

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
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R 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 4/30/15.</p> <p>Survey dates: July 7 & 8, 2015</p> <p>Facility number: 011804 Provider number: 011804 AIM number: N/A</p> <p>Census bed type: Residential: 105 Total: 105</p> <p>Census payor type: Other: 105 Total: 105</p> <p>Sample: Residential sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>	
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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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R 0148 Bldg. 00	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation, interview and record review, the facility failed to ensure hazardous chemicals and areas housing hazardous equipment/chemicals were maintained in a safe and secure manner on 3 of 3 floors in the assisted living facility and in 2 of 2 locked Keepsake Memory Care Units (North and South). This deficiency had the potential to affect 8 confused and mobile residents of the 61 residents who resided in the assisted living unit on the 3 floors of the facility and of 17 confused and mobile residents of the 44 residents who resided in the</p>	R 0148	<p>R 148 Sanitation and Safety Standards – storage 1. Upon identification of the concern the facility maintenance supervisor and administrator addressed each concern identified during the survey rounds. Doors were secured and/or cleaning chemicals were removed or secured. 2. All residents have the potential to be affected by this alleged deficient practice. The maintenance supervisor and assistance conducted a full house audit of all storage doors beauty shops, and any public areas of</p>	08/07/2015

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	<p>North and South Keepsake Memory Care units.</p> <p>Findings include:</p> <p>1. An observation on the Keepsake South Memory Care unit on 7-7-2015 from 11:05 a.m. - 11:19 a.m., indicated the following:</p> <p>At 11:05 a.m., an unlocked cabinet (had a lock but was not secured) above the sink near the entrance of the unit contained 2 boxes of a scent wave cartridge on the second shelf. Further observation indicated 2 other boxes were on top of the cabinets.</p> <p>An unlocked, open bathroom/shower room near the entrance of the unit had a 23.7 ounce container of Head and Shoulders shampoo on the back of the toilet. The label indicated "keep out of reach of children."</p> <p>At 11:10 a.m., an observation indicated a resident who had been wandering in the unit was seated across from the unattended beauty shop which had the door open. An observation inside the unattended beauty shop indicated an unlabeled glass container which contained a blue liquid, a container of Spic and Span cleaner with "keep out of</p>		<p>use for hazardous chemicals. Any concerns were immediately addressed via removal or properly locking of storage area.</p> <p>3. The administrator and designee in-serviced all staff on the guidelines pertaining to storage of hazardous chemicals and closet door security. Procedures were changed so that Housekeeping staff will verify twice daily in their designated work areas that storage areas are secured and public areas do not have hazardous chemicals present. The maintenance supervisor or designee will also check storage doors and public areas for hazardous chemicals during routine rounds. Housekeepers were in-serviced on securing their carts. Beauticians were in-serviced on proper storage of hazardous chemicals in their salons and door security.</p> <p>4. The administrator and/or designee will randomly check public areas and beauty shops for hazardous chemicals and secured storage area doors for proper function. Review will be conducted three (3) times weekly x 2 months, then weekly x 2 months, and monthly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

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	<p>reach of children" on the label and a 16 ounce bottle of Hydrocide with "keep out of reach of children" on the label. These chemicals were stored in unlocked, unsecured cabinets and within reach of a confused, mobile resident.</p> <p>At 11:15 a.m., an interview with 2 outside contracted persons who perform foot care monthly at the facility, indicated the door to the salon should have been shut when they left the room.</p> <p>An observation in the Keepsake North Memory Care unit on 7-7-2015 from 11:20 a.m. - 11:39 a.m., indicated the following:</p> <p>At 11:20 a.m., an open restroom door next to the activity area was unattended. Inside the restroom was a closet with no lock on the door handle and on the top shelf was a 16 ounce bottle of rubbing alcohol, an 8.5 ounce bottle of curl shaping gel, a 7 ounce bottle of hair spray, a 17 ounce can of hair spray and a 22 ounce container of cornstarch baby powder all with "keep out of reach of children" on the labels. On the third shelf, an uncapped 8 ounce can of hair spray was observed and had "keep out of reach of children" on the label. An observation on the 5th shelf, indicated a 7.5 ounce pump container of lemongrass</p>			

