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 12/20/2012

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: December 19 and 20, 2012 Facility number: 001142 Provider number: 001142 AIM number: N/A Survey team: Diana Sidell, RN, TC Jill Ross, RN Gloria Reisert MSW (December 19, 2012) Census bed type: Residential: 20 Total: 20 Census payor type: Other: 20 Total: 20 Sample: 6 These state findings are cited in accordance with 410 IAC 16.2.	R0000		

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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R0178	410 IAC 16.2-5-1.6(b) Physical Plant Standards - Deficiency (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all areas.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's room was free of objectionable odors for 2 of 2 observations on 2 of 2 survey days. Findings include: During the initial tour, on 12/19/12 at 11:32 a.m., with the Administrator, a strong urine odor was detected in room #15. During an observation on 12/20/12 at 12:45 p.m. and at 3:35 p.m., the urine odor was still present in room #15. During an interview on 12/20/12 at 3:33 p.m., LPN # 2 was queried about the urine odor in room #15. She indicated the resident is incontinent at times, and when he goes into the restroom, he urinates on the floor. She said he doesn't sit back far	R0178	After conducting a thorough investigation in room #15 we have determined the odor coming from the residents lift chair. after removing the chair and cleaning carpet and cleaning and sanitizing the bathroom the odor has been eliminated. We will create a team consisting of three staff members to do a check of incontinent residents' rooms and if an odor is detected we will determine why and correct the problem. This team will have a form that will be on file. these rooms will be checked prior to our Monthly Department Head meetings for a minimum of six (6) months and a maximum of eighteen (18) months. This will all be put into place and practice by February 15, 2013	02/15/2013

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	enough on the commode, and "we mop and mop and mop and change him as needed and we still can't get rid of the smell." A policy and procedure for "Housekeeping" was provided by the Administrator on 12/20/12 at 4:45 p.m. The policy included, but was not limited to: "...2. Housekeeping personnel shall utilize accepted practices and procedures to keep the facility free from offensive odors and the accumulation of dust, rubbish, dirt, and hazards. a. Floors in resident areas shall be maintained in clean condition. b. Toilet and bathing areas shall be thoroughly cleaned at least daily and sanitized as needed...."			

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R0241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview the facility failed to ensure Resident #2 was capable of administering his own nebulizer treatment (breathing treatment) in that there was no self-administration evaluation for this resident. This affected 1 of 5 residents reviewed for self-administration of medications. Findings include: Review of Resident #2 clinical record was done on 12/20/12 at 11:12 a.m. This resident was admitted 9/29/1998. Diagnoses included but were not limited to: high blood pressure, anxiety, depression, COPD (breathing difficulty), insomnia (can't sleep), and dementia. He has an order for Albuterol and Ipratropium to be used in a nebulizer 4 times everyday. There was no self-administration medication assessment found in this resident's chart. On 12/19/12 at 12:30 p.m., it was observed that the nurse gave Resident #2	R0241	After surveyors had exited on 12-20-12, LPN Supervisor was in the building for a Christmas dinner. When she had gone over the findings from the surveyor she had located the assessment in the chart behind the service plan. An assessment for a Self Medication Administration form is completed on a resident after the resident has expressed a desire to handle their own medictions administration, either some or all. We would request an order from the resident's physician and after receiving the order we then would do an assessment, as stated in our Policy and Procedure. If however, a resident would request upon admission, our policy states that a "resident may not self-administer any drug or biological for the first 14 day period". Charts of residents that self medicate are now updated to have an area marked "Self medication assessment" so all assessmsnts are easily located and are systematically in each chart the same. An in-service with LPN supervisor and assistant LPN supervisor were held with	12/26/2012

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	his canister of medicine and told him it was ready to go when he got to his room. He went to his room and shut the door. This was observed to happen again on 12/20/12 at 12:35 p.m. An interview on 12/20/12 at 11:45 a.m., with LPN #1, she indicated he did not have the self-administration assessment and he did do his own nebulizer treatment. The nurse sets it up and he takes it to his room and takes it on his own. A policy titled, "Self-Administration of medication" was received on 12/20/12 at 4:50 p.m. This policy included but was not limited to: "...2. Residents may self-administer drugs and biologicals after the 14 day post admission period if they meet the following criteria: a. The resident is oriented to person, place and time. b. Their cognitive status indicates that the resident understands and is able to articulate the following: 1. times/frequency of administration 2. doses of administration 3. route of administration 4. purpose of medication 5. storage requirements 6. untoward effects or reactions to medications 7. understand means/methods of		the Administrator on self medication assessment on December 26, 2012.	

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	documentation. c. Their functional status indicates that they are physically able to self administration of medication. d. Residents in the immediate environment of a resident who self administers medications would not be place in jeopardy. e. The resident understands the medications cannot be shared with other resident's family or staff members.			

