

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 05/11/2016
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NAME OF PROVIDER OR SUPPLIER  INDEPENDENT LIVING CLUB	STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 10 &amp; 11, 2016</p> <p>Facility number: 001132 Provider number: 001132 AIM number: N/A</p> <p>Residential Census: 35</p> <p>Sample: 9</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 5/16/16 by 29479.</p>	R 0000		
R 0117  Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency</p> <p>(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</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>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 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 interview and record review, the facility failed to ensure a minimum of one awake person, with first aid certificates, was on site at all times. This deficient practice had the potential to affect 35 of 35 residents.</p> <p>Finding includes: On 5/11/16 at 10:40 a.m., employee records and licenses were reviewed. State Form titled, "Employee Records," was provided by the Owner on 5/10/16 at 11:50 a.m. Employee records lacked documentation of first aid training for the 20 employees listed on the Employee Records form.</p> <p>During an interview on 5/11/16 at 10:40 a.m., the Office Manager indicated none of the employees had first aid certification. The Office Manager indicated she was unaware of a policy for employee first aid certification.</p>	R 0117	<p>the action to be accomplished will be to have all employees become certified for first aid residents will become affected if any new employee does not have first aid training as well as cpr measures put into place are to certify all for first aid when we re cert for cpr. the facility will no longer allow a new hire without first aid training. we will have the indpls fire dept and re cert the staff for cpr which is coming next month due date, they will cert all for first aid at this time as well. addendum: the night watchmen will both be certified as well as the nursing staff. they are the only two night employees I have at the speedway locale. this is how compliance is ensured. the don manages the nursing schedule and the office manager manages the night watch.</p>	07/31/2016

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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 active disease, (symptoms suggestive of</p>						

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	<p>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 interview and record review, the facility failed to ensure employees had two step tuberculin (TB) skin tests upon hire for 2 of 10 employees reviewed for TB skin tests prior to resident contact. This deficient practice had the potential to affect 35 of 35 residents residing at the facility.</p> <p>Findings include:</p> <p>1. On 5/11/16 at 10:40 a.m., employee records and licenses were reviewed. State Form titled, "Employee Records," was returned by the Owner on 5/10/16 at 11:50 a.m. The Employee Records form indicated Dietary Aide #4 was hired in November of 2015.</p> <p>The form titled, "TB (tuberculin) Test Certificate," dated 11/13/15 indicated Dietary Aide #4 had a TB skin test on 11/10/15. Dietary Aide #4's employee record lacked documentation of a second step TB test upon hire.</p> <p>During an interview on 5/11/16 at 10:45 a.m., the Office Manager indicated the Director of Nursing was not available to ask if Dietary Aide #4 had a second step Tuberculin (TB) upon hire. The Office Manager indicated she was responsible for the employee records and was</p>	R 0121	<p>the corrective action accomplished for those residents affected is as follows... upon new hire of an employee, they will receive their 1st tb skin test prior to start date, then after reading 1st test, with the reading having a 0mm result, they shall be given a 2nd step tb test occurring one to three weeks after the 1st step. the office manager will keep a log of when tb skin tests are done and to be scheduled yearly and thereafter. office manager will also communicate with the don of when tests are to be done. the office manager will provide a list of employees yearly tb skin test dates to the don as well. these changes went into effect 5-12-16 addendum: one of the employees in question is no longer with the company. the other employee in question will be taken care of by the don for the tb test. she will personally take care of it to ensure it is done and documented correctly.</p>	05/12/2016			

