| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 12/21/2016 |

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| MORNINGSIDE OF COLLEGE PARK | 8810 COLBY BLVD<br>INDIANAPOLIS, IN 46268 |

| (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 |
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| R 0000<br><br>Bldg. 00 | This survey was for a State Residential Licensure Survey.<br><br>Survey dates: December 21, 2016<br><br>Facility number: 013034<br>Provider number: 013034<br>AIM number: N/A<br><br>Census bed type:<br>Residential: 25<br>Total: 25<br><br>Sample: 7<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.<br><br>Quality Review was completed by 21662 on January 3, 2017. | R 0000 | **The following is the Plan of Correction for Morningside of College Park in regard to the Statement of Deficiencies for the State Residential Licensure Survey completed on December 21, 2016. This Plan of Correction is not to be construed as an admission of or agreement with findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document , we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We** | |

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

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| | | | **remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.** | |
| R 0042<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(p)<br>Residents' Rights - Noncompliance<br>(p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.<br>Based on observation and interview, the facility failed to post signage to communicate the accurate location of the most recent facility survey. This deficiency had the potential to affect 25 of 25 residents who resided in the facility.<br><br>Finding includes:<br><br>During an interview conducted on 12-21-16 at 11:05 a.m., the front desk Receptionist #7 indicated she was unsure where the sign stating the location of the most recent survey was posted. She called the Executive Director who indicated the sign was located at the entrance of the Memory Care Unit. Receptionist #7 accessed a book containing the most recent survey, which | R 0042 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice.**<br>**Corrective action included in next section.** | 01/18/2017 |

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| | was located in a cabinet behind her desk.<br><br>On 12-21-16 at 11:15 a.m., a sign on the Memory Care unit was observed, which indicated the latest ISDH (Indiana State Department of Health) Survey, Blank Complaint Forms, and Copies of Resident Rights maybe found here (with an arrow pointing down). There was not a cabinet at the location, a resident in a wheelchair was sitting under the sign. The only copy of the most recent survey available for inspection was located in the main lobby outside the Memory Care Unit behind the receptionist desk.<br><br>During an interview on 12-21-16 at 3:00 p.m., the Executive Director indicated sometimes the residents tore the signs off the walls and she believed the sign was originally located at the entrance of the Memory Care Unit. | | **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**A new sign indicating where the State Survey for Morningside of College Park is kept will be affixed to the wall at the memory care unit's front entry in a manner as to avoid removal. The sign will indicate the State Survey is located at the main lobby reception desk. The State Survey Binder will be clearly marked with corresponding signage placed above it for easy and clear access at the reception desk in the main lobby.**<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br>**Maintenance Director/Designee will inspect the new signage located on the wall at the memory care unit's front** | |

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| | | | **entry randomly noting the condition and adherence to wall. If damaged, missing, etc. Maintenance will fix, replace, etc. at that time. An identical sign is available for replacement purposes if needed. Receptionist will check the State Survey Binder weekly to ensure it is in correct location and clearly marked** | |
| R 0092<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(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:<br>(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.<br>(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 | | | |

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| | shall be documented with the names and signatures of the personnel present.<br>Based on interview and record review, the facility failed to attempt to hold fire and disaster drills in conjunction with the local fire department every six months. This deficiency had the potential to affect 25 of 25 residents who resided in the facility.<br><br>Finding Includes:<br><br>During an interview on 12-21-16 at 9:45 a.m., the Maintenance Director indicated the last fire drill with the representation from the fire department was conducted in April of 2016.<br><br>During a record review conducted on 12-21-16 at 11:00 a.m., a fire drill was recorded to have been conducted on 4-15-16. The Fire Marshall was present at the drill and signed the attendance roster. There was no further documentation provided to show communication with the fire department in regards to participation with the facility fire and disaster drills, since that date. | R 0092 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Corrective action included in next section.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**Maintenance Director rescheduled the December 29, 2016 fire drill with the Fire Marshall for January 25, 2017 along with dates for 2017** | 01/11/2017 |

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| | | | **of June 14, 2017 and December 13,2017. These dates confirmed via email exchange with Morningside and Fire Marshall dated 1.10.2017. The dates will be entered into outlook calendar for both the E.D. and Maintenance Director to enable confirmation of drill three days prior via email exchange with Fire Marshall. Each email correspondence will be included in the Fire Drill Binder located in the E.D. office.**<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br>**The above procedure will repeat each December to confirm the following year's attendance of the Fire Marshall at least one every six months. If the Fire Marshall cancels or changes the date it will be documented in the Fire Drill Binder by the Maintenance Director.** | |