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	<p>and basil antibacterial soap was stored in an open plastic tub with "keep out of reach of children" and "if swallowed, get medical help or contact a Poison Control Center" on the label.</p> <p>At 11:30 a.m., a closet in the activity area had unsecured sliding doors and was accessible to residents. Inside the closet, two containers of sanitizing wipes were observed with "keep out of reach of children" on the label.</p> <p>At 11:35 a.m., an observation of the unattended nurse's station, indicated a 4 ounce container of hand sanitizer was out on the nurse station counter. Under the nurse station counter, a cabinet which was not able to be locked, contained a 32 ounce bottle of Bright Solutions Tropical Mist and a 20.3 fluid ounce bottle of body lotion. The hand sanitizer and body lotion had "keep out of reach of children" on each label.</p> <p>An observation on the 1st floor assisted living unit on 7-7-2015 from 11:40 a.m. - 11:49 a.m., indicated the following:</p> <p>At 11:40 a.m., a door labeled "Janitor Closet" between rooms 111 and 113 was unsecured and unattended. No facility staff were observed in the hallways near the area of the closet. Inside the closet</p>			

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	<p>were cleaning chemicals which included a gallon container of carpet extractor cleaner, Spic and Span spray and glass cleaner, two 1 gallon containers of disinfecting all purpose solution, and A 456 II disinfectant cleaner with "keep out of reach of children" on the label. There were three 44 ounce containers (two yellow and one orange color) on a shelf used in the wall dispenser with labels which stated "Bathroom Cleaner" and "Glass and Surface Cleaner".</p> <p>An observation on the 2nd floor of the assisted living unit on 7-7-2015 from 11:50 a.m. - 12:09 p.m., indicated the following:</p> <p>At 11:50 a.m., a door labeled "DON" (Director of Nursing) was unlocked, unattended and used for storage. Toward the wall on the left, two containers of sanitizing wipe (PDI Sani Cloths and Clorox Bleach germicidal cloths) were observed on a lower shelf in a crate. To the left of the crate, a 945 milliliter bottle of Comet Bathroom Cleaner was sitting on top of a computer tower which was on the floor. Each container has "keep out of reach of children" on the label.</p> <p>At 11:55 a.m., a door labeled "Mechanical Closet" across from room 225 was unsecured. The room contained</p>			

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	<p>a heating/cooling unit with a label on a pipe running to the unit which indicated "Caution Hazard of Electric Shock." The door would not secure and could be opened freely.</p> <p>At 11:58 a.m., an observation of the 2nd floor beauty salon indicated the door was open, unattended and accessible. An unlabeled, plain jar with a blue liquid and a comb inside, was out on the counter just behind the sink. An 8.4 ounce bottle of Eucerin lotion was observed on a shelf to the right of the sink with "keep out of reach of children" on the label. An unlabeled white squirt bottle with a red cap and a clear liquid inside was on a shelf to the right of the sink. A 2.6 ounce container of suave deodorant was in a drawer to the right of the sink. A 32 ounce spray bottle of Windex Powerized Vinegar Glass Cleaner was in a lower cabinet to the right of the sink. Both the drawer and the cabinet did not have the ability to be locked. "Keep out of reach of children" was on both the deodorant and Windex labels.</p> <p>At 12:05 p.m., an observation of the 2nd floor unattended and accessible fitness room, indicated a 27 ounce spray bottle of Lysol Fabric Mist was on a bookshelf in the room.</p>			

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	<p>An observation in the Keepsake North Memory Care Unit on 7-7-2015 at 12:10 p.m., indicated a 4 ounce container of Purell hand sanitizer was out on top of the medication cart which was parked at the unattended nurse station. A 4 ounce container of Purell hand sanitizer was also observed on the nurse station counter.</p> <p>An observation of the 3rd floor in the assisted living unit on 7-7-2015 from 2:32 p.m. - 2:44 p.m., indicated the following:</p> <p>At 2:32 p.m., a closet door between rooms 307 and 309 was not secured and contained cable TV equipment and 11 gallons of latex paint, 1 quart of polyurethane, 1 quart of ultra latex enamel paint and 1 quart of oil based enamel paint.</p> <p>At 2:38 p.m., a door labeled "Mechanical Closet" located between rooms 303 and 305 was unsecured. The room contained a heating/cooling unit with a label on a pipe running to the unit which indicated "Caution Hazard of Electric Shock." The door would not lock and could be opened freely.</p> <p>A tour of the facility with the Executive Director (ED) and the Maintenance</p>			

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	<p>Director on 7-8-2015 from 9:45 a.m. - 10:20 a.m., indicated the following:</p> <p>At 9:45 a.m., in Keepsake South, a container of Head and Shoulders Shampoo was in the restroom shower which was located near the entrance of the unit. The Maintenance Director removed the shampoo from the shower.</p> <p>At 9:47 a.m., the upper cabinet to the left of a sink outside the restroom was unsecured with 2 boxes of scent wave cartridges on the 2nd shelf and 2 boxes of the scent wave cartridges were on top of the cabinets. An interview with the Maintenance Director indicated the cabinets should remain locked at all times.</p> <p>At 9:50 a.m., an observation of the Beauty Salon in Keepsake South indicated the hair stylist was present and residents were getting their hair done. An interview with the hair stylist with the ED present, indicated the Beauty Salon doors should be secured when the salon was unattended. An observation in the beauty salon indicated a jar of blue liquid was on the counter with combs and brushes submerged in the liquid. Further interview with the hair stylist indicated the jar contained "Barbicide" and was used to sanitize the combs and brushes.</p>			