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	<p>unaware Dietary Aide #4 had not had a second TB test.</p> <p>2. On 5/11/16 at 10:40 a.m., employee records and licenses were reviewed. State Form titled, "Employee Records," was returned by the Owner on 5/10/16 at 11:50 a.m. The Employee Records form indicated the Dietary Supervisor was hired in November of 2015.</p> <p>The form titled, "TB (tuberculin) Test Certificate," dated 01/23/15 indicated the Dietary Supervisor had a TB skin test on 1/23/15. The Dietary Supervisor's employee record lacked documentation of a second step TB test upon hire.</p> <p>During an interview on 5/11/16 at 10:45 a.m., the Office Manager indicated the Dietary Supervisor came from another nursing facility and had her annual TB test. The Office Manager indicated when employees came from other nursing facilities and had annual TB tests, she did not repeat the TB tests.</p> <p>On 5/11/16 at 11 a.m., the Office Manager provided the current TB policy. The policy indicated, "...According to the Indiana State Board of Health...employees must be screened for tuberculosis using the Mantoux method...The baseline test shall employ the two-step method. If an employee has documented proof of a negative result</p>			

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R 0144 Bldg. 00	<p>within the last twelve (12) months this shall be the first step. The second step will be given upon hire...If an employee does not have documented proof within the last twelve (12) months, the first step will be given upon hire and the second step shall be performed one (1) to three (3) weeks after the first step...."</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, record review, and interview, the facility failed to ensure the residential building was in good repair. This deficient practice had the potential to affect 35 of 35 residents.</p> <p>Findings include:</p> <p>During an initial tour on 5/10/16 from 10:00 a.m. to 10:30 a.m., the following concerns were observed:</p> <p>a. The floor tile in the dining room to the left of ice machine had a visible crack approximately 2 feet in length and 1/8 of an inch in width. Approximately a foot away from the crack on the same tile</p>	R 0144	<p>the action accomplished was to repair said deficiencies. the facility will id residents that could become affected by doing walk through tours and writing daily work orders for maint and housekeeping dept. any and all concerns will be put in a work order and copies kept in a log book kept in the office. the maint super and housekeeping super will perform these work orders and copies and maintained in log book the office manger will walk weekly tours with the above supers for quality control. also she will review the work orders visually weekly to make sure things are being completed. a group effort of all staff is how this will be monitored. communication</p>	07/31/2016			

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	<p>were 6 smaller cracks approximately 1/8 of an inch wide covering approximately a 1 foot area in length. The floor tile was mushy to the touch and indented when stepped on.</p> <p>b. Two tiles in the right corner of the dining room under the drink dispenser station were cracked and broken and missing pieces of the tile. The missing and broken area was approximately measuring 6 inches in length and 2 inches wide. Two additional tiles under the drink dispenser had smaller cracks approximately measuring 2 inches in length by 2 inches in width. Six tiles under the drink dispenser station had dark stains.</p> <p>c. The dining room lighting was dim. The light fixtures throughout the dining room had 22 light bulbs missing or not working out of the 38 light bulbs the light fixtures held.</p> <p>d. The interior hallway of the main building was dim. The light fixtures throughout the hallway had 43 missing or nonfunctioning light bulbs out of the 66 light bulbs the light fixtures held.</p> <p>e. The resident lounge light fixtures had 7 missing or nonfunctioning light bulbs out of 15 light bulbs the light fixtures held.</p> <p>On 5/10/16 at 4:10 p.m., the Maintenance work orders were reviewed from June</p>		<p>through out depts. this practice has been in place since 5-12-16 the items completed are as follows.... the tiles by the drink station were replaced 5-24-16 the floor by the ice machine will require some work by a contractor, date to be determined by their schedule the dining room light bulbs were replaced, 37/38 on 5-25-16 the hallway bulbs were replaced 66/70 on 5-26-16 resident lounge bulbs were replaced 14/15 on 5-24-16 the tables have been scrubbed and washed to remove any sticky substance, tables have also been bleached and sanitized. two tables have been procured from the sister facility and will be brought over by maintenance. this is to be scheduled b/c a uhaul is needed. addendum: the battalion chief of the speedway fire dept will obtain the u haul as he has a cdl. the owner and the chief as well as maint staff will move tables. the cleaning for tables is as follows....the tables will be cleaned daily by the aides by means of sanitization and of course cleaned after every meal setting. aides will clean and sanitize and the supervisor will ensure compliance of her aides.</p>	