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R0274	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. Based on observation, interview and record review the facility failed to ensure	R0274	An in-service with all dietary staff conducted by the Dietary	01/28/2013

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	dietary staff were doing proper hand washing and glove use. This had the potential to affect all 20 residents residing in the facility. Findings include: During dietary tour with the Dietary Manager on 12/19/12 at 10:30 a.m., Cook #1 was observed to wear gloves when she got drinks from the refrigerator, touched the lips of glasses while serving, picked up a box of saran wrap, opened bread and put it out on plates, covered the bread with saran wrap, closed the bread, touched plate covers, serving trays and covered plates with the plate covers. All this was done with the same gloves and no handwashing. On 12/19/12 at 11:52 a.m., Cook #1 served plates, touched bread, served plates, got coffee pot and served to residents, opened refrigerator, removed desserts, uncovered desserts, served desserts to the residents, put saran wrap on desserts that were left, opened refrigerator and put them in. She opened the refrigerator again and got out butter patties. All this was done with the same gloves and no handwashing. On 12/19/12 at 11:52 a.m., Cook #2 did a 5 second hand wash after removing her		manager and the Administrator was held January 15 at 10:30 am where we discussed the importance of hand washing and glove use. The staff was shown the proper way of hand washing and then had them repeat how we had shown them. We also did a visual test with a staff member posing as a cook/aide and had the real staff indicate what errors were made with glove use. In order to ensure deficient practice will not recur, the administrator and the dietary manager will visually check for correct hand washing techniques and the appropriate use of gloves by staff during and before two (2) out of the three (3) meals provided daily. these observations will be conducted five (5) to seven (7) days per week for three months then prn for the next three (3) months. If a deficient practice is observed, appropriate disciplinary actions will be conducted. These observations will start January 28, 2013	

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	gloves. She put gloves back on and grabbed a utensil from a drawer, removed the lids off the food and starting serving food again. All without changing gloves. Interview with the Dietary Manager on 12/19/12 at 10:50 a.m., she indicated she did realize Cook#1 used gloves for multiple things. A policy titled, "Glove Use" was received on 12/19/12 at 1:05 p.m., from the Administrator. This policy included but was not limited to: "...3. Gloves shall not be worn as a substitution for frequent required handwashing." A policy titled, "Hand Cleaning" was received from the Administrator on 12/19/12 at 1:05 p.m. This policy included but was not limited to: "When to Wash Hands and Exposed Arms...6. During food preparation, as often necessary to remove soil and contamination and to prevent cross contamination when changing tasks...8. Directly before touching ready-to-eat food or food-contact surfaces...How to Wash Hands and Exposed Arms...3. Vigorously rub the lathered areas of the hands and arms for at least twenty (20) seconds..."			

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R0356	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the Resident Emergency Files listed the residents' current apartment number. This deficient practice affected 7 of 20 residents reviewed for current Emergency File information. (Residential Residents #1, 5, 7, 10, 11, 12, and 13) Findings included: Review of the Current Emergency File binder as presented by LPN #1 on 12/19/12 at 11:30 a.m. indicated the following residents had incorrect	R0356	An in-service was conducted on Jan. 10, 2013 @ 10:30 am with the office manager, LPN supervisor and LPN asst. supervisor on the procedure for updating the Resident Emergency Files. At that time a Policy and Procedure was drafted on such updates. All files concerning the residents #1, 5, 7, 10, 11, 12 and 13 were updated on December 20, 2012. Files will be updated when there is a change plus the office manager will do a quarterly check on all residents charts to be sure updates were added.	01/10/2013

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	apartment numbers listed: 1. Resident #1 was admitted to the facility on 6/1/11. The apartment number listed for the resident was #16 although she currently resides in Apartment #3. 2. Resident #5 was admitted to the facility on 1/15/08. The apartment number listed for the resident was #7 although she currently resides in Apartment #10. 3. Resident #7 was admitted to the facility on 4/27/09. The apartment number listed for the resident was #7 although she currently resides in Apartment #12. 4. Resident #10 was admitted to the facility on 10/6/10. The apartment number listed for the resident was #5 although he currently resides in Apartment #15. 5. Resident #11 was admitted to the facility on 7/2/12. The apartment number listed for the resident was #27 although she currently resides in Apartment #16. 6. Resident #12 was admitted to the facility on 2/9/12. The apartment number listed for the resident was #25 although she currently resides in Apartment #17. 7. Resident #13 was admitted to the			

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	facility on 4/7/09. The apartment number listed for the resident was #1A although she currently resides in Apartment #18. During an interview with LPN #2 on 12/19/12 at 11:45 a.m., she indicated that staff will grab this blue Emergency File binder whenever there was an emergency as it contained all of the residents' current information. She also indicated there was a duplicate binder in the downstairs area that contained the same information as this one. During an interview with the Administrator at 11:55 a.m., she indicated that the Business Office Manager and the nurses were responsible for keeping the emergency binder current.			