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	<p>The hair stylist indicated the container of Hydrocide in the bottom of the left cabinet was "hers."</p> <p>At 9:57 a.m., in the Keepsake North Memory Care Unit, an observation of the unsecured restroom closet by the activity area indicated a 16 ounce bottle of rubbing alcohol, an 8.5 ounce bottle of curl shaping gel, a 7 ounce bottle of hair spray, a 17 ounce can of hair spray and a 22 ounce container of cornstarch baby powder and a 7.5 ounce pump container of lemongrass and basil antibacterial soap were inside the closet. An interview with the ED and Maintenance Director indicated the products were not to be stored in the bathroom closet and instructed the unit staff to place the personal care products in a secured area.</p> <p>At 9:58 a.m., in the Keepsake North Memory Care Unit, an observation of a closet near the activity area of the unit were not able to be secured. With the ED present, the closet doors were slid open and 2 containers of sanitizing wipes were observed. A container of Super Sani Cloth was observed on the top shelf and a container of Purell Sanitizing wipes were observed right inside the closet on top of a cart. An interview with the ED indicated the sanitizing wipes should have been in a secured location.</p>			

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	<p>At 9:56 a.m., an observation of the Keepsake North Memory Care Unit nurse station with the ED and Maintenance Director indicated a 4 ounce container of Purell Hand Sanitizer was out on top of the medication cart located at the nurse station. A staff member was observed to use another 4 ounce bottle of Purell Hand Sanitizer and was observed to place it on the nurse station counter. The Maintenance Director was observed to tell the staff member the hand sanitizer had to be placed in behind a locked door. The staff member was observed to tell the Maintenance Director "we keep it on the medication cart." The Maintenance Director and the ED were observed to give verbal instructions to the 2 staff members present on the unit that the Purell Hand Sanitizer had to be stored behind a locked door. An observation of a staff member with keys to the medication cart indicated the Purell Hand Sanitizer was placed in the medication cart and locked.</p> <p>At 9:58 a.m., an observation of the Keepsake North Memory Care Unit nurse station, a lower cabinet which did not have a lock on it, contained a spray bottle of Bright Solutions Tropical Mist and a container of body lotion. An observation indicated the Maintenance Director</p>			

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	<p>removed the Bright Solutions Tropical Mist and the body lotion from the unit.</p> <p>At 10:00 a.m., an observation of the Janitor Closet between rooms 111 - 113 indicated the door was locked and secured. The ED and Maintenance Director were informed the door was unsecured and unattended on 7-7-2015 at 11:40 a.m. Interview with the ED indicated staff had been inserviced to ensure doors to closets were secured.</p> <p>At 10:02 a.m., an observation of the DON room on the 2nd floor indicated the door was locked. An interview with the Maintenance Director and ED indicated the door was unlocked on 7-7-2015 at 11:50 a.m. Further interview with the Maintenance Director indicated after the key was used to unlock the door, staff had to remember to manually lock the door when leaving the room by turning the lock or using the key or the door would remain unlocked when closed. An observation inside the room indicated the 2 containers of sanitizing wipes (PDI Sani Cloths and Clorox Bleach germicidal cloths) and Comet Bathroom Cleaner remained and were removed by the Maintenance Director.</p> <p>At 10:05 a.m., an observation of the Mechanical Room across from Room 225</p>			

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	<p>indicated the door was not secured. An interview with the Maintenance Director indicated during earlier rounds, he found the door unsecured with the lock not working. The Maintenance Director indicated the batteries were changed in the lock, but he did not ensure that the door was secured. Further observation of the door indicated the door would not secure. An interview with the Maintenance Director indicated the door would not secure due to the strike plate being placed too low.</p> <p>At 10:10 a.m., an observation of the 2nd floor Beauty Salon indicated the Salon doors were locked. The ED and Maintenance Director were present when the Hair Stylist was interviewed earlier and were made aware the 2nd floor Salon was open and unattended on 7-7-2015 at 11:58 a.m. An observation of the counter near the sink indicated a jar with a blue liquid was out on the counter behind the sink, a bottle of Eucerin lotion was on the right side shelf, the Suave deodorant was in a drawer and the Windex Powerized Vinegar Glass Cleaner was in the lower right cabinet.</p> <p>At 10:11 a.m., an observation of the 2nd floor fitness room indicated the fitness room door was open and the room unattended. The Lysol Fabric Mist was</p>			

