

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 04/28/2015
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NAME OF PROVIDER OR SUPPLIER  OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
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R 0000  Bldg. 00	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: April 27-28, 2015</p> <p>Facility number: 013613 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 3 Total: 3</p> <p>Census payor type: Other: 3 Total: 3</p> <p>Sample: 3</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>The Plan of Correction is to serve as Oasis Dementia Care's credible allegation of compliance. Submission of this Plan of Correction does not constitute an admission by Oasis Dementia Care or its management that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
R 0026  Bldg. 00	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the</p>			

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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	<p>administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on record review and interview, the facility failed to ensure residents had a signed acknowledged residents' rights or residents' rights posted in a publicly accessible area. (Resident #1, Resident #2, Resident #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 4/27/15 at 9:50 a.m., Resident #1's clinical record was reviewed. Resident #1 was admitted on 1/12/15. Resident #1 clinical record lacked a signed residents' rights acknowledgement.</li> <li>On 4/27/15 at 10:00 a.m., Resident #2's clinical record was reviewed and found not to contain any signed resident rights in the clinical record.</li> <li>The clinical record for Resident #3</li> </ol>	R 0026	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> Residents #1, #2, nor #3 suffered no ill effects from the alleged noncompliance. Residents and/or their responsible parties have been a copy of the resident rights and have provided signed acknowledgement of such. A copy of the resident's rights is now Displayed in a public accessible area. <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures are systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> An Admission's</p>	05/22/2015

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	<p>was reviewed on 04/27/15 at 9:50 a.m. The resident's record lacked a signed residents' rights acknowledgement.</p> <p>On 4/27/15 at 2:03 p.m., the Marketing and Admission Director indicated she was unable to locate signed residents' rights acknowledgement for Resident #1, Resident #2, and Resident #3.</p> <p>4. On 4/27/15 at 10 a.m., during the tour of the facility, a copy of the residents' rights or information on how to contact the Ombudsman or appropriate agencies were not posted in a publicly accessible area.</p>		<p>Checklist Tool has been developed to use as a guide during the admission process to assure compliance of established admission protocol pertaining to resident rights and the availability and posting of such. A New Employee Checklist has been developed to use as an auditing tool to assure completion of new employee orientation will include the review of policies and procedures pertaining to resident rights and the availability of such.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> As an on going quality improvement process the administrator or designee will complete an audit of each new resident's admission file to assure compliance of receipt and acknowledgement of the posting of the resident rights in a publicly accessible area. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter. As an ongoing quality improvement process the administrator or designee will complete an audit of the new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliance to established resident rights orientation procedures. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter. Any noncompliant practices will be immediately addressed. Resident</p>	

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R 0033  Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging.		admission file audit summaries and employee file audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.				

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	<p>(E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.</p> <p>Based on observation, record review, and interview, the facility failed to display the information for contacting the Ombudsman, the office of the Secretary of Family and Social Services, the Area Agency on Aging, the local mental health center, Adult Protective Services, and the State Department of Health. This had the potential to affect 3 of 3 residents.</p> <p>Findings include:</p> <p>During an observation of the facility on 4/27/15 at 10:00 a.m., no information was observed on residents' rights, how to contact the Ombudsman, the office of the Secretary of Family and Social Services, the Area Agency on Aging, the local mental health center, Adult Protective Services, or the State Department of Health. The same was observed on 4/27/15 at 4:00 p.m.</p> <p>During review of the admission packet obtained on 4/27/15 at 10:25 a.m., the packet also lacked information on residents rights and how to contact the agencies.</p>	R 0033	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> Residents #1, #2, nor #3 suffered no ill affects from the alleged deficiency. All residents and/or representatives have been provided a copy of the Resident Rights and a list of contact names and contact information for the noted agencies. <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures are systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> The facility admission packet was reviewed and revised to include a copy of the resident rights and a list of contact names and contact information for the noted agencies. An Admission Checklist Tool has been developed to use as a guide during the admission process to assure compliancy of established admission protocol.</p>	05/08/2015

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	<p>A copy of the residents' rights or information on how to contact the Ombudsman or appropriate agencies were not posted in a publicly accessible area.</p> <p>During an interview on 4/27/15 at 3:50 p.m., the Administrator indicated the information had not posted.</p>		<p>New employee orientation will include the review of policies and procedures pertaining to resident rights and the availability of such along with the location of the posting of a list of contact names and contact information for the noted agencies</p> <p>A New Employee Checklist Tool has been developed to use as a guide during employee Orientation to assure compliancy of established orientation protocol.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> As an on going quality improvement process the administrator will complete an audit of each new resident's admission packet to assure compliancy of receipt of a copy and acknowledgement of the posting of the resident rights in a publicly accessible area. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of a new employee file reconciling</p>	

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R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:		the New Employee Checklist Tool to the employee's record to assure compliance to established resident rights orientation procedures. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.  Any noncompliant practices will be immediately addressed. Resident admission file audit summaries and employee file audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.	

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	<p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure the Administrator was responsible for the overall management of the facility, in that, the Administrator failed to arrange or provide assistance with obtaining</p>	R 0090	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> The Marketing director immediately completed a chart review of residents #1, #2 and #3.</p>	05/12/2015

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	<p>medical care for 2 of 3 residents. The Administrator failed to arrange emergency agreements for transfer and/or care in the event of an emergency for 3 of 3 residents. (Resident #1, Resident #2, Resident #3)</p> <p>Findings include:</p> <p>1. During record review on 4/27/15 at 10:00 a.m., the clinical record of Resident #2 was reviewed. Resident #2's clinical record indicated the resident did not have a physician at the facility. The clinical record indicated during the pharmacy review in March, 2015, the pharmacist had not located who the attending physician was. The clinical record indicated Resident #2's physician orders were from a physician the resident had while living in another state.</p> <p>During an interview on 4/27/15 at 10:25 a.m., RN #1 indicated Resident #2 had a physician at the facility.</p> <p>During an interview with the Administrator on 4/27/15 at 4:00 p.m., the Administrator indicated he did not know Resident #2 did not have a attending physician since arriving at the facility.</p>		<p>to assure the identification of the primary care physician was noted.</p> <p>Signed Physician Orders were obtained for the residents lacking orders and/or physician signatures were obtained on telephone orders previously received.</p> <p>The administrator completed a review of the Policy and Procedure entitled "Medical Evaluation" which contains the protocol for the requirement and selection of a primary care physician to assure compliancy.</p> <p>Licensed nursing staff was immediately instructed on the completion of the Resident Face Sheet to assure documentation of the primary care physician</p> <p>The administrator continues to attempt to arrange an emergency relocation agreement and hospital transfer agreement <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures aresystematic changes that have been put into place to ensure that the allegeddeficient practice does not recur include:</b> An Admission's Checklist Tool</p>				