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	<p>2015 to May 2016. The work orders lacked documentation of cracks in the dining room floor, and lacked documentation of the nonfunctioning light bulbs in the main building.</p> <p>During a tour with the Maintenance Director on 5/10/16 at 10:35 a.m., the Maintenance Director indicated he was aware of the flooring in the dining room being cracked. He indicated the flooring by the ice machine was deteriorating under the tile and would continue to crack. He indicated the flooring by the drink dispenser station had been replaced multiple times, but it kept, "getting wet from the drink dispenser," and was "rotting away." He indicated there was no current plan to replace the deteriorating flooring or cracked tiles. The Maintenance Director indicated he was aware of the light bulbs not working. He indicated the Owner was looking for new energy efficient lights and he was waiting to hear back from her before ordering light bulbs. He indicated it had been approximately one month since he stopped replacing the light bulbs.</p> <p>During an interview on 5/10/16 at 11:25 a.m., Resident #9 indicated he had bought his own light bulbs for the interior hallway light fixtures outside his door and for the light to the exterior entrance</p>						

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R 0154 Bldg. 00	<p>of his apartment because he was unable to see to get into his room.</p> <p>During an interview on 5/10/16 at 4:00 p.m., the Owner indicated there was no policy for maintenance. Staff and residents were supposed to place a maintenance work order for areas of concern.</p> <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. Based on observation, record review, and interview, the facility failed to ensure dining room tables were maintained in good repair. This deficient practice had the potential to effect 35 out of 35 residents that eat in the dining room.</p> <p>Finding includes:</p> <p>During an observation, on 5/10/16 at 10:10 a.m., all dining room tables were discolored, with areas of dark and light spots. The tables had areas that were</p>	R 0154	<p>the corrective action was to ensure the dining room table was in good repair the dietary super will watch the cleaning and sanitizing of said tables to ensure they don't stay wet after cleaning so no residents will become affected the measures put into place were as follows.... the tables have been scrubbed and washed to remove any sticky substance, tables have also been bleached and sanitized. this was all complete by 5-20-16 two tables have been procured from the sister facility and will be</p>	07/31/2016

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	<p>buckled and uneven. The varnish and stain on the tables were worn through in spots in front of chairs and they felt sticky to the touch. Two tables, in the back of the dining room against the outside wall, had areas that were raised, dark, and warped and they were wet and spongy. The areas were approximately 1 foot by 1 foot.</p> <p>A review of the work order book, on 5/10/16 at 4:10 p.m., lacked documentation of a work order for dining room tables.</p> <p>During an interview, on 5/10/16 at 4:10 p.m., the Maintenance director indicated the tables have been discolored and warped for the last 2 months. He further indicated the two tables with the raised, wet, buckled areas were caused when the tables were cleaned with bleach and left wet, the wood warped and the water got trapped underneath and never dried. He indicated there were no plans to replace the tables and they were not able to be repaired.</p> <p>During an interview with the owner, on 5/10/16 at 4:15 p.m., she indicated she was aware of the condition of the dining room tables, and if there was a problem with the tables a work order should have been made out for maintenance. She</p>		<p>brought over by maintenance. this is to be scheduled b/c a haul is needed. the dietary super will communicate with maintenance if an issue arises that is beyond dietary addendum: the battalion chief of the speedway fire dept will obtain the u haul as he has a cdl. the owner and the chief as well as maint staff will move tables. the cleaning for tables is as follows....the tables will be cleaned daily by the aides by means of sanitization and of course cleaned after every meal setting. aides will clean and sanitize and the supervisor will ensure compliance of her aides.ond the dietary cleaning.</p>	