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| R 0095<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(l)(1-2)<br>Administration and Management<br>-Noncompliance<br>(l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:<br>(1) meet the needs or preferences, or both, of cognitively impaired residents; and<br>(2) gain understanding of the current standards of care for residents with dementia.<br><br>Based on interview and record review, the facility failed to ensure the Dementia Care Director had the required credentials to oversee the Reflections Dementia Care Unit for 1 of 1 employee record reviewed for Dementia Care Director required credentials (Director of Nursing). | R 0095 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.** | 01/18/2017 |

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| | Finding includes:<br><br>During an interview on 12/21/16 at 9:15 a.m., the Executive Director (ED) with the Director of Nursing (DON) in attendance, the ED indicated the DON was the Dementia Care Director. She indicated the DON's had "always" been the Dementia Care Director.<br><br>During an interview on 12/21/16 at 4:00 p.m., the DON indicated she had received a certification, not a degree for her LPN (Licensed Practical Nurse) education. She supplied her LPN license at that time, which indicated she was an LPN with an active license.<br><br>During an interview on 12/21/16 at 4:55 p.m., the ED indicated she did not know the Dementia Care Director had to have a degree if she was a healthcare personnel staff member. | | **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Corrective action included in next section.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**The current Executive Director (RCA) is now the director of the Alzheimer's/Dementia Special Care Unit.**<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br>**Current Executive Director (RCA) as the Alzheimer's/Dementia Special Care Unit Director has 12 hours documented dementia specific training.** | |

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| | | | **Current Executive Director (RCA) as the Alzheimer's/Dementia Special Care Unit Director has 6 hours additional dementia specific training and will continue to accumulate 6 additional hours annually.** | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br>(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 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. | R 0117 | **What corrective action(s)** | 01/18/2017 |

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| | Based on interview and record review, the facility failed to ensure there was a CPR (Cardiopulmonary Resuscitation) and First Aid certified staff member in the facility available for residents at all times. This deficient practice had the potential to affect 25 of 25 residents currently residing in the facility.<br><br>Finding includes:<br><br>The CPR and First Aid certifications were reviewed on 12/21/16 at 4:30 p.m.<br><br>There was no CPR and First Aid certified staff members available in the facility on duty for the following dates from 6:00 p.m. to 6:00 a.m.:12/11/16, 12/15/16, 12/16/16 and 12/17/16.<br><br>During an interview on 12/21/16 at 4:55 p.m., the Executive Director indicated she had provided all the CPR and First Aid certifications she had available for her staff and she knew the facility was lacking in CPR and First Aid coverage. | | **will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur and how will the corrective action(s) be monitored to ensure the deficient practice will not recur?**<br>**E.D. and DON will audit LPN files for proof of current certification of CPR and First Aid for each LPN staff member. An LPN is staffed 24/7 so** | |

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| | | | **this will cover every shift, every day so there will be a staff member certified in CPR and First Aid available for residents at all times.**<br>**Any LPN lacking certifications in CPR and/or First Aid will not be allowed to work until providing proof of certification in CPR and First Aid . A class on CPR is scheduled for January 2017 to ensure each LPN has the opportunity to become certified. Any LPN lacking First Aid certification will be instructed on how to take the course online.**<br>**A copy of each LPN's certifications for CPR and First Aid will be kept in a binder labeled "Staff Licenses & Other Credentials". E.D./DON will do a monthly review of each LPN to verify each is current with CPR and First Aid certifications.**<br>**Any LPN hired will be required to give proof of current certification for** | |

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| | | | **CPR and First Aid during the "pre hire" stage when presenting copies of I.D. and LPN License.** | |
| R 0121<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(f)(1-4)<br>Personnel - Noncompliance<br>(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:<br>(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.<br>(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.<br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. | | | |