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	<p>not observed out on the shelf, but a desk with a bottle of hand sanitizer and lotion were out on top of the desk.</p> <p>At 10:12 a.m., an observation with the ED and Maintenance Director of the 3rd floor Mechanical Closet door between rooms 303 and 35 indicated the door was not secured. An observation indicated the lock worked, but the door just was not secured.</p> <p>At 10:15 a.m., an observation with the ED and Maintenance Director of the closet between rooms 307 - 309 indicated it was locked and secured. An interview with the ED and the Maintenance Director indicated they were made aware the door was ajar and unattended on 7-7-2015 at 2:32 p.m. The contents of the closet included 11 gallons of assorted latex paint with "Keep out of Children" and "Do not take internally" in bold letters on the labels. In addition, a quart container of polyurethane and a quart container of ultra latex enamel paint with "keep out of reach of children" on the labels and a quart of oil based enamel with "Vapor Harmful...May Affect Brain and Nervous System, causing dizziness, headache or nausea" and "Keep out of Reach of Children" on the label were stored in the closet.</p>			

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	<p>An interview with the Assisted Living Wellness Director #2 on 7-8-2015 at 9:40 a.m., indicated there were 8 confused and mobile residents in the assisted living portion of the facility.</p> <p>An interview with the ED and the Maintenance Director on 7-8-2015 at 10:17 a.m., indicated the staff were inserviced regarding the security of the doors. The ED indicated staff were instructed to check that the closet doors were locked and secured.</p> <p>An interview with the Maintenance Director on 7-8-2015 at 11:05 a.m., indicated the paint in the closet between rooms 307 and 309 should have not been stored there.</p> <p>An interview with the Keepsake Wellness Director #3 on 7-8-2015 at 12:25 p.m., indicated a list of confused and mobile residents for the Keepsake Memory Care Units were provided. The list indicated there were 7 confused and mobile residents on the North unit and 10 on the South unit.</p> <p>Product labels and MSDS (Material Safety Data Sheets) information were provided by the Maintenance Director on 7-8-2015 by 2:15 p.m. and included the following:</p>			

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	<p>A "Safety Data Sheet" for Head and Shoulders Shampoo dated 2-4-2015 indicated "...causes eye irritation...."</p> <p>A copy of the label for Hydrocide indicated "...germicide and disinfectant...keep out of reach of children...danger..."</p> <p>A MSDS for Spic and Span cleaner dated 4-7-2015 indicated "...do not breathe mist...immediately call a Poison Center or doctor if swallowed...keep out of reach of children...."</p> <p>A MSDS for Isopropyl Alcohol dated 4-4-2014 indicated "...ingestion...Call Poison Control immediately...."</p> <p>A MSDS for Aussie hair spray dated 11-16-2000 indicated "...ingestion rinse out mouth with water and administer large amounts of milk...contact Poison Control Center...keep out of reach of children...."</p> <p>A MSDS for Non-Aerosol Hair Spray/Spritz dated 8-2-2002 indicated "...eye contact...promptly flush with water...get prompt medication attention if irritation persists...ingestion...get prompt medical attention...consult physician immediately...."</p>			

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	<p>A MSDS for Baby Powder Cornstarch dated 2-28-2008 indicated "...keep out of reach of children...inhalation...if affected person is not breathing, apply artificial respiration...if breathing is difficult, give oxygen...get medical attention...ingestion...if the material is swallowed, get medical attention...."</p> <p>A copy of the label for the Lemongrass and Basil Antibacterial Hand Soap indicated "...warnings for external use only...hands only...when using this product avoid contact with the eyes...keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>A copy of the label for Purell instant hand sanitizer indicated "...keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>A copy of the label for the studio beauty refreshing body lotion indicated "...keep out of reach of children...if swallowed, seek medical attention or call a Poison Control Center immediately...."</p> <p>A MSDS for Bright Solutions tropical mist was undated and indicated "...ingestion...call a physician</p>			

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	<p>immediately...keep out of reach of children...."</p> <p>A MSDS for Clorox Healthcare Bleach Germicidal Wipes dated 1-5-2015 indicated "...avoid contact with eyes, skin and clothing...ingestion...call a doctor or poison control center...."</p> <p>A MSDS for Super Sani-Cloth Germicidal Disposable Wipes dated 2-24-2012 indicated "...do not get in eyes or on clothing...avoid contact with skin...keep out of reach of children...."</p> <p>A MSDS for Comet disinfecting Sanitizing bathroom cleaner dated 6-18-2015 indicated "...first aid measures for ingestion...drink 1 or 2 glasses of water...do not induce vomiting...get medical attention immediately if symptoms occur...keep out of reach of children...."</p> <p>A MSDS for Windex Commercial Line Multi-Surface Cleaner Vinegar dated 6-27-2011 indicated "...keep out of reach of children..."</p> <p>A copy of the Eucerin skin fortifying body lotion label indicated "...keep out of reach of children...for external use only...avoid contact with eyes...."</p>			

