STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS ALZHEIMER'S SPECIAL CARE CENTER	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00191991. Complaint IN00191991 - Unsubstantiated due to lack of evidence. Survey dates: February 8, 9, and 10, 2016 Facility number: 012706 Provider number: 012706 AIM number: N/A Census bed type: Residential: 61 Total: 61 Sample: 9 These State findings are cited in accordance with 410 IAC 16.2-5. Q.R. completed by 14466 on February 17, 2016.	R 0000		
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (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 observation, interview, and record review, the facility failed to administer two different eye drops separated by 5 or more minutes as indicated by facility policy for 1 of 5 residents reviewed for medication administration. (Resident #7) Findings include: On 2/9/2016 at 12:20 p.m., Qualified Medication Aide #1 (QMA) was observed to administer one drop of Polymyxin B Sulfate-Trimethoprim Ophthalmic drops (for bacteria infections), into Resident #7's left eye. QMA #1 was then observed to immediately administer one drop of Prednisolone AC (an anti-inflammatory) 1% 5 milliliter (ML) into Resident #7's left eye. QMA #1 failed to wait 5 or more minutes before administering the second eye drop medication. On 2/9/2016 at 2:50 p.m., the Health Services Director (HSD) indicated, QMA #1 should have waited up to five minutes	R 0091	1.Resident #7 willcontinue to have eye drops administered correctly 2.Residents in thecommunity have potential to be affected. 3.Staff who administer eye drops will be reeducated as to the policy to properly administer eyedrops as stated in the Geriatric Medication Handbook eighth edition; whichstates that "Eye drop administration procedure for adults…When one or more eyedrops must be administered at the same time, allow a five minute period betweeneach." The HSD/designee will be responsible for this training to be completedby 3/18/16. In addition, the staff thatadminister medication will have annual Medication administration training withPost-test utilization the JEA Medication Training manual which includes thecorrect way to administer eye drops. The HSD/designee will be responsible forthis annual training. 4.Routine observation of eye drop administration will occur weekly x 1 month, and then monthly x 3 months, on every	03/31/2016

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	before administering the second eye drop. On 2/9/2016 at 2:50 p.m., the HSD provided the policy Medication Pass Observation undated, and indicated it was the policy currently being used by the facility. The policy indicated, " ... 23. If more than one eye preparation if ordered for the same time, administration of each preparation is separated by several minutes; usually 5 (five) minutes ..." The Geriatric Medication Handbook Eighth Edition indicated, "Eyedrop Administration Procedure for Adults ... Note: When two or more different eyedrops must be administered at the same time, allow a 5-minute period between each."		shift, 7 days a week, then routinely as needed. 5.Date completed: 3/31/16	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and record review, the facility failed to ensure an outside dumpster lid was closed when not in use.	R 0155	1.The dumpster lidwill remain closed tightly when dumpster not in use 2.No residents aredirectly	03/31/2016

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	Finding include: On 2/9/16 at 12:12 p.m., during environment tour the outside dumpster lid was observed opened. Trash was observed to be inside. The Maintenance Supervisor did not deny the lid was open. On 2/9/16 at 3:31 p.m., the Maintenance Supervisor indicated he did not have a policy regarding outside dumpster. On 2/11/16 at 8:24 a.m., a review of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT MANUAL: 410 IAC 7-24-180," dated November 13, 2004, indicated, "....Outside receptacles (a) Receptacles and waste handling units for refuse ... containing food residue and used outside the retail food establishment shall ... have tight-fitting lids, doors, or covers ..."		affected by the dumpster lid being open as it is located outside thefacility 3.Staff will bereeducated that when removing garbage from the facility they should ensure thatthe lid to the dumpster is closed securely after use. The MaintenanceDirector/designee will re-train staff on this practice by 3/11/16 4.Routine audits ofthe dumpster area will be done daily x 1 week. Weekly x 1 monthly then monthlyx 3. Date completed: 3/31/16	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request.			

