over for storage on the shelves.</p> <p>A policy titled "Food Storage" dated 7/16/2012, was provided by the DDS on 3/30/15 at 10:49 a.m., indicated "...Procedure...4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled...6. Scoops must be provided for bulk foods... Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers...15. Frozen foods:... d. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded...."</p>				

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F 441 SS=F Bldg. 00	<p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>						

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	<p>Based on observation, interview and record review, the facility failed to ensure contact isolation procedures were followed for 2 of 7 residents reviewed for contact isolation. (Resident #3 and #1) The deficient practice had the potential to affect 14 of 14 residents residing on the skilled unit.</p> <p>Findings include:</p> <p>1. On 3/25/15 at 9:33 a.m., a sign that indicated "Please see Nurse before entering Thank You" and an isolation cart was observed set up with hand sanitizer, gloves, masks and gowns inside the cart and placed in front of the doors leading into the Skilled Nursing Facility Unit. At that time, the Director of Nursing (DON) indicated there was a Gastrointestinal outbreak on the unit with nausea, vomiting and diarrhea. He indicated six residents were affected at that time. He indicated everyone was being asked to follow contact precautions when coming onto the unit.</p> <p>On 3/26/15 at 4:12 p.m., a sign was observed hanging on Resident #3's closed door that indicated, "Please see Nurse before entering Thank You." CNA #3 walked into Resident #3's room without a protective gown. At that time, CNA #3 indicated she should have worn a gown,</p>	F 441	<p><b><u>What corrective action will be taken by the facility?</u></b> All healthcare staff re-educated to the established infection control procedures on 3/25/15. Currently, no resident is on contact isolation.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b> All residents have the potential to be affected by the alleged practice. All healthcare staff have been re-educated to the infection control program. Education completed on 3/25/15. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b> The DON will monitor the staff when a resident requires contact isolation procedures to ensure that the established infection control procedures are followed by all healthcare staff. The DON will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The DON will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the DON and the results will be brought to the next scheduled QA</p>	04/30/2015

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	<p>gloves and mask and indicated there were no gowns available.</p> <p>Resident #3's record was reviewed on 3/27/15 at 4:34 p.m. A physician's order, dated 3/25/15, indicated room isolation.</p> <p>A nurses' progress note, dated 3/26/15, indicated the resident was in contact isolation.</p> <p>During an interview on 3/26/15 at 4:20 p.m., Resident #3 indicated nursing staff had not been putting the isolation protective equipment on every time they came into her room to provide care.</p> <p>During an interview on 3/26/15 at 4:31 p.m., the Director of Nursing (DON) indicated he was aware CNA #3 entered Resident #3's room without an isolation gown on and he was in the process of re-educating staff on proper isolation policies and procedures.</p> <p>2. On 3/26/15 at 4:05 p.m., a sign was observed hanging on Resident #1's closed door that indicated, "Please see Nurse before entering Thank You." Resident #1 asked CNA #3 why she was donning personal protective equipment. CNA #3 indicated to the resident she needed to put on protective equipment before entering the room. Resident #1 indicated</p>		Committee. This practice will continue for 3 months or until a pattern of compliance is established.		

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	<p>no other staff put on the isolation equipment when they entered her room.</p> <p>Resident #1's record was reviewed on 3/30/15 at 11:26 a.m. A Minimum Data Set (MDS) assessment, dated 2/20/15, indicated a BIMS (Brief Interview for Mental Status) score of 13 out of 15, indicated the resident was cognitively intact.</p> <p>A physician's order, dated 3/25/15, indicated room isolation.</p> <p>A nurses' progress note, dated 3/26/15, indicated the resident was in contact isolation.</p> <p>During an interview on 3/26/15 at 4:42 p.m., Resident #1 indicated nursing staff had not worn the isolation protective equipment every time they entered her room to provide care. She indicated staff took her to the bathroom without using the protective isolation equipment. While the resident was being interviewed, the DON was observed delivering additional isolation gowns to her room.</p> <p>During an interview on 3/26/15 at 4:31 p.m., the DON indicated he was aware CNA #3 entered another resident's room without wearing an isolation gown and</p>			

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R 000  Bldg. 00	<p>indicated he was in the process of re-educating staff on proper isolation policies and procedures.</p> <p>A policy titled "Contact Precautions" was provided by the DON on 3/30/15 at 11:08 a.m., which indicated "PURPOSE: It is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident or by contact with items in the resident's environment... II. Gloves and Hand Hygiene... B. Gloves should be worn when entering the room and while providing care for the resident... III. A. A gown should be donned prior to entering the room or resident's cubicle... VI... Clostridium difficile and other infectious causes of diarrhea..."</p> <p>3.1-18(j)</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 000		