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	<p>2. The record for Resident #3 was reviewed on 04/27/15 at 9:50 a.m. The clinical record lacked documentation of signed physician's orders for medications.</p> <p>During review of the policy book, obtained from the Administrator on 4/26/15 at 9:45 a.m., indicated the facility did not have a policy for obtaining a physician for the residents.</p> <p>3. The Administrator indicated on 4/27/15 at 10:10 a.m., the facility was " working on " obtaining a contract with an Emergency Shelter (with local assisted living facility) and " working on " a contract with local hospital (name of hospital) for Hospital Transfer Agreement. Neither had been obtained at the time of the survey.</p>		<p>has been developed to use as a guide during the admission process to assure compliance to established admission protocol.</p> <p>New employee orientation will include the review of policies and procedures pertaining to admission protocol including but not limited to Physician Services and Orders</p> <p>A New Employee Checklist Tool has been developed to use as an auditing tool in assuring completion and documentation of the new employee orientation process</p> <p>The Chief Executive Officer will meet with the administrator weekly to monitor the administrator's progress and performance in overall management of the facility.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> As an on going quality improvement process the administrator or designee will complete a chart audit for all new admissions on an ongoing basis reconciling the Admission's Checklist Tool to the resident's medical record. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p>				

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R 0091  Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following:		As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliancy to established orientation procedures pertaining to admission protocol including but not limited to Physician Services and Orders. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.  Any noncompliant actions will be immediately corrected.  Resident chart and employee file audit summaries will be reviewed during weekly executive management meetings. Executive management recommendations will be Implemented and reviewed at the quarterly Quality Assurance Committee Meetings to determine if any additional interventions are needed.	

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	<p>(1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to have a complete policy book to ensure resident care in that, policies were missing for physician services, dietary sanitation and staffing, food storage, infection control for handwashing, and glove use, dementia staff, and staff inservices. This had the potential to affect 3 of 3 residents.</p> <p>Findings include:</p> <p>A policy book was obtained from the Administrator on 4/27/15 at 9:45 a.m., as follows:</p> <p>1. During record review on 4/28/15 at 10:45 a.m., the employee files indicated the Resident Rights and Abuse training had not been completed.</p> <p>The policy book did not contain a policy for inservices.</p> <p>2. The policy manuel lacked a policy for the dietician. During an interview on 4/27/15 at 10:20 a.m., the Administrator indicated the facility did not have a contract with a</p>	R 0091	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> Residents #1, #2, nor #3 suffered no ill effects from the alleged deficiency. The administrator immediately began reviewing the current policy book to assure identification and development of any missing policies pertaining to the noted findings. <b>Other residents thathave the potential to be affected by the alleged deficient practice have beenidentified by:</b> All residents were identified as having thepotential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> The executive management team shall review and approve the facility's Policy and Procedure Manuals to assure the presence of policies and procedures for all aspects of operations including but not limited to the noted findings. Completion of the systematic changes will be within the following time frame: 50% completion by 05/27/2015, 75% completion by 06/12/2015and</p>	06/27/2015			

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	<p>dietician. The Administrator further indicated the residents received their meals from a local restaurant. During an interview on 4/27/15 at 2:15 p.m., the Administrator (Adm) indicated the facility did not have a food service supervisor. The Adm indicated all meals were ordered from a local restaurant. The Adm further indicated he did not have a contact for a dietician.</p> <p>3. The policy book lacked a policy for kitchen foods and storage of food items.</p> <p>4. The policy manuel lacked a policy for obtaining, reviewing and/or revising of diet orders and/or physician's orders.</p> <p>During an interview with the Adm on 4/27/15 at 10:15 a.m., the Adm indicated the facility did not have a policy for physician's orders.</p> <p>5. The policy book lacked a policy for handwashing and glove use.</p> <p>During an interview on 4/28/15 at 10:15 a.m., the Administrator indicated the policy manuel was complete and correct. The Administrator indicated he oversees the infection control of the facility. The Administrator indicated inservicing had not been given to the employees except when they were hired. The Administrator</p>		<p>100% completion by 06/27/2015.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the executive management team will review all new and/or revised policies and procedures before staff training and implementation. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter to assure new and/or revised policies and procedures are approved by the executive management team before training and implementation. Audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance meetings to determine if additional interventions are needed.</p>				

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R 0092  Bldg. 00	<p>indicated each supervisor was responsible for overseeing their staff.</p> <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review, the facility failed to provide a fire or disaster drill every month, in that, no fire or disaster drills were conducted.</p> <p>Findings include:</p>	R 0092	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> No specific residents were identified. The administrator reviewed policies and procedures pertaining to Disaster Preparedness-</p>	05/27/2015

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	<p>During an interview on 4/27/15 at 10:10 a.m., the Administrator indicated the facility had completed fire drills since the opening of the facility. The Administrator indicated he did not have documentation for the fire or disaster drills.</p> <p>A policy titled, "Fire Drill Procedure" and obtained from the Adm on 4/27/15 at 9:45 a.m., indicated the director or designee will monitor and document staff performance during routine scheduled fire drills as well as during false alarm incidents.</p>		<p>Fire Safety. Staff was inserviced on Disaster Preparedness Fire Safety and the necessity of holding Monthly fire drills.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified:</b> All residents had the potential to be affected. <b>The measures aresystematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>The administrator reviewed policies and procedures pertaining to Disaster Preparedness- Fire Safety. Staff was in-serviced on Disaster Preparedness - Fire Safety and the necessity of holding Monthly fire drills and annual disaster drills</p> <p>The administrator shall be responsible for assuring the completion of monthly fire drills and annual disaster drills.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete monthly audits to assure compliancy to policy requirements.</p> <p>Any non-compliancy will be immediately corrected.</p> <p>Audit summaries will be reviewed during weekly executive management meeting. The</p>				



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	<p>Based on record review and interview, the facility failed to designate a Director for the Dementia Unit, in that, the facility did not have a Dementia Director designated for the dementia unit. This had the potential to affect 3 of 3 residents in the facility.</p> <p>Findings include:</p> <p>During record review of the employee files on 4/28/15 at 10:25 a.m., the files indicated the facility did not have a qualified designated dementia program director.</p> <p>A policy book was obtained from the Administrator (Adm) on 4/27/15 at 9:45 a.m. The policy book did not contain a policy for a dementia program director.</p> <p>During an interview on 4/28/15 at 11:15 a.m., the Adm indicated the facility did have a program director who was an LPN but he did not have credentials for the LPN. The Adm further indicated the employee file was correct and complete.</p>		<p><b>those residents founded to be affected by the alleged deficient practice include:</b> Residents #1, #2, nor #3 suffered no ill effects from the alleged deficiency. The administrator currently is the acting Director of the Dementia Unit. The executive management team is currently reviewing employee resumes to determine if a present employee meets the noted requirements of the Director's position. <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> A facility staffing tool is being developed to list all staffing positions noting title and the employees specifically designated for the positions. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> As an ongoing quality improvement process the administrator will review and audit required staffing positions to</p>				

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R 0117  Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person				assure each position is appropriately filled. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter. Any non-compliant practices will be immediately corrected. Audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.		