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	<p>A copy of Suave anti-perspirant/deodorant label indicated "...for external use only...keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>A MSDS for Continental Joe Industrial Cleaner dated 5-29-2014 indicated the cleaner was a clear to slight hazy, amber in color and "...keep out of reach of children...."</p> <p>A MSDS for Stainless Steel Cleaner and Polish dated 7-21-2014 indicated "...causes damage to organs...cardiovascular system...keep out of reach of children...if exposed...call a poison center or doctor...."</p> <p>A MSDS for Shine-Up Lemon dated 1-18-2005 indicated "...keep out of reach of children...."</p> <p>A MSDS for Crystal Spotter carpet spotting agent dated 1-3-2012 indicated "...first aid measures...ingestion...seek medical advice...."</p> <p>2. An observation on 7/7/15 at 12:20 p.m., in the Keepsake North (a Memory Care Unit) Nurse's Station, which was unattended, a 4 ounce bottle of (Brand) Hand Sanitizer Gel was sitting out in the center of the desk in the nurses station</p>			

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	<p>and was visible from the hallway. There was also a 4 ounce bottle of (Brand) Hand Sanitizer Gel sitting out and visible on top of the medication cart. The (Brand) Hand Sanitizer Gel's label indicated, "...Warnings...For external use only...when using this product do not use in or near the eyes...Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>An observation on 7/8/15 at 8:45 a.m., in the Keepsake North Nurse's Station, which was unattended, a 4 ounce bottle of (Brand) Hand Sanitizer Gel was sitting out and visible on top of the medication cart.</p> <p>A current policy, "Locking of Doors" dated 7-2-2015 and provided by the ED on 7-8-2015 at 1:00 p.m., indicated no information regarding the locking and securing of Janitor closets, Mechanical Closets, Beauty Salon doors and hall closets.</p> <p>An interview with the ED on 7-8-2015 at 1:15 p.m., indicated the facility did not have a policy regarding chemical and personal care product storage.</p> <p>This deficiency was cited on the 4-30-2015, and the facility failed to</p>			

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R 0272 Bldg. 00	<p>implement a systemic plan of correction to prevent recurrence.</p> <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, interview and record review the facility failed to ensure coleslaw was served at the recommended temperature on the Keepsake North Memory Unit and on the Keepsake South Memory Unit and pureed food was served at the recommended temperature on the Keepsake South Memory Unit potentially affecting 26 of 26 residents who resided on the Keepsake North Memory Unit and 18 of 18 residents who resided on the Keepsake South Memory Unit.</p> <p>Findings include:</p> <p>A facility menu for the lunch meal on 7/7/15, indicated Ham and Potato soup and a choice of Beer Battered Cod served with Housemade Chips and Cole Slaw, or Gravy Covered Pork Cutlet served with a Sweet Potato and Cole Slaw.</p>	R 0272	<p>R 272 Food and Nutritional Services – foodtemperatures</p> <p>1. Afteridentification of the concern the facility food service director attempted tomeet with dietary server #1 forretraining on food temperatures, but he choose to resign immediately. Food Services Director then in-serviced alldietary team members on food temperature procedures and continued monitoring.</p> <p>2. All residents have the potential to beaffected by this alleged deficient practice. The facility food services staff will monitor and record food servingtemperatures to ensure that items are at the proper and safe servingtemperatures. Any concerns will be addressedaccordingly. Any non compliance with procedures by dietarystaff will result in further training and/or disciplinary action.</p> <p>3. Thefacility’s administrator and food services director have</p>	08/07/2015

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	<p>During an observation of the lunch meal in the Keepsake North Memory Unit kitchenette on 7/7/15, the following was observed:</p> <p>At 11:40 a.m., Dietary Server #1 was observed to take the temperatures of the food for the lunch meal. The temperatures of the ham and potato soup, the beer battered cod, and the sweet potato were within the recommended range at the time of service. The temperature of the gravy covered pork cutlet registered 134 degrees on the facility thermometer. Dietary Server #1 indicated the pork cutlet was not at the recommended temperature and would be returned to the facility kitchen for re-heating.</p> <p>At the request of the surveyor, Dietary Server #1 took the temperature of the coleslaw, which was in a steam table pan on the counter. The pan was not placed on ice to keep the coleslaw cold. The temperature of the coleslaw registered 58 degrees on the facility thermometer. Dietary Server #1 did not indicate the coleslaw was not at the recommended temperature. He was then observed to remove the steam table pan of the pork cutlets and take the pan back to the facility kitchen for re-heating. He was</p>		<p>in-serviced foodservice personnel on the facility's "Food Temperatures" policy and procedures in the event food is not at the proper temperature. In service included supplemental materials provided by corporate food services director. Food services leaders are also obtaining updated ServSafe training via local community program. Operationally, the food service team leaders will confirm at time of service that food is being served at proper temperature. Administrator/designee are also monitoring by daily observation. 4. The administrator and/or designee will conduct audit reviews of the serving temperatures of food, ensuring temperatures are recorded and proper. Reviews will be conducted randomly daily x 4 weeks, then weekly x 2 months, and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