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R 0191 Bldg. 00	<p>further indicated they did not have a policy on maintaining furniture.</p> <p>410 IAC 16.2-5-1.6(o) Physical Plant Standards - Deficiency (o) Each facility shall have an adequate kitchen that complies with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the kitchen was free from vermin and flying insects and the screen on the exterior kitchen storm door was free of holes for 2 of 2 kitchen observations. These deficient practices had the potential to affect 35 of 35 residents who ate food prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During kitchen observations on 5/10/16 from 10:16 a.m. to 11:10 a.m., and from 11:26 a.m. to 11:35 a.m., small dark black droppings were observed on a preparation table with containers of corn meal, macaroni, corn starch, and frying oil on top. The mesh screen in the window of the kitchen storm door had a hole on the right side of the seam measuring approximately 1 inch in width by 2 inches in length. The top of the mesh screen had a hole measuring approximately 1 inch in length and less</p>	R 0191	<p>the corrective action accomplished was to fix the screen on the door and call the pest company for extra service other than the already done monthly service. the facility will id other residents to become affected by maintaining the screens. the measures put into place are as follows... the screen was repaired 5-12-16 the pest control was called 5-11-16 no more droppings have been seen anywhere the places in question were completely bleached and sanitized. the dietary manager will communicate with the maint super re the screen should there be repair needed. she knows to report to the office as well so a work order can be made so there is a record of the request and the office manger and supers can record this in the log books made for the deficiencies of this survey. a pest control policy was given to the survey team, a copy was made for them as well as monthly statements showing the pest control services</p>	05/16/2016

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	<p>than a 1/2 inch in width. Multiple flying insects were observed in the kitchen around bunches of bananas</p> <p>During an interview on 5/10/16 at 10:16 a.m., the Dietary Manager (DM) indicated there were flying insects occasionally, especially near the bananas. The DM indicated she was unsure when the last time the pest control company came out to spray for the insects. At 10:20 a.m., the Dietary Manager (DM) indicated she was aware the storm door's window screen had holes in it. At 11:07 a.m., the Dietary Manager (DM) indicated the droppings were, "mouse droppings." The DM indicated the droppings were to be cleaned off the table daily and there were mouse traps in the kitchen. The DM indicated there were also four sticky insect traps in the kitchen.</p> <p>During an interview on 5/10/16 at 2:29 p.m., the Owner indicated they had a pest control company that sprayed for pests when the facility notified them they had been observed. The Owner indicated she was unaware there were mice droppings in the kitchen. The Owner indicated she did not have itemized bills from the company that showed what pests the company treated. The Owner indicated there was no policy related to pest</p>						

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R 0217  Bldg. 00	<p>prevention.</p> <p>On 5/10/16 at 1:22 p.m., the Owner provided the current policy titled, "Exterior Kitchen Screen Door Policy." The policy indicated, "The kitchen screen door is to remain closed at all times...This prevents insects from entering."</p> <p>Section 413 of the Indiana "Retail Food Establishment Sanitation Requirements", dated 11/13/04, indicated, "...if the windows or doors...are kept open for ventilation or other purposes...the openings shall be protected against the entry of insects and rodents by...sixteen (16) mesh to one (1) inch screens...."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by</p>						

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	<p>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 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 service plans were developed for 7 or 7 residents reviewed for service plans (Resident's #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>1. Resident #2's record was reviewed on 5/10/16 at 2:35 p.m. A nursing progress note, dated 5/9/15, indicated Resident #4 moved into the facility on 5/9/15. The record lacked documentation a service plan had been developed.</p> <p>2. Resident #3's record was reviewed on 5/10/16 at 3:00 p.m. A nursing progress note, dated 7/27/11, indicated Resident #4 moved into the facility on 7/27/11. The record lacked documentation a service plan had been developed.</p>	R 0217	<p>the action accomplished was to come up with a new service plan. and I note the facility does have what they consider a service plan as it was implemented by a survey team for us. they came up with it, they approved it. it has been in play for every year since. we use the med sheet that is signed by the physician, the don, the qma, and the resident themselves. this has all meds, dx, and allergies and diet on it. we were told to use this as a means of service plan b/c we as a facility do not provide any treatments or services except the meds. hence the reason for using this form. if any thing else is needed, the residents reach outside of the facility to receive. the residnets sign every month in front of nursing and can ask questions and have things explained, documentation of this was shown to the survey team. the measures</p>	08/31/2016			