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	A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure residents received weights on admission for 1 of 9 residents reviewed for weights on admission. (Resident #9) Findings include: Resident #9's clinical record was reviewed on 2/10/16 at 10:30 a.m. Diagnosis included, but were not limited to: Alzheimer's disease, osteopenia, and hypertension. Nurses' admission assessment dated 5/11/15, lacked documentation of an admission weight for Resident #9. On 2/10/16 at 10:30 a.m., the HSD (Health Services Director) indicated Resident #9's weight was not completed on admission. The first weight was completed on 6/1/15.	R 0214	1.Resident #9 is nolonger in the community. 2.Residents beingadmitted to facility have the potential to be affected. 3.Nurses will bere-educated on facility admission policy by the HSD/designee by 3/18/16. Nurseadmitting resident or designee will obtain weight upon resident's arrival tofacility and document in admission nursing assessment note. Utilization of theadmission tool 'New Move-In Checklist', that is placed in the frontof each new resident record will be re-iterated and monitored during the auditprocess. The HSD/designee will also utilize the 24 hour report to ensure allcomponents of the admissions to include weights were completed. 4.Admission chartaudits on date of admission by Charge nurse following admitting nurse tocomplete any tasks not done. Routine chart audits will be completed by theHSD/designee weekly X 4 weeks, monthly X 3, then routinely and randomly. 5.Date completed 3/31/16	03/31/2016
R 0273 Bldg. 00	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			

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	standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure staff disposed of expired foods, utilized unexpired chemical testing strips, covered facial hair, and stored clean equipment in an sanitary manner as indicated by facility policy for 1 of 1 kitchen. Findings include: 1.) On 2/8/16 at 9:31 a.m., an initial kitchen tour was completed with the Dietary Manager (DM) present. The following was observed: a.) A pan of chopped meat was observed in the refrigerator with a date in of 2/5/16, and did not have an expiration date. The DM indicated the meat should have been removed on 2/7/16, and staff should have labeled the expiration date. b.) A measuring scoop was observed in a bulk storage container of sugar. The dietary manager indicated the scoop should not be in the container and the DM was observed to remove the scoop from the storage container. c.) An industrial mixer was observed to be uncovered and not in use. The Dietary Manger indicated it was used last	R 0273	I. Dietary department will continue to serve and store food in a safe, clean manner as ordered for residents in the facility. II. Residents in the facility have the potential to be affected. III. Staff who handle and store food and equipment will be reeducated on procedures for proper food handling and storage, proper equipment handling and storage, and proper kitchen attire to include proper hair coverings by the Dietary manager/designee by3/18/16. IV. Dietary manager/or designee will observe safe food handling, equipment handling and storage, and proper kitchen attire 7 days per week for 4 weeks then monthly X 3 months, then routinely for all meals. Date completed: 3/31/16	03/31/2016

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	Saturday and they will keep it covered in the future when not in use. 2.) On 2/9/16 at 11:45 a.m., the Dietary Manager (DM) was observed to test the chemical quality in a cleaning bucket with a chemical testing strip. The container of chemical testing strips was observed to have an expiration date of 5/1/13. The DM indicated she was unaware the strips had an expiration date. 3.) On 2/10/16 at 11:54 a.m., a pan was observed to be stacked on a storage rack and contain moisture. The Dietary Manager (DM) indicated the pan should not be stored wet and she was observed to remove the pan. At this same time Dietary Aide #1 was observed to have uncovered facial hair. The DM indicated she was unsure of how long Dietary Aide #1's facial hair was, but if someone had facial hair stubble they should wear a beard cover. On 2/9/16 at 3:52 p.m., the Dietary Manager provided the facility policy, "Dry Food Storage-Inservice," undated, and indicated it was the policy currently being used. The policy indicated, "....Scoops are not to be stored in food containers ..." On 2/11/16 at 8:24 a.m., a review of the			

