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 05/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE KNOLL ASSISTED LIVING CENTER	607 WILSON CREEK RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 20 and 23, 2016 Facility number: 001142 Provider number: 001142 Census bed type: Residential: 21 Total: 21 Sample: 7 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5. Quality Review Completed by 34233 on May 24, 2016	R 0000		
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 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			

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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	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 interview and record review, the facility failed to ensure employees received three hours of dementia training annually for 2 of 5 staff reviewed for dementia training. (Maintenance #1 and QMA #2) Findings include: Employee records were reviewed on 05/23/2016 at 9:15 A.M. The employee record for Maintenance #1 indicated the employee had completed dementia	R 0120	Tag: R120 1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice: As the deficiency was related tostaff inservices, no resident would have been directly negatively affected bythe missing inservice. Although theAdministrator and Operations Manager believe that the missing inservice hadbeen conducted in a timely manner, the documentation	06/22/2016

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	training, for one hour on 09/18/2015 and one hour on 04/22/2015, for a total of two hours of dementia training. There was no third hour of dementia training completed for 2015. The employee record for QMA #2 indicated the QMA had had completed dementia training, for one hour on 09/18/2015 and one hour on 04/22/2015, for a total of two hours of dementia training. There was no third hour of dementia training completed for 2015. During an interview on 05/23/2016 at 12:08 P.M., the Operations Manager indicated staff were to have three inservices, one hour each, on dementia every year. She further indicated she could not find the third hour of inservice for the 2015 dementia training. The current facility policy, titled "Policy and Procedure Dementia" and dated 1-05-05, was provided by the Operations Manager on 05/23/2016 at 10:22 A.M. and was reviewed at that time. The policy indicated, "...train all new staff members specifically on dementia...3 hours annually..."		had been removed by theprevious Administrator and was unable to be located and unable to be observedby the surveyors. Corrective action willbe achieved by the facility making certain that all required inservices will beconducted timely and correctly filed to assure availability for review byfuture surveys. 1.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken: The absence of the requiredinservice would have the potential ofimpacting all residents equally. Thecorrective action previously described in No. 1 of this plan of correction will insure that all residents areprotected in the same manner. 1.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur: It will be the practice of thisfacility to continue to conduct all required inservices in a timely manner andto retain copies of each per state regulation.	

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			1.How the corrective action(s) will be monitoredto ensure that the deficient practice will not recur, ie., what qualityassurance program will be put into place: It will be the responsibility ofthe Administrator, with the assistance of the Operations Manager, to conduct areview of all inservice documentation to be certain that each requiredinservice has been completed in a timely manner and remains properly filed.Corrective action will be taken in the form of conducting inservices that havenot been completed and/or insuring that inservices have been filed and areretained according to state requlation. 1.By what date the systemic changes will becompleted: Systemic changes will be in placeby 6/22/2016.	