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	<p>3. Resident #4's record was reviewed on 5/10/16 at 1:00 p.m. A nursing progress note, dated 9/13/15, indicated Resident #4 moved into the facility on 9/13/15. The record lacked documentation a service plan had been developed.</p> <p>4. Resident #5's record was reviewed on 5/10/16 at 3:22 p.m. A nursing progress note, dated 5/2/96, indicated Resident #5 moved into the facility on 5/2/96. The record lacked documentation a service plan had been developed.</p> <p>5. Resident #6's record was reviewed on 5/10/16 at 2:15 p.m. A nursing progress note, dated 8/14/13, indicated Resident #6 moved into the facility on 8/14/13. The record lacked documentation a service plan had been developed.</p> <p>6. Resident #7's record was reviewed on 5/10/16 at 2:40 p.m. A nursing progress note, dated 7/27/11, indicated Resident #7 moved into the facility on 7/27/11. The record lacked documentation a service plan had been developed.</p> <p>7. Resident #8's record was reviewed on 5/10/16 at 3:10 p.m. A nursing progress note, dated 4/10/14, indicated Resident #8 moved into the facility on 4/10/14. The record lacked documentation a</p>		<p>put into place are we have made a service plan policy to use in the future this was created by the don and the owner. the facility will examine each resident once a month to determine the service plan is appropriate. revise if needed. resident will sign to aknowledge. the plans will be coordinated by the don and nursing dept. each nsg staff who conducts any part of the plan shall sign and date to certify their completion of the plan. this will be ongoing to catch up on all residents due to the fact we have already been using a plan that was deemed acceptable by the board. addendum: the manager will fax the idea for new service plan. the writer is at a mobile lap top and has no way to forward from said device.</p>	

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R 0273 Bldg. 00	<p>service plan had been developed.</p> <p>During an interview, on 5/10/16 at 3:45 p.m., the Director of Nursing indicated the facility does not create service plans for residents.</p> <p>During an interview, on 5/10/16 at 4:00 p.m., the owner indicated they do not have service plans for residents because they do not provide services beyond giving medications. She further indicated they did not have a policy for care plans.</p> <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. Based on observation, interview, and record review, the facility failed to ensure kitchen equipment was clean and maintained, food was stored under sanitary conditions, and dishes were sanitized according to chemical manufacturer's instructions for 1 of 1 kitchen observation. These deficient</p>	R 0273	the corrective actions accomplished are to repair and complete the nutritional services deficiencies. the facility will id other residents to become affected by the dietary super doing more quality control tours and cleaning schedules and observation of her staff. the measures put into place are as	05/13/2016

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	<p>practices had the potential to affect 35 of 35 residents who consumed food from the facility's kitchen.</p> <p>Findings include:</p> <p>During a kitchen and food storage tour with the Dietary Manager on 5/10/16 from 10:15 a.m. to 11:37 a.m., the following was observed:</p> <p>a. The freezer in the basement, numbered " 5, " had a gasket missing from around the door. Frost had collected around the freezer walls.</p> <p>b. The ice machine in dining room area was missing one half of the gasket on left side of the access door. The gasket on the right side was covered in a black colored substance. Three bolts in the upper back portion inside the ice chest were covered with black and brown substances.</p> <p>c. Dietary Aide (DA) #1 was washing lunch dishes in the 3 compartment sink. The DA#1 indicated the sanitizing sink was the third sink and indicated there were two gallons of water in the sink with two teaspoons of Keystone Multi-Quat Sanitation solution to sanitize the dishes after the rinse cycle</p> <p>d. Opened, undated spaghetti and macaroni were in the storage room. Opened and undated dry seasonings stored above food prep area included, but</p>		<p>follows..... the gasket on the freezer shall be replaced the freezer was defrosted 5-12 the ice machine was drained and cleaned and sanitized on 5-13 bags of ice were bought and used up till the point of cleaning the sink system has been updated and staff trained to change solution and start again if food starts to build up or suds are gone. the rinse station in the third sink will be one tablet to every 1 and a half gallon and test strips will be used. dishes will be dried on rack and then put away this was in effect 5-13-16 the food items will be labeled. they will have an entry date and then when opened will be dated again. labels will include a common name if needed to accurately id food these changes went into effect 5-13-16 the staff was trained on thermometer cleaning they will use thermometer probes, fold around thermometer and use slight pressure to clean, then let air dry. this was in effect 5-13-16 addendum: the manager will fax the idea the manf instructions. the writer is at a mobile lap top and has no way to forward from said device. the freezer gasket will be done by Friday july 8th.</p>	