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	"RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT MANUAL: 410 IAC 7-24-180," dated November 13, 2004, indicated, ".... (b) Clean equipment and utensils shall be stored as follows ... (3) Covered ..."			
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview, and record review, the facility failed to ensure a medication was available from the pharmacy for a resident who was prescribed an antibiotic for 1 of 5 residents reviewed for medication administration. (Resident #7) Findings include: On 2/9/2016 at 12:20 p.m., Qualified Medication Aide #1 (QMA) was observed to gather medications for Resident #7. QMA #1 entered Resident #7's room and gave resident her p.o. (by	R 0297	1.Resident #7 willcontinue to receive medications as ordered. 2.Residents in thecommunity have the potential to be affected 3.Staffadministering medications will assure that the medication is available to beadministered and if it is not, staff will follow the Non-availability ofmedication policy which states that if a medication is supplied by a resident'sresponsible party and the responsible party does not supply the medication, thecommunity will obtain the necessary medication from a pharmacy of the community'schoice. Staff will be reeducated on the non-available medication policy by theHSD-designee by 3/18/16. 4.Routineobservation of medication pass weekly x1 month then monthly	03/31/2016

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	mouth) medications. The medications included, but were not limited to Keflex (an antibiotic) 250 milligrams (mg) 1 capsule. On 2/9/2016 at 12:25 p.m., review of the Medication Administration Record (MAR) indicated the Keflex had been discontinued (D/C'd). During an interview on 2/9/2016 at 3:26 p.m., QMA#1 indicated, the MAR says it has been D/C'd, but she was told in report that Resident #7 is still on the Keflex, because there were still doses in the drawer. QMA #1 indicated she did give Resident #7 Keflex during the medication administration on 2/9/2016. The clinical record for Resident #7 was reviewed on 2/9/2016 at 2:00 p.m. Diagnoses included, but were not limited to dementia. Physician's order dated 1/29/2016, indicated Resident #7 was to receive Keflex 250 mg 1 capsule by mouth three times a day for 7 days. The medication was to begin on 1/29/2016 and end on 2/5/2016, for a wound to the left forearm. On 2/9/2016 at 3:00 p.m., the Health Services Director (HSD) indicated there had been a problem with the pharmacy		x3 months, thenroutinely and randomly utilizing the Medication Monitoring Tool. In addition,the HSD/designee will conduct routine monitoring of the medication carts/MAR'sutilizing the Medication Cart Monitoring log weekly x 4 weeks, monthly X 4 months, then routinely and randomly. Date complete: 3/31/16	

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	getting the medication to the facility and the medication did not start on 1/29/2016. On 2/9/2016 at 3:50 p.m., the HSD provided a hand written note from local pharmacy #1 undated. The note indicated, "On 1/29/2016 an order for Keflex was sent to our pharmacy. Being the weekend the delivery was not set to go out until the following Monday 2/1/2016. The medication was sent to [name of facility] by mistake because we were not aware she had been transferred to [name of facility]. The medication was then sent out on February 2nd when we knew she was at [name of facility]." Review of nurses notes dated 2/1/2016 at 7:00 p.m. indicated, License Practical Nurse #1 (LPN) called local pharmacy #1 to check on ordered prescription from 1/29/2016. "Med has not arrived to facility. Spoke with pharmacy tech [technician] who advises med [medication] will be sent to facility on 2/2/2016. Will call local pharmacy #2 and update for our medical records." On 2/10/2016 at 9:00 a.m., the Business Office Manager (BOM) provided a script dated 2/9/2016, from Resident #7's physician. The script indicated Resident #7 started Keflex 250 mg three times a day on 2/4/2016.			

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	On 2/10/2016 at 11:47 a.m., a nurse from Resident #7's physician's office indicated, Resident #7's Keflex was ordered on 1/29/2016 but, due to a mix up at the pharmacy the medication was not started until 2/4/2016. On 2/10/2016 at 11:45 a.m., the HSD provided the skin sheets for Resident #7's left arm wound from the Wound Healing Center of (acute care hospital). The skin sheets indicated on 1/29/2016 at 2:30 p.m. the left arm wound measured proximal (beginning) 3.7 x 0.5 x 0.2 and distal (distant) 0.3 x 1.7 x 0.2. On 2/5/2016 at 9:50 a.m. the left arm wound measured 9.2 x 0.4 x 0.3. The 2/5/2016, skin sheet did not address whether the measurement was distal or proximal. On 2/10/2016 at 12:15 p.m., the HSD indicated she had spoken with the Wound Healing Center and the 1/29/2016, was measured both proximal and distal due to skin separating the two but on 2/5/2016, the wound had only one measurement because the wound had become one opened wound with no skin separating it. On 2/9/2016 at 11:59 a.m., the HSD indicated the facility does not have a policy related to medications being available for residents. She provided at			