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| | (4) An employee with symptoms or signs of 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.<br><br>Based on interview and record review, the facility failed to ensure an employee received a Tuberculin skin test (TB) screening (a skin test used to determine if a person had been exposed to Tuberculosis) in the prescribed time frame for 1 of 5 employees screened for TB (Server #3).<br><br>Finding includes:<br><br>The employee records were reviewed on 12/21/16 at 4:00 p.m.<br><br>A document titled "Employee Tuberculosis Skin Test Screening" dated 11/17/16, provided by the Executive Director on 12/21/16 at 5:25 p.m., indicated Server #3's First Step PPD (Purified Protein Derivative) was administered on 11/17/16. The read by, date and time read and results area was blank. The Second Step was administered on 11/19/16 at 1:00 p.m.<br><br>During an interview on 12/21/16 at 5:25 p.m., the Executive Director (ED) indicated she was not sure about what the | R 0121 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Server #3, LPN #5, C.N.A. #6, receiving new PPD first step with the second step to be administered between 1-3 weeks after the first step PPD test completed. Each step will be documented on the Morningside of College Park Employee Tuberculosis Skin Test** | 01/18/2017 |

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| | time frame was for giving or reading the TB tests.<br><br>During an interview on 12/21/16 at 5:50 p.m., the Director of Nursing (DON) indicated PPD tests were to be read within 48-72 hours and the second step PPD tests were to be administered between one to three weeks after the first step PPD test was administered.<br><br>During an interview on 5/12/16 at 3:45 p.m., the Administrator indicated she had no further PPD information to provide for LPN #5 or CNA #6.<br><br>A current policy untitled and undated, provided by the Executive Director on 12/21/16 at 4:00 p.m., indicated "...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 [a skin test to determine if a person had been exposed to TB] method (5 TU [Tuberculin Unit], 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: (1) At the time of employment, or within one (1) month prior to employment, and at least | | **Screening form, read date with read by signature complete.**<br>**E.D./DON will conduct audit on current staff member PPD records. If no proper documentation of a staff member's required PPD (two step or Annual) is found the staff member will receive a two step PPD. Each step will be documented on the Morningside of College Park Employee Tuberculosis Skin Test Screening form, read date with read by signature complete.**<br>**In service for LPN's on PPD 2 Step and Annual procedures (certifications, administering, recording, reading, timing and documentation.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**DON will track PPD's for staff members by** | |

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| | 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 soul be performed one (1) to three (3) weeks after the first step...." | | **recording on a control sheet all pertinent information regarding PPD 2 Step and Annual start dates, 2nd step dates, annual dates. DON will enter this information into Outlook Calendar for 1 week prior (two step) and 1 month prior (Annual) to due date and inform staff member of PPD date, schedule the time with staff member and administer PPD on the date. All completed documentation of Two Step PPD or Annual PPD will be added to the binder titled "Immunizations and TB Tests/Hepatitis Vaccinations" and kept in the ED office.** | |
| R 0123<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(h)(1-10)<br>Personnel - Nonconformance<br>(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:<br>(1) The name and address of the employee.<br>(2) Social Security number.<br>(3) Date of beginning employment.<br>(4) Past employment, experience, and | | | |

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| | education, if applicable.<br>(5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable.<br>(6) Position in the facility and job description.<br>(7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills.<br>(8) Signed acknowledgement of orientation to residents' rights.<br>(9) Performance evaluations in accordance with facility policy.<br>(10) Date and reason for separation.<br><br>Based on interview and record review, the facility failed to ensure general specific orientation information was completed for 2 of 2 new employees being reviewed for new employee records (CNA #2 and Server #3) and an employee's license was kept active (Beautician).<br><br>Findings include:<br><br>The employee records were reviewed on 12/21/16 at 4:00 p.m.<br><br>1. CNA #2's employee record lacked general orientation information to indicate it had been completed when he was hired.<br><br>CNA #2's was hired on 11/10/16.<br><br>2. Server #3's employee record lacked | R 0123 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Business Office Manager will create a form stating what is covered under general orientation for each new hire including a** | 01/18/2017 |

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| | general orientation information to indicate it had been completed when she was hired.<br><br>Server #3 was hired on 11/21/16.<br><br>During an interview on 12/21/16 at 4:52 p.m., the Business Office Manager (BOM) with the Executive Director (ED) in attendance, the BOM indicated she did not have any further information for CNA #2 or Server #3 regarding their general orientation information. She taught the new employees about the employee handbook, but she did not have the employees sign any form to indicate they had been given that information because she did not know she had to have record of the employees general orientation to the facility. The ED indicated she did not have any further general orientation information in these employees records.<br><br>3. The Beautician's license expired on 8/1/16.<br><br>During an interview 12/21/16 at 4:52 p.m., the BOM with the ED in attendance, the BOM indicated the Beautician's license was expired and she knew it. | | **signature line for both staff member and Business office Manager/Designee. Every current staff member having received general orientation from Business Office Manager/Designee at time of hire will be given the form for signature. The completed and signed form will be included in the new hire's file. Beautician notified and will furnish copy of her current license.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**The general orientation form will be included in the new hire onboarding packet and a line added to the onboarding checklist to include this form. Prior to start date Business Office Manager will audit the new hire paperwork and checklist to ensure the general** | |