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	<p>was not limited to, ground black pepper, onion powder, chili powder, and garlic powder.</p> <p>During an observation on 5/10/16 at 11:43 a.m., the Cook used a thermometer while checking food temperatures. The thermometer was wiped with a dry paper towel between each food item tested for temperature</p> <p>During an interview on 5/10/16 at 10:30 a.m., the DM indicated that she was told by the cook the freezers were thawed and cleaned two months ago. At 10:48 a.m., the DM indicated that she was unaware the gasket was missing from left side of the ice chest door and indicated the black colored substance on the right gasket could have been dirt and the black and brown substances covering the bolts in the ice chest could have been mold or dirt. At 11:34 a.m., the DM indicated all food items should have been labeled with dates opened.</p> <p>During an interview on 5/10/16/16 at 11:46 a.m., the Cook indicated the food thermometer should have been wiped with a paper towel between checking temps of different foods and indicated that he had not been educated on a policy for cleaning the thermometer.</p>						

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	<p>During an interview on 5/10/16 at 11:59 a.m., the DM indicated staff should have rinsed the thermometer with water then wipe it with a dry paper towel.</p> <p>The manufacturer's directions for the Keystone Multi-Quat Sanitation were reviewed on 5/10/16 at 11:42 a.m., and indicated, "...Restaurant and bar rinse...Sanitize in a solution of 0.25 ounce to 0.67 ounce in one gallon of water...."</p> <p>The current policy provided by the Owner on 5/10/16 at 1:18 p.m., titled " Proper Storage for Foods, " indicated, " ...All products must be dated as to the date received...Once the product has been opened, it is necessary to date and label the product showing the date it was placed back into storage ...."</p> <p>The current policy provided by the Owner on 5/10/16 at 1:18 p.m., indicated, " ...Refrigerator/Freezer Storage...Maintain regular maintenance on coolers...."</p> <p>The current policy provided by the Owner on 5/10/16 at 1:18 p.m., titled, "Temperature," lacked indication for the method of cleaning a thermometer.</p>			

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R 0409  Bldg. 00	<p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on record review and interview, the facility failed to ensure residents received annual tuberculosis screening for 1 of 7 residents reviewed for tuberculosis screening (Residents #3). Finding includes: On 5/10/16 at 3:00 p.m., Resident #3's record was reviewed. The form titled, "Mantoux Results," dated 4/7/15, indicated Resident #3 received a tuberculosis (TB) test on 4/7/15. Resident #3's record lacked documentation of a TB test for 2016. During an interview on 5/10/16 at 3:50 p.m., the Director of Nursing indicated Resident #3's annual TB test for 2016 had been missed and should have been done in April. On 5/10/16 at 4:25 p.m., the Owner provided the current policy titled, "Tuberculin Test (Mantoux)." The policy lacked documentation regarding the</p>	R 0409	<p>the action accomplished for those residents found to be affected is to keep a log of dates when tb tests are due the office manager shall provide the don a list of residents and date when the tb tests are due. the don will administer the tb tests annually. this list will be updated monthly or when a new resident moves in or out. these changes went into affect 5-13-16 the log books have been updated by the office manager the don has given the resident in question a tb test and has been signed off by the medical director. addendum: the date the resident in question recvd the ppd was the day after the survey, 5-13-16 an audit was done by the don personally on all res charts to ensure proper screening. her findings and dates were communicated to the office manager for her computer files.</p>	05/13/2016			

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	frequency of resident Tuberculin testing. The Owner indicated they followed state regulations on the frequency of TB testing of residents.				