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	that time the local pharmacy #2, Health Care Facility/Pharmaceutical Service Agreement dated 11/15/2011, and indicated it is what the facility uses as a contract for medications. The HSD indicated there is no such service agreement with local pharmacy #1 for Resident 7's medications but the facility can get up to a 3 days supply of medication from local pharmacy #2 if needed. The service agreement indicated, " ...F. A patient of responsible party seeking Pharmaceuticals from a pharmacy other than local pharmacy #2 must make provisions for delivery of same with such pharmacy ..."			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and			

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	(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure residents' medication regimen was reviewed every sixty days by a pharmacist for 1 of 5 residents reviewed for pharmacy review. (Resident #3). Findings include:Resident 3's clinical record was reviewed on 2/8/16 at 1:45 p.m. Resident #3 was admitted on 6/20/14. A review of Resident #3's Physician's Orders indicated the following: On 7/29/15 the pharmacist reviewed the resident's July 2015, orders. Resident #3's clinical record lacked documentation of any other pharmacy review dates. On 2/8/16 at 2:51 p.m., the DNS (Director of Nursing Services) indicated the consulting pharmacist comes into the facility every 60 days to review medications. On 2/9/16 at 11:59 a.m., the DNS provided the facility agreement, "Health Care facility/Pharmaceutical Service	R 0298	I. Residents #1,2, 3 will continue to receive pharmacy consult review II. Residents in the community may be affected III. Staff will be educated on pharmacy review policy by theHSD/designee by 3/18/16. Pharmacy to provide consultant as per agreement.Meeting with pharmacy consultant will take place to go over expectations ofconsultant visits by 3/18/16 with the Administrator and the HSD. IV. Routine review of consultant visits as per Pharmacyagreement will take place every 60 days by the HSD/designee. Notes from thesevisits will be kept in a binder in the Administrators office and anyrecommendations will be followed up by the HSD/designee. v. Date completed: 3/31/16	03/31/2016

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	Agreement," dated November 15, 2011, and indicated it was the current agreement currently being used by the facility. The agreement did not address the pharmacist review of the residents' drug regimen every sixty days.			
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 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. (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. Based on interview and record review, the facility failed to ensure residents	R 0410	1.Residents #4 and#8 no longer reside in the community.	03/31/2016

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		A. BUILDING 00 B. WING	02/10/2016

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	received a two-step tuberculin skin test prior to or upon admission as indicated by facility policy for 2 of 5 residents whose clinical records were reviewed. (Resident #4, Resident #8). Findings include: 1. Resident #4's clinical record was reviewed on 2/9/2016 at 11:00 a.m. Diagnoses included but, were not limited to CHF (congestive heart failure). Resident #4 was admitted to the facility on 1/12/2016. Resident #4's clinical record indicated the first step tuberculin test was administered on 1/13/2016 and read on 1/15/2016. The second step tuberculin test was administered on 1/23/2016 and read on 1/25/2016. On 2/9/2016 at 2:49 p.m., the Health Services Director (HSD) did not deny the tuberculin test should have been given prior to or upon admission and indicated there is a problem with the date the test was given. 2. Resident #8's clinical record was reviewed on 2/10/2016 at 10:00 a.m. Diagnoses included but, were not limited to dementia.		2.Residents beingadmitted to facility have the potential to be affected 3.Staff who administer andread tuberculin mantoux tests will be reeducated on the policy on tuberculinmantoux administration by the HSD/designee by 3/18/16. Nurses will be re-educated onfacility admission policy by the HSD/designee by 3/18/16. Nurse admittingresident or designee will obtain TB/Mantoux upon resident's arrival to facilityas needed and document in MAR. Utilization of the admission tool 'New Move-in Checklist', that is placed in the front of each new resident recordwill be re-iterated and monitored during the audit process. The HSD/designeewill also utilize the 24 hour report to ensure all components of the admissionsto include weights were completed. 4.Admission chart audits ondate of admission by Charge nurse following admitting nurse to complete anytasks not done. Routine chart audits will be completed by the HSD/designeeweekly X 4 weeks, monthly X 3, then routinely and randomly. 5.Datecompleted: 3/31/16	