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| | | | **orientation has been completed and the form is signed properly. A copy of staff licenses or certificates are required and kept in a binder titled "Reflections Memory Care Staff Licenses and other Credentials" located in ED office. This binder will be audited to ensure each staff member requiring a license and/or certificate (including beautician) have submitted a copy of such and it is maintained in the binder.** | |
| R 0185<br><br>Bldg. 00 | 410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance<br>(i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire marshal. The facility shall:<br>(1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level.<br>(2) Provide each resident the following items upon request at the time of admission:<br>(A) A bed:<br>(i) of appropriate size and height for the resident;<br>(ii) with a clean and comfortable mattress; and<br>(iii) with comfortable bedding appropriate to | | | |

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| | the temperature of the facility.<br>(B) A bedside cabinet or table with a hard surface and washable top.<br>(C) A cushioned comfortable chair.<br>(D) A bedside lamp.<br>(E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device.<br>(3) Provide cubicle curtains or screens if requested by a resident in a shared room.<br>(4) Provide a method by which each resident may summon a staff person at any time.<br>(5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area.<br>(6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare.<br>(7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by residents in wheelchairs. | | | |
| | Based on observation, interview and record review, the facility failed to provide a functional method by which each resident could summon a staff person at any time for assistance. This deficiency had the potential to affect 25 of 25 residents who resided in the facility<br><br>Finding includes:<br><br>During the environmental tour on | R 0185 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents** | 01/18/2017 |

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| | 12-21-16 at 9:45 a.m., with the Director of Maintenance in attendance. The Maintenance Director indicated at that time, the facility utilized a wireless call button system. There was a call button affixed to each resident's bathroom wall. In addition, each resident had a call pendant wrist bracelet. After the call button was pushed, pagers carried by the nurses and the aides would be notified. Nurses and aides were also to carry walkie talkies to communicate who would be responding to the call button notification.<br><br>On 12-21-16 at 10:02 a.m., the bathroom call button in Apartment #18 was pushed to test the function. No one responded to the call button as of 10:12 a.m. At 10:12 a.m., the Maintenance Director called Maintenance Tech #4 and had him reset the call light.<br><br>During an interview on 12-21-16 at 10:17 a.m., Maintenance Tech #4 indicated once a call button was pushed it alerted the pagers and continued to alert pagers every five minutes until the page was answered up to 10 times than it stopped paging the pagers. The system print out page displayed the last time the pagers were alerted, if a response to the page occurred, and the time the call button was reset. | | **having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Pagers and walkie talkies distributed to aides and LPN's. Pagers, walkie talkies and system checks performed. Aides and LPN's in service on "Maintaining Security for Residents Residing in the Reflections Memory Care Unit" which includes policies and procedures for carrying, use, maintenance of pagers and walkie talkies. New aides and LPN's will be in-serviced on same as part of memory care staff orientation. New pagers and/or walkie talkies will be ordered for "back up" to ones currently being used in case of malfunction.**<br>**What measures will be put into place or what systemic changes the** | |

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| | A record titled, "History as of 12/21/16 10:13 A, SMARTcare v5.00", was provided by Maintenance Tech # 4 on 12-21-16 at 10:17 a.m., showed the second response from the call button in the bathroom of Apartment #18 occurring at 10:07 a.m. The activation was cleared at 10:12 a.m., with no response from the staff to the alert.<br><br>During an interview on 12-21-16 at 10:20 a.m., LPN #1 indicated the residents' call lights would alert the pagers. She conveyed all CNAs and Nurses were to carry pagers and walkie talkies while on duty for the facility call button system to function. She indicated she did not have a walkie-talkie or pager on her person and she was unaware that the bathroom call button for Apartment #18 had been activated. LPN #1 opened the drawer where pagers and walkie talkies were stored. The drawer contained 5 pagers, 5 of the 5 pagers displayed the notification of a call from the bathroom in Apartment #18. LPN #1 indicated at that time, all of the facility pagers where contained in the drawer and she did not believe any of the three CNAs on duty had pagers on their person. LPN #1 closed the drawer without removing a pager or walkie talkie to have on her person and continued working. | | **facility will make to ensure that the deficient practice does not recur?**<br>**Prior to each shift LPN on duty will assign a pager and walkie talkie to each aide and self. LPN will press a resident pendant and confirm each pager is working properly along with a test of all walkie talkies to ensure correct channel and proper communication amongst all walkie talkies being used. All will be documented on the "Pager and Walkies Shift Test Form" by LPN on duty for each of the three daily shifts.**<br>**Maintenance Director will test all exit doors, lock and page equipment monthly to ensure it is in good working order.** | |