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	<p>awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure at least one staff member was on duty at all times who was certified in First Aid and CPR (cardiopulmonary resuscitation), in that, 11 (eleven) days lacked a First Aid certified staff member and 4 days lacked a CPR certified staff member. (4/18/15 - 4/28/15)</p> <p>Findings include:</p> <p>The staffing schedule was provided by the Administrator (Adm) on 4/27/15 at 12:10 p.m. The schedule was reviewed for the time period of 4/18/15 - 5/1/15.</p> <p>The CPR certifications for staff was provided by the Adm and reviewed on 4/28/15 at 11:20 a.m. The schedule indicated the facility lacked an employee with CPR certification on any shift for the following dates: 4/20/15, 4/21/15, 4/25/15, and 4/26/15..</p> <p>During an interview with the Adm on 4/28/15 at 11:10 a.m., the Adm indicated he did not have a staff member with First Aid certification on the schedule from</p>	R 0117	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> No residents were identified as affected.</p> <p>All nurses and QMAs have completed CPR and First Aid classes and documentation of such is on file.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents had the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> Employee Job Descriptions and Requirements have been reviewed and revised to assure compliancy.</p> <p>A New Employee Checklist Tool has been developed to be used as a guide during the hiring and orientation process.</p> <p>The tool is to be completed by the administrator or designee to assure a new employee meets the requirements of a position and supporting</p>	05/14/2015



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	<p>specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to ensure inservices were provided for 10 of 10 employees reviewed, in that, Resident Rights training and Abuse training inservices were not completed. (LPN #1, RN #1, COTA (certified occupational therapy assistant) #1, Hskg (housekeeper) #1, CNA #1, LPN #2, CNA #2, Receptionist</p>	R 0120	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b>                      No specific residents were identified.                      Resident Rights and Abuse Prevention were inclusive in new employee orientation and completed within the previous four (4) months. An annual in-service schedule will be</p>	05/27/2015

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	<p>#1, Administrator, CNA #3)</p> <p>Findings include:</p> <p>During record review on 4/28/15 at 10:45 a.m., the employee files indicated the Resident Rights and Abuse training had not been completed.</p> <p>A policy book was obtained from the Administrator on 4/27/15 at 9:45 a.m. The policy book did not contain a policy for inservices.</p> <p>During an interview on 4/28/15 at 10:50 a.m., the Administrator indicated the training had been completed but he did not have documentation for the training.</p>		<p>Developed and implemented. Topics will include but are not limited to Resident Rights and Abuse Prevention.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents had the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>In-services will be pre-planned annually based upon noted requirements per regulations as well as recommendations of the executive management team.</p> <p>The administrator or designee will complete monthly audits to assure compliancy to the planned in-service schedule.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete monthly audits to assure compliancy to policy requirements.</p> <p>Any non-compliancy will be immediately corrected.</p> <p>Audit summaries will be reviewed during weekly executive management meeting. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality</p>				

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R 0121 Bldg. 00	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of</p>		Assurance Meetings to determine if any additional interventions are needed	

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	<p>active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure tuberculin (TB) skin tests were completed for 3 of 10 staff members reviewed for TB skin tests, in that, 1 employee had not had a skin test prior to employment and 2 employees had not received the second step skin test. (CNA #2, LPN #1, Receptionist #1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During record review on 4/28/15 at 10:15 a.m., the CNA #2 had not received the a TB skin test prior to or on employment .</li> <li>2. During record review on 4/28/15 at 10:15 a.m., LPN #1 had not received the 2nd (second) step TB skin test within 1 (one) to 3 (three) weeks after the first step was completed.</li> <li>3. During record review on 4/28/15 at 10:15 a.m., Receptionist #1 had not received the 2nd (second) step TB skin test within 1 (one) to 3 (three) weeks after the first step was completed.</li> </ol>	R 0121	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> No specific residents were identified.</p> <p>Tuberculin skin tests have been administered to employees lacking documentation of such with 75% completion by 05/27/2015 and 100% completion by 06/07/2015.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents had the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> Policy and Procedures have are being reviewed and revised to assure compliancy with standards pertaining to employee tuberculin skin tests.</p> <p>A New Employee Checklist Tool has been developed to be used as an auditing tool in assuring completion of employee health screening Completion of the systematic changes will be within</p>	06/07/2015

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	During an interview on 4/28/15 at 11:10 a.m., the Administrator indicated he was unable to locate the employees TB skin tests.		<p>thefollowing time frame: 75% completion by 05/27/2015 and 100% completion by 06/07/2015.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliancy to established pre-employment health screening policy and procedures including but not limited to an assessment for tuberculosis. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>Any non-compliancy will be immediately corrected.</p> <p>Employee file audit summaries will be reviewed during weekly executive management meetings. The outcome of this tool and executive management recommendations will be reviewed at the quarterly Quality Assurance Committee Meetings to determine if any additional interventions are needed</p>		

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R 0123  Bldg. 00	<p>410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.</p> <p>Based on record review and interview, the facility failed to ensure employee records were complete and accurate for 10 of 10 employees, in that, no general or specific job descriptions were located. (LPN #1, RN #1, COTA (certified occupational therapy assistant) #1, Hskg (housekeeper) #1, CNA #1, LPN #2, CNA #2, Receptionist #1, Administrator, CNA #3)</p> <p>Findings include:  The employee files were provided by the</p>	R 0123	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> No specific residents were identified.</p> <p>Specific job descriptions are being reviewed and acknowledged by all current employees and shall become a part of the employee file.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents had the potential to be affected. <b>The measures or systematic</b></p>	05/27/2015			

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	<p>Administrator (Adm) on 4/28/15 at 9:45 a.m.</p> <p>During review of the employee files on 4/28/15 at 10:15 a.m., the general and specific job descriptions were not located in the files.</p> <p>During an interview with the Adm on 4/28/15 at 11:00 a.m., the Adm indicated the employee files were complete and correct. The Adm indicated the staff would be given the job description by the person in charge of them but the facility did not have any documentation to show the employee received any job descriptions upon employment.</p>		<p><b>changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>Employee policy and procedures have been reviewed and revised to assure the availability of specific job descriptions and the employee review and acknowledgement of such.</p> <p>A New Employee Checklist Tool has been developed to be used as an auditing tool in assuring complete and accurate employee records.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure the inclusion of a job description specific to the employee's designated position. Audits shall be completed weekly x 4, monthly x 2, and quarterly thereafter</p> <p>Any non-compliance will be immediately corrected.</p> <p>Employee file audit summaries will be reviewed during weekly executive management meetings. The outcome of this</p>	