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R 217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(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:</p> <p>(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 interview and record review, the facility failed to update the service plan to reflect services provided for fall safety for 2 of 9 residents reviewed for service plans. (Residents # 161 and 167)</p> <p>Findings include:</p>	R 217	<p><b><u>What corrective action will be taken by the facility?</u></b> The care plans for residents #161 and #167 were updated 4/17/15. All care plans and physician orders have been audited to ensure that the care plans reflect the services provided for fall safety. Audits (attachment #6) completed on</p>	04/30/2015			

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	<p>On 3/30/15 at 1 p.m., the record review for Resident #161 was completed. Diagnoses included, but were not limited to, gout, dementia, high blood pressure and osteoarthritis.</p> <p>The Assisted Living Assessment, dated 11/6/14, indicated the resident required escort assistance to meal and activities in the community daily for mobility and transfer. The Safety Interventions section indicated the resident had fallen in the past 6 months and required Falls Management Interventions from staff daily.</p> <p>The Individual Care Plan Review, dated 11/6/14, indicated the resident had multiple falls and bruising to her face and the resident would follow up with therapy due to falls.</p> <p>The Care Plan, dated 2/6/15, indicated the resident was independent with transfers daily with staff assistance as needed over the next six months.</p> <p>The physician's orders, dated 3/27/15, indicated the resident was to have a chair and bed alarm in place to prevent falls. This was not documented on the Care Plan in the chart.</p>		<p>4/17/15. No other discrepancies noted from review of care plans and are reflective of all services provided. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b> All care plans and physician orders have been audited to ensure that they correlate with the interventions pertaining to fall safety. Audits completed on 4/17/15. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b> The RCD will audit the care plans on a weekly basis to ensure that they are updated to correlate with the physician orders and interventions pertaining to fall safety. The RCD will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The RCD will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>	

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R 273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper food storage, disposal of expired foods and failed to ensure pans were stored under sanitary conditions. The deficient practice had the potential to affect 32 of 32 residents in the facility receiving food from the kitchen.</p> <p>Findings include:</p> <p>The following observations were made during a kitchen tour with the Director of Dining Services (DDS), which began on 3/23/15 at 11:46 p.m.</p> <p>1. The following items were observed in the dry storage area:</p> <p>a. A plastic container of sprinkles used for ice cream topping had a two ounce black plastic cup laying</p>	R 273	<p><b><u>What corrective action will be taken by the facility?</u></b>The CDM educated the dietary staff on proper food storage, disposal of expired foods and storage of pans under sanitary conditions on 3/23/15.<b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b>All residents have the potential to be affected by the alleged practice. The CDM will continue to follow the established policy and procedures of conducting a sanitation audit (attachment #5) of the main kitchen on a weekly basis and the RD will audit on a monthly basis.<b><u>What measures will be put into place to ensure the practice does not recur?</u></b>The CDM will continue sanitation monitoring on a weekly basis and</p>	04/30/2015

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	<p>inside of the container. The DDS indicated</p> <p>at that time the plastic cup was used to serve the sprinkles from the container and the plastic cup should not have been in the plastic container.</p> <p>b. A bag with 3.5 pounds of buttermilk pancake mix remaining dated 3/20/15 was opened, but the bag was not securely closed or wrapped.</p> <p>c. A bag with 1 pound of two way Chocolate cake mix remaining dated 3/9/15, was opened, but was not securely closed or wrapped. The DDS indicated at that time the Kitchen staff should have rolled the top of the bags back down and wrapped the package in plastic wrap.</p> <p>d. A bottle with 3/4 gallons of light corn syrup remaining was open, but had not been dated with an open date. The DDS indicated at that time the light corn syrup should have had an open date and use by date on the bottle.</p> <p>2. The walk-in freezer was observed to have six 1 pound frozen egg yolk cartons with the use by date 4/27/14, stamped on the carton. The DDS indicated at that</p>		<p>the RD on a monthly basis. The CDM will bring any identified issue to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b> The CDM will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the CDM and the results will be brought to the next scheduled QA Committee. This practice will continue on an ongoing basis.</p>		

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	<p>time the egg yolk cartons were expired and should have been thrown out.</p> <p>3. The following pans were observed to be wet. The DDS identified the types of pans and the liquid on the pans as water:</p> <p>a. There were four (40/210) size plastic pans observed with beads of water between the pans and on the top of the last pan that was stacked.</p> <p>b. There was two 6 inch deep full size plastic pans observed with water between them. When the top pan was picked up the water ran off that pan onto the pan below it.</p> <p>c. There were two full quart measuring containers observed with beads of water between them.</p> <p>d. There was one sixth size metal pan used for the steam table observed with water running off of it onto another sixth size metal pan stacked underneath it.</p> <p>e. There was one third size metal pan used for the steam table observed with water onto another third size metal pan underneath it.</p>			

