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 05/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKEDALE MICHIGAN CITY	1400 E COOLSPRING AVE MICHIGAN CITY, IN 46360

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the investigation of Complaint IN00197516. Complaint IN00197516 - Substantiated, no deficiencies related to the allegations are cited. Survey dates: May 17 & 18, 2016 Facility number: 010610 Provider number: 010610 AIM number: N/A Census bed type: Residential: 70 Total: 70 Sample: 10 These State findings are cited in accordance with 410 IAC 16.2-5. Quality review completed by 32883 on 5/20/16.	R 0000	Plan of correction is not to be construedas an admission of or agreement with finding and conclusions inthe Statement of Deficiencies, or the proposed administrative penalty(with right to correct) on the community Rather, it is submitted as confirmationon our ongoing efforts to comply with statutory and regulatoryrequirements In this document, we have outlined specific actions inresponse to each allegation or finding We have not presented all contraryfactual or legal arguments, nor have we identified mitigating factors Weremain committed to the delivery of quality health care services and willcontinue to make changes and improvement to satisfy the objective	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but			

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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	is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure three (3) hours of annual dementia training was completed for 3 of 8 employees reviewed for dementia training. Finding includes:	R 0120	*Two of the three associates found to be non-compliant participated in a 3 hour in service on dementia on 5/31/16. The third associate is no longer employed at facility.* In-service attendance logs for associates were reviewed by the Executive Director/Designee to verify the	05/31/2016

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	The Dementia Training Logs for the year of 2015 were reviewed on 5/18/16 at 12:00 p.m., and indicated the following: a. LPN #1, who had been working at the facility since 11/21/12, did not receive the three hours of annual dementia training for the year of 2015. b. LPN #2, who had been working at the facility since 6/25/12, did not receive the three hours of annual dementia training for the year of 2015. c. CNA #1, who had been working at the facility since 9/16/13, did not receive the three hours of annual dementia training for the year of 2015. Interview with the Business Office Manager on 5/18/16 at 12:45 p.m., indicated she was responsible for ensuring the employees received their annual dementia training. She further indicated she did not have a system in place to keep track of the employees and their training, nor did she check at the end of 2015 to ensure all employees had completed their annual (3) hours of dementia training. Interview with the Administrator on 5/18/16 at 12:52 p.m., indicated all of the		correct of amount of required hours of dementia training A tickler file/spreadsheet has been devised and implemented in order to document and to monitor training as it occurs to verify compliance with Indiana State - required training as well as Brookdale Standards The Executive Director has provided an inservice to the Business Office Manager as well as department managers to inform them of the state requirements and the need to verify compliance in each department On a quarterly basis, training records will be reviewed by the Business Office Manager/HR designee to verify required training is complete and documented if an associate fails to attend the required training for any reason associates will be scheduled for make- up training that must be completed timely Corrective action, up to and including suspension or termination may occur, if non-compliance is noted New hires will not be allowed to have independent resident contact until they complete Brookdale's foundations training, which satisfies state's requirements Business Office Coordinator/HR designee will monitor the documentation and completion of training following each inservice ED and or delegate will audit for compliance monthly and will direct additional corrective action based on audit	

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	above employees had not received their three hours of annual dementia training.		findings	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a functional environment related to dirty carpet, marred walls, torn and stained floor tile, and dirty ceiling vents for 1 of 2 buildings. (The Clairebridge Memory Care building) Findings include: An Environmental Tour was completed 5/18/16 at 10:45 a.m., with the Maintenance Supervisor. The following was observed in The Clairebridge Memory Care building: 1. The carpet in the B Hall was observed dirty and dingy throughout and around the resident's rooms. 2.The vinyl floor tile was concaved throughout the B Hall shower room. The tile was stained and discolored. There were holes in the floor tile and the tile was peeling away from the metal strip by the shower stall. The shower room walls	R 0144	·B Hall bathroom in Claire Bridge building was cleaned ·walls repaired and painted May 20, 2016 ·Vinyl flooring is being replaced and should becomplete by June 15, 2016. ·Carpet Clare Bridge Building-B-Hall- hallwaywas cleaned on May 12, 2016 and MD will provide maintenance cleaning on amonthly basis. MD/ED will monitorcondition of carpet and work to get replaced if condition of carpet worsens. MD will audit the physical condition of thebuilding on a weekly basis and report findings to the Executive Director. Outstanding maintenance issues and necessaryrepairs will be reviewed with the ED weekly. ED and/or their delegate will audit physical plant of other areas on amonthly basis to verify ongoing compliance	05/19/2016