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	Resident #8 was admitted to the facility on 4/9/2015. Resident #8's clinical record indicated the first step tuberculin test was administered on 4/10/2015 and read on 4/13/2015. The second step tuberculin test was administered on 4/25/2015 and read on 4/28/2015. On 2/10/2016 at 10:30 a.m., the Health Services Director (HSD) indicated the tuberculin test for Resident #8 was in fact administered on 4/10/2015. On 2/9/2016 at 11:31 a.m., the HSD provided the policy Mantoux Tuberculin Skin Test Record undated, and indicated it was the one currently being used by the facility. The policy indicated, " ... b. Prior to admission each resident will be required to ... ii. Documentation of a negative Mantoux 2-step skin test or other tuberculosis screening test recommended by the U.S. Centers for Disease Control and Prevention (CDC) administered within three (3) months before the date the resident is admitted to the facility or upon admission ..."			

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R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to ensure handwashing was followed during medication administration and gloves were used prior to administering eye drops as indicated by the facility policy for 3 of 5 residents observed for medication administration. (Resident #5, Resident #6, Resident #7). Findings include: 1). On 2/9/2016 at 12:00 p.m., Qualified Medication Aide #1 (QMA) was observed to gather the medications for Resident #5. QMA #1 entered the resident's room and handed Resident #5 his p.o. (by mouth) medication. No hand sanitizer or hand washing was observed before or after the medication administration. QMA #1 was then observed to walk back to the medication cart and gather the medication for Resident #6. 2). On 2/9/2016 at 12:10 p.m., QMA #1 was observed to enter Resident #6's room	R 0414	I. Resident's #5, 6, 7 willreceive medications as ordered. Administered per infection control procedures II. Residents in thecommunity have potential to be affected. III.Staff administeringmedications will be reeducated on handwashing policies and use of handsanitizer during medication pass by the HSD/designee by 3/18/16 utilizing thenotes in the Medication Training manual for handwashing. IV. Routine observation of medication pass weekly x 1 month, then monthly x 3 months, on every shift, 7 days a week, then routinely and randomly as needed by the HSD/designee utilizing the Medication Monitoring tool will be completed. V.Date completed: 3/31/16	03/31/2016

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	and hand the resident her p.o. (by mouth) medication. After the p.o. medication was given, QMA #1 was observed to DON (put on) gloves and administer Resident #7's eye drops to both eyes. No hand sanitizer or handwashing was observed before or after administering the p.o. medication and eye drops or after removing the gloves. QMA #1 was then observed to walk back to the medication cart and gather the medication for Resident #7. 3). On 2/9/2016 at 12:20 p.m., QMA #1 was observed to enter Resident #7's room and hand the resident her p.o. (by mouth) medication. After the p.o. medication was given, QMA #1 was observed to administer two different eye drops to Resident #7's left eye. No hand sanitizer or handwashing was observed before or after the medication administration and no gloves were used during administration of the eye drops. During an interview on 2/9/2016 at 12:33 p.m., QMA #1 indicated the facility policy is to wash hands after every third resident. On 2/9/2016 at 2:48 p.m., the Health Services Director (HSD) indicated staff should be using hand gel between each resident during medication administration			

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	and should wash hands after the fourth resident. Gloves are to be worn when administering eye drops. On 2/9/2016 at 2:50 p.m., the HSD indicated the facility does not have an actual policy related to hand washing during medication pass but, provided the Medication Pass Observation Policy undated, and indicated it was the policy being used by the facility. The policy indicated, " ...7. Med giver washes hands prior to starting the med pass ... 17. Hand washing is performed after each resident if there has been direct resident contact, use of sanitizer is used between residents not to exceed 4 (four) times between hand washing ... 22. Hand washing is performed prior to administration of eye drops and gloves are used ..."			