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NAME OF PROVIDER OR SUPPLIER  OASIS DEMENTIA CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 WASHINGTON AVE EVANSVILLE, IN 47714
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R 0154 Bldg. 00	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>During observation, interview and record review, the facility failed to have a fully functional kitchen in that, the kitchen (which is not being used but was unlocked and accessible to residents) and GiGi's kitchen which was a small kitchenette type room, was used by residents for supplemental food and fluids, the freezer temperature was not maintained, there was no appropriate food storage, a saw laying on a counter in the empty kitchen, wires were hanging out of an uncovered box on wall, pitchers under sink with condensation in them,</p>	R 0154	<p>tool and executive management recommendations will be reviewed at the quarterly Quality Assurance Committee Meetings to determine if any additional interventions are needed</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> The administrator immediately: removed the item noted as finding #1, placed a plate cover over item #2, secured the items noted in #3 in a locked storage area, adjusted the thermostat for the refrigerator noted in #4, disposed of items noted in items #5, #6, #7, #8, #9, #10, #12, washed, sanitized and air dried the items noted as #11, ordered a new Magnetic seal for the refrigerator noted as item #13. The seal will be installed upon</p>	06/12/2015

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	<p>chemicals accessible in the empty kitchen, fish food in freezer, rubber gaskets hanging off bottom of refrigerator. This had the potential to affect 3 of 3 residents in the facility.</p> <p>Findings include:</p> <p>On 4/27/15 at 9:10 a.m., the main kitchen (which was not being utilized yet due to lack of residents, and was unlocked making it accessible to residents ) was observed and was found to have:</p> <ol style="list-style-type: none"> <li>1. A rusty hand saw on the counter.</li> <li>2. An uncovered outlet box on a wall had exposed wires hanging from it.</li> <li>3. Four cleaning agents which included: Resolve Carpet Cleaner- which indicated to "keep out of reach of children, was an eye irritant," "Quat" Sanitizer: which indicated "Keep out of reach of Children, call doctor or poison control, if inhaled call 911, " Coffee Pot Cleaner which indicated "Keep out of reach of children. flush eyes if causes irritation, call doctor or poison control if ingested call doctor," and Super Premium Lime Remover which indicated "Corrosive if ingested call doctor or 911."</li> </ol>		<p>Receipt.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>Policies and Procedures are being developed to assure facility practices are in accordance with 410 IAC 7-24 including but not limited to assuring there is a secure clean and functional kitchen pertaining to the receiving, storage, preparation and distribution of meal services. Dietary staff will be in-serviced and trained on the policies and procedures to assure an understanding of . Employee Orientation Policies and Procedures are being reviewed and revised to include a "New Employee Check List tool" to monitor completion and documentation of the orientation process to assure staff have received training. Completion of the systematic changes will be within the following time frame: 75% completion by 05/27/2015 and 100% completion by 06/12/2015.</p> <p><b>The corrective action taken to monitor performance to assure</b></p>				

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	<p>On 4/27/15 at 9:20 a.m., GiGi's kitchen (which was a small supplemental kitchen used only by the residents) was observed and found to have:</p> <p>4. The freezer temperature was 9 (nine) degrees F (Fahrenheit), a recheck at 1:20 p.m., found the freezer temperature to be 6 (six) degrees F.</p> <p>5. In the freezer was a bag of opened chicken nuggets, with no open date, and/or expiration date and was not sealed.</p> <p>6. Two boxes of Saltwater and Fresh Water Fishfood, in small sealed cubes, which indicated not for human consumption.</p> <p>7. A bag of opened lettuce, unsealed with no open date, was observed in the refrigerator.</p> <p>8. A container of vegetable soup with no date or resident name.</p> <p>9. Three bags of rotten, odorous potatoes were observed in a cabinet.</p> <p>10. A cabinet which contained a bag of sugar and flour, neither which were dated or enclosed in a container.</p>		<p><b>compliance through quality assurance is:</b></p> <p>The administrator or designee will complete audits of the dietary department utilizing a check list document. Audits shall be completed weekly x 4, monthly x 2, and quarterly thereafter.</p> <p>Any non-compliance will be immediately corrected.</p> <p>Audit summaries will be reviewed during weekly executive management meetings. The outcome of this tool and any executive management recommendations will be reviewed at the quarterly Quality Assurance Committee meetings to determine if any additional interventions are needed.</p>	

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	<p>11. A cabinet had 3 pitchers, which had condensation in them, and a package with cord tie backs with large amount of condensation in them.</p> <p>12. A box of instant Idaho potatoes which was opened, not enclosed and no date of when they were opened.</p> <p>13. The rubber seal was hanging off the bottom of the refrigerator.</p> <p>On 4/27/15 at 11:50 a.m., RN #1 indicated the refrigerator was used only for residents.</p> <p>On 4/27/15 at 12:00 p.m., CNA #1 indicated Gigi's kitchen was only used by residents. She indicated when resident's family bring in food, a date and resident's name was placed on it. She further indicated if the food was homemade, it would be thrown out in a day or two.</p> <p>On 4/27/15 at 4:00 p.m., during an interview, the Administrator indicated GiGi's kitchen was for residents and laughed at the findings.</p> <p>On 4/28/15 at 10:14 a.m., a follow up observation of GiGi's kitchen indicated the potatoes, the cords with condensation, and the open bag of lettuce had been removed.</p>			

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R 0217 Bldg. 00	<p>On 4/28/15 at 10:18 a.m.,observed in the large unused kitchen, the saw had been removed, the chemicals had been removed, and a wall cover had been placed over the open wires.</p> <p>A policy book was received from the Administrator on 4/27/15 at 9:45 a.m. The book indicated there was not a policy for kitchen foods and storage of different items.</p> <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</p>			

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	<p>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 record review and interview, the facility failed to ensure a service plan was signed by the resident and/or the resident's family member for 3 of 3 residents who were reviewed. (Resident #1, Resident #2, Resident #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The record for Resident #3 was reviewed on 04/27/15 at 9:50 a.m. The resident's record failed to reveal a service plan that was signed by the resident or resident's family member.</li> <li>2. On 4/27/15 at 10:00 a.m., the clinical record for Resident #2 failed to reveal a service plan which was signed by the resident or residents family member.</li> <li>3. On 4/27/15 at 9:50 a.m., Resident #1's clinical record was reviewed. Resident #1 was admitted on 1/12/15. Resident #1's clinical record lacked a service plan signed by the resident and/or family.</li> </ol> <p>On 4/27/15 at 11:05 a.m., the Administrator indicated the signed</p>	R 0217	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b></p> <p>The Resident Service Plans have been reviewed with and signed by the appropriate resident representatives.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>The Policy and Procedure for the development and implementation of the Resident Service plan has been review with licensed nursing staff.</p> <p>Employee Orientation Policies and Procedures have been reviewed and revised to include a New Employee Check List tool to monitor completion and documentation of instruction on the development and implementation of the Resident Service Plan including but not Limited to the resident and/or</p>	05/15/2015