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	were marred and paint chipped. The inside of the shower room door was scuffed with black marks. The ceiling vent was dirty and dusty. Interview with the Maintenance Supervisor at that time, indicated the other two shower rooms were renovated last year, however, the B Hall shower room was not included in the renovation. Interview with the Administrator on 5/18/16 at 11:00 a.m., indicated she was aware of the carpet on the B Hall and did not know why it was not removed last year with all the renovations.			
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 observation and interview, the facility failed to maintain an effective pest control program to ensure the facility was free of pests related to ants in 1 of 3 shower rooms in the Clairebridge Memory Care building. (The B Hall shower room) Finding includes: On 5/18/16 at 10:45 a.m., during the Environmental tour with the Maintenance	R 0149	·Ecolab was brought in May 19, 2016 for ant extermination process. No ants have been noted anywhere in community since this was done. ·Ecolab will continue to do preventive spray for bugs on a monthly basis. ·MaintenanceDirector (MD) will monitor both buildings on a weekly basis checking for any return of ants. A Pest Control binder will be available for associates or residents to communicate sightings if noted in	05/19/2016

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	Supervisor in the Clairebridge Memory Care building, live ants were observed crawling on the floor, on the walls and on top of the sink in the B Hall shower room. The live ants were also observed crawling in the shower stall. Interview with the Maintenance Supervisor at that time, indicated he was unaware of the ants. He further indicated the shower room was currently being used by staff to bathe residents. The Maintenance Supervisor indicated the Pest Control Company had last been in the facility on 5/9/16, however, they treated for mice and cockroaches in the kitchen and hallways.		between checks by Maintenance Director. Associates have been re-educated bythe Maintenance Director/Designee on the purpose of the Pest Control communication Binder. · Additional actions will be at the discretionof the Executive Director, based on new findings; if there is concern noted, Ecolab will be brought back in for further treatment.	
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 and interview, the facility failed to serve food under sanitary conditions related to grease on the stove back splash, dusty lights, dried food on the inside and outside of the ice machine, and 15 open seasoning containers on the shelf for 2 of 2 kitchens observed. (The Assisted Living Kitchen & Clairebridge Memory Care Kitchen)	R 0273	·Kitchens were cleaned thoroughly on May 19th and 20th, 2016. ·Dietary Services Director (DSD) re-introduced the cleaning log process requiring a sign off of associates who perform the cleaning tasks on a daily basis. Dietary associates were re-educated on the process by the DSD. ·DSD will inspect the	05/19/2016

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	Findings include: 1. On 5/17/16 at 8:25 a.m., the following was observed during the Brief Kitchen Sanitation tour in the Assisted Living Kitchen. a. There was a large accumulation of grease build up on the stove back splash. b. The lights above the stove were dusty. c. The ice machine had dried food on the inside and outside. 2. On 5/17/16 at 8:55 a.m., the following was observed during the Brief Kitchen Sanitation tour in the Clairebridge Memory Care Kitchen. a. There were 15 open seasoning containers on the shelf. Interview with the Dietary Food Manager on 5/18/16 during the Full Kitchen Sanitation tour, indicated all of the above were in need of cleaning and/or repair.		cleanliness of the kitchen on a weekly basis and make corrections or delegate corrective action as necessary. · ED and/or delegate will perform a monthly inspection to ensure compliance in kitchen cleanliness. ED will be responsible for directing additional corrective action based on audit findings.	