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	<p>not observed to take the steam table pan of the coleslaw to the facility kitchen.</p> <p>At 12:25 p.m., Dietary Server #1 returned to the Keepsake North Memory Care Unit kitchenette with the re-heated pork cutlets. The temperature of the gravy covered pork cutlets registered at 144 degrees on the facility thermometer. He then began serving food to the residents, including the coleslaw which had not been kept on ice to keep it cold.</p> <p>During an observation of the lunch meal in the Keepsake South Memory Unit kitchenette on 7/7/15, the following was observed:</p> <p>At 12:40 a.m., Dietary Server #1 was observed to take the temperatures of the food for the lunch meal. The temperatures of the ham and potato soup, the beer battered cod, and the sweet potato were within the recommended range at the time of service. The temperature of the gravy covered pork cutlet registered 137 degrees on the facility thermometer. Dietary Server #1 indicated the pork cutlet was not at the recommended temperature and would be returned to the facility kitchen for re-heating.</p> <p>Two plates containing 3 bowls of pureed</p>			

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	<p>food were brought to the kitchenette at the same time as the steam table pans of food and were placed on the counter. There was no source of heat to keep the plates warm. Dietary Server #1 was not observed to take the temperatures of the pureed food.</p> <p>At the request of the surveyor, Dietary Server #1 took the temperature of the coleslaw, which was in a steam table pan on the counter. The pan was not placed on ice to keep the coleslaw cold. The temperature of the coleslaw registered 56 degrees on the facility thermometer. Dietary Server #1 did not indicate the coleslaw was not at the recommended temperature. He was then observed to remove the steam table pan of the pork cutlets and take the pan back to the facility kitchen for re-heating. He was not observed to take the steam table pan of the coleslaw to the facility kitchen.</p> <p>At 1:20 p.m., Dietary Server #1 returned to the Keepsake South Memory Care Unit kitchenette with the re-heated pork cutlets. The temperature of the gravy covered pork cutlets registered at 159 degrees on the facility thermometer.</p> <p>After returning to the kitchenette, Dietary Server #1 asked the surveyor if the temperature of the coleslaw was good.</p>			

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	<p>The surveyor in return asked him if he thought the temperature of the coleslaw was good. He replied it was. By the time he returned from the facility kitchen with the pork cutlets, the thermometer had turned itself off so the final temperature at the time of service could not be obtained. He then began serving food to the residents, including the coleslaw which had not been on ice to keep it cold. The two plates containing pureed food were also served to residents. Dietary Server #1 was not observed to take the temperatures of the pureed food prior to service.</p> <p>A Food Temp Log, provided by the Director of Dietary Services on 7/8/15 at 8:40 a.m., indicated hot food was to be 140 degrees of hotter and cold food was to be 37 degrees to 41 degrees.</p> <p>The Executive Director and the Director of Dietary Services were interviewed on 7/8/15 at 10:45 a.m. During the interview they indicated cold foods were to be 41 degrees or below at the time of service. They also indicated the temperature of the plates containing the bowls of pureed food should have been taken prior to service.</p> <p>A current facility policy "Food Temperatures", with a review date of</p>			

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R 0414 Bldg. 00	<p>12/5/12 and provided by the Director of Dietary Services on 7/8/15 at 11:11 a.m., indicated "...Food temperatures are taken and recorded at the time of each meal service...If hot foods are not 140 degrees they will be reheated until temperature reaches 140 degrees or higher...Cold food and beverages which are not 41 degrees or below will be chilled on ice or in the freezer...Cold foods and beverages will be held on ice or in the cooling unit during meal service...."</p> <p>This deficiency was cited on the 4-30-2015, and the facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) 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>			