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	<p>service plan should have been located in the clinical record. The Administrator further indicated if the signed service plan was not located in the clinical record there were not any.</p> <p>On 4/27/15 at 2:00 p.m., the Marketing and Admissions Director indicated the service plans had not been signed.</p> <p>On 4/27/15 at 3:52 p.m., the "Resident Service Plan" policy, undated, was reviewed, the policy included, but was not limited to: "The resident will sign and date his or her Service Plan after review and discussion, indicating his or her agreement with the plan."</p>		<p>resident representative's signed acknowledgement of the plan.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an on going quality improvement process the administrator will complete an audit of the resident record within 10 days of admission to assure compliance with established policies and procedures pertaining to Resident Service Plan development and notification. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of a new employee file reconciling the New Employee Checklist Tool to the employee's record to assure completion of orientation pertaining to but not limited to Resident Service Plan development and notification. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>Any noncompliant practices will be immediately addressed.</p> <p>Audit findings will be reviewed during weekly executive management team meetings.</p>				

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R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to administer medication ordered by the resident's physician for 3 of 3 residents reviewed, in that, residents did not have signed physician's orders for medications and 1 of 3 residents did not have an attending physician at the facility. (Resident #1, #2, #3)</p> <p>Findings include:</p> <p>1. Resident #1 clinical record was reviewed on 4/27/15 at 9:50 a.m. The resident was admitted on 1/12/15. The diagnosis included, but was not limited to, history of UTI ( urinary tract infection), anxiety, dementia, AMS (altered mental state), hyperthyroidism,</p>	R 0241	<p>Executive management team recommendations will be submitted quarterly to the Quality Assurance Meeting to determine if any additional interventions are needed</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> The Marketing director immediately completed a chart review of residents #1, #2 and #3. Signed Physician Orders were obtained for the residents lacking orders and/or physician signatures were obtained on telephone orders previously received.</p> <p>The administrator completed a review of the Policy and Procedure entitled "Medical Evaluation" which contains the protocol for the requirement and selection of a primary care physician.</p> <p>The administrator completed a</p>	05/08/2015			

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	<p>HTN (hypertension), hyperlipidemia, depression, and seizure disorder. Medications listed on an unsigned admission physician order form included but was not limited to, the following: Exelon Patch 9.5 mg 1 patch every 24 hours (anti-Alzheimer's drug) Klonopin 0.5 mg tab 1 po tid (three times per day) (anti-convulsions drug) Systane Ophthalmic Drops 2 drops in both eyes qid (four times per day) Coenzyme Q 10-100mg po qd (every day) Potassium Gluconate 595 mg po qd Ibuprofen 200 mg po bid (two times per day) D3 1000 IU po qd</p> <p>2. On 4/27/15 at 10:00 a.m., the clinical record for Resident #2 was reviewed. The clinical record lacked documentation of signed physician's orders for medications. The clinical record further indicated Resident #2 did not have an attending physician at the facility. Resident #2 was admitted on 3/6/15. The diagnosis included but was not limited to, Alzheimer 's, chronic kidney disease, HTN, DM (Diabetes Mellitus) type 2, and HLD(hyperlipidemia). The following medications were listed on an unsigned medication form: Myrbetriq 25 mg po (usually given once</p>		<p>review of the Policy and Procedure entitled "Prescribed Medication Orders".</p> <p>Policy and Procedures pertaining to Physician Services and Orders were reviewed with staff involved in the admission process.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having thepotential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>An Admission's Checklist Tool has been developed to use as a guide during the admission process to assure compliancy of established admission protocol.</p> <p>Current employees have been instructed on the use of the Admission's Checklist Tool.</p> <p>An Employee Orientation Documentation form will be utilized to indicate the completion of new employee orientation pertaining to admission protocol including but not limited to Physician Services and Orders.</p> <p>A New Employee Checklist Tool</p>				

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	<p>a day)(antispasmodic bladder medication) Mirtazapine 15 mg po (usually given at bedtime) (antidepressant) Atorvastatin 10 mg (usually given once a day)(used to lower lipid level) Benazepril 10/12.5 mg po (usually given once a day) ( antihypertensive) Escitalopram 10 mg po qd (antidepressant) Atenolol 50 mg po qd (angina) Abilify 5 mg po qd (anti-psychotic) Tylenol ES tabs 2 prn - pain</p> <p>During an interview on 4/27/15 at 10:25 a.m., RN #1 indicated Resident #2 had a physician at the facility. During an interview with the Administrator on 4/27/15 at 4:00 p.m., the Administrator indicated he did not know Resident #2 did not have a attending physician since arriving at the facility.</p> <p>3. Resident #3 clinical record was reviewed on 4/27/15 at 9:50 a.m. The resident was admitted on 3/21/15. The diagnosis included but was not limited to, dementia with behavioral disturbances, Vitamin. D deficiency, atrial fibrillation, atherosclerotic cardiovascular disease, IBS (irritable bowel syndrome), urinary incontinence, reflux, HTN, hyperlipidemia, and amaurosis fugax. The following medications were listed</p>		<p>has been developed to be used as an auditing tool in assuring completion of the new employee orientation process. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete a chart audit on each new admission reconciling the Admission Checklist Tool to the resident's medical record including but not limited to Physician Services and Orders. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter. As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliancy to established orientation procedures pertaining to admission protocol including but not limited to Physician Services and Orders. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter. Any noncompliant practices will be immediately addressed. Resident admission chart audit</p>				

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R 0268  Bldg. 00	<p>on an unsigned physician form: Omeprazole 20 mg po bid (anti-ulcer) Vitamin D 50,000 IU po weekly Sucralfate Gm 1 po bid (anti-ulcer) Olanzapine 5 mg ½ tab po bid (anti-psychotic) Propafenone HCl 150 mg po daily (treatment of Atrial Fibrillation) Calcium Carbonate 500 mg po every 2 hours prn - indigestion Aleve 220 mg po every 8 hours prn - pain Docusate Sodium 50 mg with Sennosides 8.6 mg po daily prn q 8 hours if no BM Diphenhydramine HCl 25 mg po prn - allergies every HS Lorazepam 0.5 mg po tid prn - anxiety Procera AVH po every day Namenda XR 28 mg po daily (anti Alzheimer's) Exelon Patch 9.5 mg po daily (anti-Alzheimer's)</p> <p>During review of the policy book, obtained from the Administrator on 4/26/15 at 9:45 a.m., indicated the facility did not have a policy for obtaining a physician for the residents and/or signed physician orders.</p> <p>410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a</p>		<p>summaries and employee file audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations and actions will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.</p>				

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	<p>balanced distribution of the daily nutritional requirements.</p> <p>During interview, observation, and record review, the facility failed to provide three (3) well-balanced meals a day seven (7) days a week, in that, all meals were provided from a local restaurant and the daily nutritional requirements could not be assured. This had the potential to affect 3 of 3 residents at the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 4/27/15 at 9:50 a.m., Resident #1's clinical record was reviewed. Resident #1's clinical record lacked a signed diet order.</li> <li>On 4/27/15 at 10:00 a.m., the clinical record for Resident #2 was reviewed. Resident #2's clinical record lacked signed physician's diet order.</li> <li>The clinical record for Resident #3 was reviewed on 04/27/15 at 9:50 a.m. The resident's record lacked a signed physician's diet order.</li> <li>During an interview on 4/27/15 at 10:20 a.m., the Administrator indicated the facility did not have a contract with a dietician. The Administrator further indicated the residents received their</li> </ol>	R 0268	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b></p> <p>Residents #1, #2, nor #3 suffered no ill effects from the alleged deficiency.</p> <p>Weekly menus are being developed to assure three (3) well-balanced meals Seven (7) days a week.</p> <p>Signed diet orders have been obtained for 3 of 3 residents.</p> <p>Interviews are being conducted in search of a consulting dietician</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> New policies and procedures are being developed and implemented pertaining to the establishment of a functional dietary department including but not limited to the meal planning and the employment of a consultant dietician. Completion of the systematic changes will be within the following time frame: 50% completion by 05/27/2015, 75% completion by 06/12/2015 and 100% completion by 06/27/2015.</p> <p><b>The corrective action taken to</b></p>	06/27/2015			