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	<p>f. There were two 4 inch size metal steam table pans observed with beads of water between the pans.</p> <p>g. There was one 4 inch half size metal steam table pan observed with beads of water on top of another half size stacked pan.</p> <p>h. There were two 4 one-half size metal steam table pans observed with beads of water in between the pans.</p> <p>During an interview on 3/23/15 at 12:00 p.m., the DDS indicated the pans had water between them and on top of them. He indicated the Kitchen staff should have made sure the pans were dry before they brought them over for storage on the shelves.</p> <p>A policy titled "Food Storage" dated 7/16/2012, was provided by the DDS on 3/30/15 at 10:49 a.m., indicated "...Procedure...4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled...6. Scoops must be provided for bulk foods... Scoops</p>			

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R 354 Bldg. 00	<p>are not to be stored in food or ice containers, but are kept covered in a protected area near the containers...15. Frozen foods:... d. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded...."</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review, the facility failed to ensure a transfer form was completed for 1 of 2 residents reviewed for transfer to an acute care facility (Resident #271).</p> <p>Findings include:</p>	R 354	<p><b><u>What corrective action will be taken by the facility?</u></b> Transfer forms (attachment #7) are utilized for all residents in the Assisted Living setting. Nursing staff educated to the proper utilization of transfer forms for all residents transferred to a different healthcare setting by 4/17/15.</p>	04/30/2015

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	<p>The record for Resident #271 was reviewed on 3/30/2015 at 4:35 p.m. Diagnoses included, but were not limited to, osteomyelitis, general muscle weakness and diabetes.</p> <p>The nursing note, dated 3/27/2015 indicated, "QMA [Qualified Medication Aide] called staff to room to assess resident, not feeling well. BS [Blood Sugar] 208... cold and clammy...[name of doctor's group] made aware.</p> <p>A physician's order, dated 3/27/2015, indicated, "May send resident to ER for eval [evaluation] et [and] treat." The record did not indicate a transfer form was completed.</p> <p>During an interview on 3/31/2015 at 9:45 a.m., RN #5 indicated there should have been a transfer form but she could not locate it.</p> <p>During an interview on 3/31/2015 at 9:55 a.m., the DON indicated there was no transfer form available for this resident. The DON indicated a transfer form was not filled out.</p>		<p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b>All residents have the potential to be affected by the alleged practice. All nursing staff will be educated to the use of the transfer form for all resident transfers by 4/17/15. <b><u>What measures will be put into place to ensure the practice does not recur?</u></b>The RCD will review all records for all residents transferred to a different healthcare setting 5 days per week to ensure that the proper transfer form was utilized. The RCD will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up. <b><u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b>The RCD will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/31/2015	
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R 410  Bldg. 00	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure admission tuberculin (TB) screening was completed for 1 of 5 residents reviewed for TB screening. (Resident #161)</p> <p>Finding included:</p> <p>On 3/30/15 at 1 p.m., the record review for Resident #161 was completed. Diagnoses included, but were not limited to, gout, dementia, high blood pressure and osteoarthritis.</p> <p>The resident was admitted to the facility</p>	R 410	<p><b><u>What corrective action will be taken by the facility?</u></b>Resident #161 received a PPD on 4/8/15. The second step will be placed on 4/22/15.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b></p> <p>All resident charts have been audited to ensure that the admission PPDs are placed and documented in a timely manner. Audit (attachment #8) completed</p>	04/30/2015			

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	<p>on 7/27/14.</p> <p>A document titled, " Medical History and Physical" dated 7/15/14, indicated,"...Date of PPD: [Purified Protein Derivative]...handwritten to side indicated please obtain from [name of facility]...."</p> <p>On 3/30/15 at 4:30 p.m., the Resident Care Director indicated she had not been able to locate the PPD upon admission for Resident #161.</p>		<p>by 4/17/15.<u>What measures will be put into place to ensure the practice does not recur?</u>The nursing staff has been educated to the admission PPD procedure. Education completed 4/17/15. The RCD will audit all new admissions 5 days per week for timely PPD documentation. The RCD will bring any identified issues to the next scheduled morning management interdisciplinary meeting for review and recommendations for follow-up.<u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u>The RCD will bring the results of the audits to the monthly QA Committee for review and recommendations. Any recommendation made by the committee will be followed up by the RCD and the results will be brought to the next scheduled QA Committee. This practice will continue for 3 months or until a pattern of compliance is established.</p>		