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	<p>Based on observation, interview and record review the facility failed to ensure the nursing staff washed their hands with soap and water at the appropriate times during medication administration and also failed to use hand hygiene in between residents' medication administration for 9 of 17 residents (Resident # 5, #6, #7, #8, #9, #10, #11, #12 and #13) observed during medication administration. The nursing staff also failed to use a paper towel to turn off the water faucet after hand washing was performed for 1 of 17 residents (Resident #4) observed during administration of a nebulizer (breathing) treatment and during hand washing prior to checking a blood sugar by 1 of 2 nurses and 1 QMA (Qualified Medication Aide) (Nurse #4), potentially affecting 85 of 105 residents whose medications were administered by the facility.</p> <p>Findings include:</p> <p>1. An observation on 7/7/15 at 12:55 p.m., LPN (Licensed Practical Nurse) #4 removed Rx (prescription) nebulizer medication from the medication cart and checked the medication order on the MARS (Medication Administration Record Sheet). The LPN gathered supplies to administer the nebulizer treatment. LPN #4 was not observed to</p>	R 0414	<p>R 414 Infection Control – hand washing</p> <p>1. No adverse effects were identified or noted due to this alleged deficient practice. Residents #5, #7, #8, #9, #10, #11, #12 and #13 remain healthy. LPN #4, QMA #6 and LPN #5 were immediately retrained on the concern identified.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. It is the intent of this community to ensure that all staff follow proper infection control procedures.</p> <p>3. The regional Director of Clinical Service conducted a series of hand washing in-service, utilizing Glogerm ultraviolet light, reviewed the facility's handwashing policy and addressed hand washing technique include how to turn off water, length of time, use of hand sanitizer, proper use of disposable gloves and the difference between contaminated and uncontaminated gloves. The in-service also included "return demonstration" by each participant to ensure understanding.</p> <p>4. The administrator and/or designee will conduct random daily observations of staff during medication passes, meal times, and personal care episodes to observe staff for proper hand washing practices. They will also randomly select three (3)</p>	08/07/2015			

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	<p>perform handwashing or hand hygiene before removing the medication from the medication cart for administration.</p> <p>An observation on 7/7/15 at 1:00 p.m., LPN #4 washed his hands with soap and water, lathered his hands with the soap for 25 seconds before he rinsed his hands with water. The LPN turned the running water faucet off with his wet, bare hand before he dried his hands with clean, dry paper towels and then donned disposable gloves to administer a nebulizer treatment to Resident #4.</p> <p>An observation on 7/7/15 at 1:05 p.m., LPN #4 removed the disposable gloves, washed his hands with soap and water, lathered his hands with the soap for 20 seconds before he rinsed his hands with water. LPN #4 then turned the running water faucet off with his wet, bare hand before he dried his hands with clean, dry paper towels.</p> <p>An observation on 7/7/15 at 1:15 p.m., LPN #4 washed hand his hands with soap and water, lathered his hands with the soap for 25 seconds before he rinsed his hands with water. The LPN turned the running water faucet off with his wet, bare hand before he dried his hands with clean, dry paper towels and donned disposable gloves and removed the</p>		<p>employees during each review todemonstrate technique. Review will be conducted 5 times a week x 2months, 3 times a week x 2 months, weekly x 2 months, then monthly thereafter. Results of these audits will be reviewed bythe QA Committee, who will establish the threshold of compliance and makefurther recommendations accordingly.</p>	

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NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
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	<p>nebulizer mask from Resident #4.</p> <p>An observation on 7/7/15 at 1:20 p.m., LPN #4 removed the disposable gloves after he rinsed the nebulizer mask and nebulizer medication administration cup. LPN #4 washed his hands with soap and water, lathered his hands with the soap for 28 seconds before he rinsed his hands with water. The LPN turned the running water faucet off with his wet, bare hand before he dried his hands with clean, dry paper towels.</p> <p>2. An interview with QMA #6 on 7/8/15 at 11:30 a.m., indicated hand washing with soap and water should be done before beginning medication set up and medication administration. She indicated hands should be lathered for 20 seconds before rinsing with water. She also indicated hand gel could be used in-between residents' medication administration and indicated hand washing with soap and water should be done after every 3 residents. She further indicated the water faucet should be turned off with a clean, dry paper towel.</p> <p>An interview with LPN #5 on 7/8/15 at 12:30 p.m., indicated hands should be washed with soap and water before medications were administered and after every third resident. LPN #5 indicated</p>			

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	<p>hand gel was to be used in-between 3 resident's medication administration but handwashing with soap and water should be done if a resident or their belongings were touched or a contaminated surface was touched, like a resident's water glass. She also indicated hands should be lathered with soap for at least 20 seconds during hand washing before rinsing hands with water. LPN #5 indicated the water faucet should be turned off with a clean, dry paper towel because the germs could be transferred to the hands if the paper towel was wet. LPN #5 further indicated hand washing with soap and water should be done before and after using disposable gloves.</p> <p>An interview with Assisted Living (AL) Wellness Director #2, on 7/8/15 at 12:40 p.m., indicated handwashing with soap and water should be done before and after administering medications. She indicated hand hygiene with hand gel could be used in-between 3 residents and after the third resident, hand washing with soap and water should be done. She also indicated hand washing with soap and water should be done if hands come into contact with a resident, the resident's belongings, any contaminated objects or if hands were visibly soiled. She indicated hands should be lathered for at least 20 seconds before the hands were rinsed with water.</p>			