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R 0269 Bldg. 00	<p>meals from a local restaurant.</p> <p>During an observation at on 4/27/15 at 12:05 p.m., CNA #1 was observed to be removing food from disposable containers and placing the food on plates. The plates were then served to the all the residents.</p> <p>During an interview with RN #1 on 4/27/15 at 12:20 p.m., RN #1 indicated the food was ordered by each resident from a local restaurant. RN #1 indicated the residents received all three meals from the restaurant daily.</p> <p>During an interview on 4/27/15 at 2:00 p.m., the Marketing and Admissions Director indicated the physician's orders for diet orders were not signed.</p> <p>410 IAC 16.2-5-5.1(b) Food and Nutritional Services - Noncompliance (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician.</p> <p>Based on observation, interview, and record review, the facility failed to have menus and/or meals approved by a registered dietician. This had the potential to affect 3 of 3 residents in the facility.</p>	R 0269	<p><b>monitor performance to assure compliance through quality assurance is:</b></p> <p>As an on going quality improvement process the consulting dietician will complete monthly audits of the dietary department to compliancy with established policies and procedures. Audits shall be completed monthly</p> <p>Any noncompliant practices will be immediately corrected</p> <p>Audit findings will be reviewed during the next upcoming weekly executive management team meetings. Executive management team recommendations will be submitted quarterly to the Quality Assurance Meeting to determine if any additional interventions are needed</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> The executive management team is currently recruiting to contract the services of a registered dietician to approve mealsand/or menus.</p>	06/27/2015			

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	<p>Findings include:</p> <p>During an observation at on 4/27/15 at 12:05 p.m., CNA #1 was observed to be removing food from disposable containers and placing the food on plates. The plates were then served to the all the residents.</p> <p>During an interview with RN #1 on 4/27/15 at 12:20 p.m., RN #1 indicated the food was ordered by each resident from a local restaurant. RN #1 indicated the residents received all three meals from the restaurant daily.</p> <p>The policy manuel was obtained from the Administrator and reviewed on 4/27/15 at 9:45 a.m. The policy manuel lacked a policy for the dietician.</p> <p>During an interview on 4/27/15 at 10:20 a.m., the Administrator indicated the facility did not have a contract with a dietician. The Administrator further indicated the residents received their meals from a local restaurant.</p>		<p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> A facility staffing tool is being developed to list all staffing positions noting: title and the employees specifically designated for the positions. Completion of the systematic changes will be within the following time frame: 50% completion by 05/27/2015, 75% completion by 06/12/2015 and 100% completion by 06/27/2015.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete a monthly audit to assure all positions are filled. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>Any non-compliant practice will be corrected immediately. Audit summaries will be reviewed during weekly executive management team meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality</p>				

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R 0273  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 and interview, the facility failed to maintain a food preparation and serving area in accordance with state and local sanitation and safe food handling standards, in that, the facility did not have a designated kitchen area for preparing meals and the serving area for the resident's meals was not maintained. This had the potential to affect 3 of 3 residents.</p> <p>Findings include:</p> <p>During an observation on 4/27/15 at 9:10 a.m., the main kitchen (which was not being utilized yet due to lack of residents, but was unlocked and accessible to residents) was observed and was found to have the following:</p> <ol style="list-style-type: none"> <li>1. A rusty hand saw on the counter.</li> <li>2. An uncovered outlet box with exposed</li> </ol>	R 0273	<p>Assurance Meetings to determine if any additional interventions are needed.</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> Residents #1, #2, nor #3 suffered no ill effects from the alleged deficiency. The administrator immediately: removed the item noted as finding #1, placed a plate cover over item #2, secured the items noted in #3 in a locked storage area, adjusted the thermostat for the refrigerator noted in #4, disposed of items noted in items #5, #6, #7, #8, #9, #10, #12, washed, sanitized and air dried the items noted as #11, ordered a new magnetic seal for the refrigerator noted as item #13. The seal will be installed upon receipt. The kitchen was secured with the installation of lockset. <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures or systematic</b></p>	06/05/2015			

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	<p>wires hanging from it was observed on the wall.</p> <p>3. Four (4) cleaning agents which included: Resolve Carpet Cleaner - which indicated to "keep out of reach of children, was an eye irritant," "Quat" Sanitizer: which indicated "keep out of reach of children, call doctor or poison control, if inhaled call 911," Coffee Pot Cleaner which indicated "keep out of reach of children; flush eyes if causes irritation, call doctor or poison control if ingested call doctor," and Super Premium Lime Remover which indicated "corrosive, if ingested call doctor or 911."</p> <p>During an observation on 4/28/15 at 10:18 a.m., the saw had been removed, the chemicals had been removed, and a wall cover had been placed over the open wires.</p> <p>On 4/27/15 at 9:20 a.m., GiGi's kitchen (a small supplemental kitchen used by the residents) was observed and found to have the following:</p> <p>4. The freezer temperature was 9 (nine) degrees F (Fahrenheit). During an observation on 4/27/15 at 1:20 p.m., the temperature of the freezer was 6 (six)</p>		<p><b>changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>Policies and Procedures are being developed to assure facility practices are in accordance with 410 IAC 7-24 including but not limited to assuring there is a secure clean and functional kitchen pertaining to the receiving, storage, preparation and distribution of meal services. Dietary staff will be in-serviced and trained on the policies and procedures to assure an understanding of .</p> <p>Employee Orientation Policies and Procedures are being reviewed and revised to include a "New Employee Check List tool" to monitor completion and documentation of the orientation process to assure staff have received training.</p> <p>A consulting dietician will be employed to provide oversight of the dietary department.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>The administrator or designee will complete audits of the dietary department utilizing a check list document. Audits shall be completed weekly x 4, monthly x 2, and quarterly thereafter. Any non-compliance will be immediately corrected. Audit summaries will be reviewed during weekly executive</p>				

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	<p>degrees F.</p> <p>5. An open bag of chicken nuggets with no open date and no expiration date was located in the freezer. The bag was unsealed.</p> <p>6. Two (2) boxes of Saltwater and Fresh Water fish food, in small sealed cubes, were observed in the freezer. The container indicated the fish food was not for human consumption.</p> <p>7. A bag of opened lettuce, unsealed with no open date, was observed in the refrigerator.</p> <p>8. A container of vegetable soup was observed in the refrigerator with no date or resident's name on it.</p> <p>9. Three (3) bags of rotten and odorous potatoes were located in a cabinet.</p> <p>10. An open bag of sugar was observed in a cabinet with no open date on it. The sugar was not enclosed in a container.</p> <p>11. An open bag of flour was observed in a cabinet with no date on it. The flour was not enclosed in a container.</p> <p>12. Three (3) pitchers, which were located in the bottom of a cabinet under a</p>		<p>management meetings. The outcome of this tool and any executive management recommendations will be reviewed at the quarterly Quality Assurance Committee meetings to determine if any additional interventions are needed.</p>				

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	<p>sink, had condensation in them.</p> <p>13. A package of drapery cord tie backs were observed in the bottom of a cabinet under a sink. The tie backs had a large amount of condensation on them.</p> <p>14. A box of instant Idaho potatoes was opened in a cabinet. No date was located on the box and the box was not enclosed in a container.</p> <p>15. A rubber seal was observed hanging off the bottom of the refrigerator.</p> <p>On 4/28/15 at 10:14 a.m., a follow up observation of GiGi's kitchen indicated the potatoes, the cords with condensation, and the open bag of lettuce had been removed.</p> <p>On 4/27/15 at 11:50 a.m., RN #1 indicated the refrigerator is used only for residents.</p> <p>On 4/27/15 at 12:00 p.m., CNA #1 indicated Gigi's kitchen is only used by residents. She indicated when resident's family bring in food, a date and the resident's name was placed on it. She further indicated if the food was homemade, it would be thrown out in a day or two.</p>			

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R 0274 Bldg. 00	<p>On 4/27/15 at 4:00 p.m., during an interview, the Administrator indicated GiGi's kitchen was for residents and laughed at the findings.</p> <p>A policy book was received from the Administrator on 4/27/15 at 9:45 a.m. The book lacked a policy for kitchen foods and storage of food items.</p> <p>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.</p>			

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	<p>(E) An individual with training and experience in food service supervision and management.</p> <p>(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.</p> <p>(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.</p> <p>Based on observation and interview, the facility failed to provide an organized food service department directed by a supervisor competent in food service management, in that, the facility did not have a food service supervisor. This had the potential to affect 3 of 3 residents.</p> <p>Findings include:</p> <p>During an observation at on 4/27/15 at 12:05 p.m., CNA #1 was observed to be removing food from disposable containers and placing the food on plates. The plates were then served to all the residents.</p> <p>During an interview on 4/27/15 at 2:15 p.m., the Administrator (Adm) indicated the facility did not have a food service supervisor. The Adm indicated all meals were ordered from a local restaurant. The Adm further indicated he did not have a contact for a dietician.</p>	R 0274	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> An employee experienced in food service management has been assigned the position of food service supervisor. <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b> The administrator is developing and implementing new policies and procedures pertaining to the establishment of a functional dietary department including but not limited to the employment of a foodservice supervisor. <b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b> As an ongoing quality</p>	05/25/2015			

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R 0275 Bldg. 00	<p>410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.</p> <p>Based on record review and interview, the facility failed to ensure diet orders were reviewed and revised by a physician for 3 of 3 residents, in that, physician's diet orders were not obtained, reviewed and/or physician's orders signed. (Resident #1, #2, #3)</p> <p>Findings include:</p>	R 0275	<p>improvement process on a bi-weekly basis the administrator or designee will review facility staffing schedules to assure compliancy with the facility staffing policies.</p> <p>The Chief Executive Officer will audit weekly staffing schedules on a bi-weekly basis x 2, monthly x 2 and quarterly thereafter.</p> <p>Audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations and actions will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b></p> <p>The Marketing director immediately completed a chart review of residents #1, #2 and #3. to assure the identification of a signed diet order. If absent, one was obtained.</p>	05/15/2015

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	<p>1. On 4/27/15 at 9:50 a.m., Resident #1's clinical record was reviewed. Resident #1's clinical record lacked documentation the physician had ordered a diet for the resident on admission. The recompilation orders contained a diet "Regular" diet but the record lacked a physician order for the diet.</p> <p>2. On 4/27/15 at 10:00 a.m., the clinical record for Resident #2 was reviewed. Resident #2's clinical record lacked documentation the physician had ordered a diet for the resident.</p> <p>3. The record for Resident #3 was reviewed on 04/27/15 at 9:50 a.m. Resident #3's clinical record lacked documentation the physician had ordered a diet for the resident.</p> <p>The policy manuel was received from the Administrator (Adm) and reviewed on 4/27/15 at 9:45 a.m. The policy manuel lacked a policy for reviewing/revising of diet orders or physician's orders.</p> <p>During an interview with the Adm on 4/27/15 at 10:15 a.m., the Adm indicated the facility did not have a policy for physician's orders.</p>		<p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having thepotential to be affected.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>An Admission's Checklist Tool has been developed to use as a guide during the admission process to assure compliancy of established admission's protocol.</p> <p>Current employees have been instructed on the use of the Admission's Checklist Tool.</p> <p>An Employee Orientation Documentation form will be utilized to indicate the completion of new employee orientation pertaining to admission protocol including but not limited to Physician Services and Orders including diet orders.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an on going quality improvement process the administrator will complete a chart audit on each new admission reconciling the Admission's Checklist Tool to the resident's medical record.</p> <p>Audits shall be completed weekly</p>				

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R 0349 Bldg. 00	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure residents had signed physician's orders for medications, diet, and an annual health statement, for 3 of 3 residents reviewed. (Resident #1, Resident #2, Resident #3)</p> <p>Findings include:</p>	R 0349	<p>x 4, monthly x 2, quarterly thereafter.</p> <p>Any noncompliant actions will be immediately corrected.</p> <p>Chart audit summaries and will be reviewed during weekly executive management meetings. The outcome of this tool and executive management recommendations will be reviewed at the quarterly Quality Assurance Committee Meetings to determine if any additional interventions are needed</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> The Marketing director immediately completed a chart review of residents #1, #2 and #3. Signed Physician Orders for medications, diet and a health statement were obtained for the</p>	05/15/2015	

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(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	
	<p>1. On 4/27/15 at 9:50 a.m., Resident #1's clinical record was reviewed. Resident #1's clinical record lacked a signed diet order.</p> <p>2. On 4/27/15 at 10:00 a.m., the clinical record for Resident #2 was reviewed. No signed doctors orders for medications, diet orders, or an annual health statement were found.</p> <p>3. The record for Resident #3 was reviewed on 04/27/15 at 9:50 a.m. The resident's record failed to reveal signed physician's orders for medications, diet orders, or an annual health statement.</p> <p>During an interview on 4/27/15 at 2:00 p.m., the Marketing and Admissions Director indicated the doctors orders for medications and diet orders were not signed, and the residents did not have a signed health statement.</p>		<p>residents lacking such.</p> <p>The administrator completed a review of the Policy and Procedure entitled "Medical Evaluation" which contains the protocol for the requirement and selection of a primary care physician.</p> <p>The administrator completed a review of the Policy and Procedure entitled "Prescribed Medication Orders".</p> <p>Policy and Procedures pertaining to Physician Services and Orders were reviewed with staff involved in the admission process.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential of being affected. <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>The administrator is currently reviewing, revising and implementing new policies and procedures pertaining to maintaining clinical records. As an immediate corrective action an Admission's Checklist Tool has been developed to use as a guide during the admission process to assure</p>		