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	<p>She further indicated hands should be dried with clean paper towel, the paper towel should be thrown away and the water faucet should be turned off with a clean paper towel.</p> <p>3. On 7/8/15 at 8:45 a.m. LPN #4 was observed in the south locked, dementia unit dining room. He had been observed to give a resident her medication at the dining room table. LPN #4 returned to the medication (med) cart. He documented the medications he had given to the resident. Without hand hygiene, he then removed the prepoured medication cup for Resident #5. LPN #4 took the medication to the resident at her table. Resident #5 indicated to LPN #4 she didn't have any chocolate milk to drink with her medication. LPN #4 carried the resident's empty cup and med cup and went to the kitchen area in the dining room. LPN #4 was observed to open the refrigerator, open the milk container and then pour the milk into the resident's cup. He then recapped the milk and by opening the refrigerator door, returned the milk to the refrigerator. LPN #4 then took the cup of milk and the resident's med cup to her at the table. After Resident # 5 took her medication, LPN #4 returned to the medication cart and without hand hygiene, he removed Resident #6's prepoured med cup and</p>			

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	<p>delivered it to the resident at the dining room table. After the resident took the medication, LPN #4 returned to the medication cart and without hand hygiene, LPN #4 removed Resident #7's prepoired medication from the cart. LPN #4 gave the medications to the resident at the dining room table and then returned to the medication cart. Without hand hygiene, LPN #4 then removed the prepoired medication cup for Resident #8 and gave them to the resident at the dining room table. LPN #4 then returned to the med cart and without hand hygiene, LPN #4 removed the prepoired medication cup for Resident #9. LPN #4 also poured a liquid, nutritional product for this resident, from a can which was sitting on the med cart. He carried the medication cup and liquid product to the resident at her dining room table. After he administered the resident's medication, LPN #4 returned to the medication cart. Without hand hygiene, LPN #4 then removed Resident #10's prepoired med cup. LPN #4 administered the meds and then returned to the med cart. Again without hand hygiene, LPN #4 removed Resident #11's med cup from the cart. LPN #4 then took the med cup to the resident at the dining room table and gave the resident the medication. LPN #4 then returned to the med cart and without hand hygiene, he removed the</p>			

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	<p>prepoired medication cup for Resident #12 from the med cart. LPN #4 also poured a liquid, nutrition product for this resident into a cup. After LPN #4 gave the resident her medication, he returned to the cart. Without hand hygiene, LPN #4 then removed the prepoired medication for Resident #13 and gave them to the resident. LPN #4 returned to the medication cart without hand hygiene.</p> <p>4. On 7/8/15 at 11:07 a.m. LPN #4 was observed to wash his hands in preparation for a glucometer check. LPN #4 turned the water on, obtained soap, and lathered his hands with friction for at least 20 seconds. He then rinsed his hands and with his clean hands, turned the water faucet off. LPN #4 was then observed to dry his hands with a paper towel.</p> <p>On 7/8/15 at 12:46 p.m., the AL Wellness Director #2 provided the current facility's policy, Hand Washing, dated 5/22/13, which indicated, "...Hands are washed:...Before and after caring for a resident...Turn water on...Wet your hands with clean, running water...and apply soap....Rub your hands together to make a lather and scrub them well....Continue rubbing your hands for a minimum of 20 seconds....Rinse you hands well under running water....Dry</p>			

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	<p>hands with a clean paper towel...Using the paper towel, turn off the faucet. (Don't use your hands to turn off the water as they are clean and the faucet is contaminated...."</p> <p>On 7/8/15 at 1:05 p.m., the AL Wellness Director #2 provided the current facility's policy, Hand Sanitizer, dated 5/22/13, which indicated, "...1. hands can be sanitized using hand sanitizing agents to prevent the spread of germs....2. If hands are visibly soiled, hands must be washed using soap and water following the hand washing policy....6. Hand sanitizer may be used 3 times before hands must be washed with soap and water...."</p> <p>On 7/8/15 at 1:05 p.m., the AL Wellness Director #2 provided the non-dated facility's contracted Pharmacy's policy, Procedures for Medication Assistance, which indicated, "...Hands are washed thoroughly prior to assisting the resident who self-administers medications using the appropriate hand washing technique. Hands must be washed any time the resident or medication containers are touched...."</p> <p>This deficiency was cited on the 4-30-2015, and the facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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