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			<p>compliance of established admission protocol.</p> <p>Current employees have been instructed on the use of the Admission's Checklist Tool.</p> <p>An Employee Orientation Documentation form will be utilized to indicate the completion of new employee orientation pertaining to clinical record requirements and maintenance including but not limited to physician orders for medications, diet and an annual health Statement. A New Employee Checklist Tool has been developed to be used as an auditing tool in assuring completion of the new employee orientation process</p> <p>Current employees have been instructed on the use of the New Employee Checklist Tool.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete a chart audit on each new admission reconciling the Admission Checklist Tool to the resident's medical record including but not limited to Physician Services and Orders. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>As an ongoing quality improvement process the</p>	

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R 0356  Bldg. 00	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.		administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliancy to established orientation procedures pertaining to admission protocol including but not limited to Physician Services and Orders. Audits shall be completed weekly x 4, monthly x 2, quarterly thereafter. Any noncompliant practices will be immediately addressed. Resident admission chart audit summaries and employee file audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations and actions will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.	

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	<p>(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.</p> <p>Based on interview and record review, the facility failed to maintain an emergency file for 3 of 3 residents reviewed. (Resident #1, Resident #2, Resident #3)</p> <p>Findings include:</p> <p>On 4/27/15 at 10:50 a.m., RN #1 indicated there was not an emergency file for any of the residents (Resident #1, #2, # 3).</p> <p>On 4/27/15 at 3:52 p.m., the "Resident Identification" policy, undated, was reviewed. The policy included, but was not limited to: "Upon obtaining consent, two copies of the photograph will be made. One copy will be placed in the front of each resident's section of the Medication Administration Record. The second copy will be placed in the emergency file for each resident."</p>	R 0356	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b>                  An Emergency File has been compiled and placed at the nurses station for each of the affected residents  <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents were identified as having the potential to be affected <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b>                  An Admission's Checklist Tool has been developed to use as a guide during the admission process to assure compliancy.</p> <p>New employee orientation will include the review of policies and procedures pertaining to admission protocol including but not limited to the Resident</p>	05/15/2015			

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			<p>Emergency File.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete a chart audit on each new admission reconciling the Admission Checklist Tool to the resident's medical record including but not limited to the Resident Emergency File. Audits shall be competed weekly x 4, monthly x 2, quarterly thereafter.</p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliancy to established orientation procedures pertaining to admission protocol including but not limited to the completion of a Resident Emergency File. Audits shall be competed weekly x 4, monthly x 2, quarterly thereafter. Any non-compliancy will be immediately corrected. Resident admission file audit summaries and employee file audit summaries will be reviewed during weekly executive management</p>	

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R 0407 Bldg. 00	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on record review and interview, the facility failed to establish an infection control program that provided education on infection control and universal precautions for the staff, in that, the facility did not have a policy for handwashing and glove use. This had the potential to affect 3 of 3 residents.</p> <p>Findings include:</p> <p>The policy manuel, obtained from the Administrator and reviewed on 4/27/15 at</p>	R 0407	<p>meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.</p> <p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b> A policy and procedure for hand washing and glove use has been written and implemented with 1-1 instruction to the staff. <b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents had the potential to be affected. <b>The measures or systematic changes that have been put into place to ensure that the</b></p>	05/27/2015

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	<p>9:45 a.m., lacked a policy for handwashing and glove use.</p> <p>During an interview on 4/28/15 at 10:15 a.m., the Administrator indicated the policy manuel was complete and correct. The Administrator indicated he oversees the infection control of the facility. The Administrator indicated inservicing had not been given to the employees except when they were hired. The Administrator indicated each supervisor was responsible for overseeing their staff.</p>		<p><b>alleged deficient practice does not recur include:</b></p> <p>New employee orientation policy and procedures were reviewed to assure the inclusion of policies and procedures pertaining to infection control including but not limited to hand washing and glove use.</p> <p>A New Employee Checklist Tool has been developed to be used as an auditing tool in assuring completion of employee orientation.</p> <p>An on going inservice program shall include infection control techniques including but not limited to hand washing and glove use.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>As an ongoing quality improvement process the administrator or designee will complete an audit of each new employee file reconciling the New Employee Checklist Tool to the employee's record to assure compliancy to established orientation procedures pertaining to infection control including but not limited to hand washing and glove use.</p> <p>Audits shall be competed weekly x 4, monthly x 2, quarterly thereafter.</p>	

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R 0410 Bldg. 00	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				Any non-compliance will be immediately corrected. Employee Record audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.  Audit summaries will be reviewed during weekly executive management meetings. The outcome of those summaries and executive management recommendations will be reviewed at the quarterly Quality Assurance Meetings to determine if any additional interventions are needed.		

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	<p>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.</p> <p>(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.</p> <p>Based on interview and record review, the facility failed to ensure a Tuberculin skin test was completed prior to or on admission in 2 of 3 residents reviewed. (Resident #2, Resident #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 4/27/15 at 10:00 a.m., the clinical record for Resident #2 indicated no Tuberculin skin test had been administered. The resident was admitted on 3/6/15.</li> <li>The record for Resident #3 was reviewed on 04/27/15 at 9:50 a.m. The resident's record failed to reveal the Tuberculin test results.</li> </ol> <p>During an interview on 4/27/15 at 2:00 p.m., the Marketing and Admission Director indicated a Tuberculin skin test had been administered to Resident #2.</p> <p>On 4/28/15 a policy book was received from the Administrator which indicated,"</p>	R 0410	<p><b>The corrective action taken for those residents founded to be affected by the alleged deficient practice include:</b></p> <p>Tuberculin skin tests have been completed for the noted residents.</p> <p>Policy and Procedures have been reviewed and staff educated on tuberculin skin testing standards.</p> <p><b>Other residents that have the potential to be affected by the alleged deficient practice have been identified by:</b> All residents had the potential to be affected. The record for resident #1 was reviewed to assure compliancy <b>The measures or systematic changes that have been put into place to ensure that the alleged deficient practice does not recur include:</b></p> <p>An Admission's Checklist Tool has been developed to use as a guide during the admission process to assure compliancy to established tuberculin skin testing policy and procedures.</p>	05/22/2015

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	Upon the resident's admission, per 3, the primary care physician must certify that each resident is free of communicable disease including tuberculosis in an infectious stage prior to admission."		New employee orientation will include the review of policies and procedures pertaining to admission protocol including but not limited to tuberculin skin testing.  A New Employee Checklist Tool has been developed to use as an auditing tool in assuring completion of the new employee orientation process		