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| | During an interview with the Director of Nursing (DON) with Executive Director (ED) in attendance on 12-21-16 at 10:30 A.M. The ED indicated the facility policy required all Nurses and CNAs to carry a pager and walkie talkie on their person while on duty for the call button system to work effectively. The DON and ED communicated they were unaware the nurse and aides were not carrying pagers and walkie talkies.<br><br>During an interview on 12-21-16 at 10:52 a.m., CNA #5 indicated she had a pager on her person, but did not have a walkie talkie. She reported she obtained the pager from a drawer when she arrived for her shift at 6:00 a.m. She relayed she did receive the page from the bathroom in Apartment #18 at 10:02 a.m., however, she was with another resident and since she did not have a walkie-talkie on her person she was unable to communicate with the other CNAs to ensure someone was responding to the notification.<br><br>A current policy titled, "Maintaining Security for Residents Residing in the Reflections Memory Care Unit" undated, provided by DON on 12-21-16 at 11:50 a.m., indicated "...The facility shall ensure that all residents in its Reflections Memory Care unit will remain safe and | | | |

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| | secure, while in the unit at all times...The facility will orient all staff working on the unit to ensure they are trained and follow the proper procedures regarding the security of the unit...Pagers will be carried by all personnel on the unit during each shift: nurses and aides alike...Pagers will alert staff when one of the doors to the Reflections Memory Care Unit opens...If a staff member is providing care to a resident and is not able to immediately respond to the door alert, he or she will alert another staff member using their walkie talkie to notify other staff that they must check the door and/or monitor...." | | | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br>Based on observation, interview and record review, the facility failed to ensure all foods were labeled and dated and expired foods were disposed of. This deficient practice had the potential to affect 25 of 25 residents who received | R 0273 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** | 01/18/2017 |

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| | food from the kitchen.<br><br>Findings include:<br><br>During an initial tour of the kitchen on 12/21/16 at 9:25 a.m., the following were observed:<br><br>In the reach-in refrigerator in the kitchen preparation area:<br>-a container of pasta was prepared on 12/14/16<br>-a container of tomato paste prepared on 12/8/16<br>-a container of light gravy prepared on 12/14/16<br>-a container dark gravy prepared on 12/5/16<br>-a platter of sliced cheeses with a use by date of 12/20/16<br>-a container parmesan cheese prepared on 12/14/16<br>- multiple container tray with tomatoes, onions, peppers, lettuce, mushrooms, green onions, not labeled or dated<br>- a carton of scrambled egg mix, opened and not dated<br>-a container of turkey burger patties with a preparation date of 12/14/16<br><br>In the dry storage area, the following were observed:<br>- all canned goods did not have a received by date | | **No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Complete inspection of reach-in freezer located in the kitchen was done immediately. All items expired and/or not labeled were disposed of including:**<br>**-a container of pasta was prepared on 12/14/16**<br>**-a container of tomato paste prepared on 12/8/16**<br>**-a container of light gravy prepared on 12/14/16**<br>**-a container dark gravy prepared on 12/5/16**<br>**-a platter of sliced cheeses with a use by date of 12/20/16**<br>**-a container parmesan cheese prepared on 12/14/16** | |

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| | -an opened bag of pasta, no opened date<br>-an opened bag of black eyed peas, no opened date<br>-an opened bag of long grain white rice, no opened date<br>- an opened bottle of vegetable oil, no opened date<br>-an opened container of chow mien noodles, no opened date<br>-a bottle of vanilla extract, no opened date<br>- a jar of honey, no opened date<br><br>During an observation of handwashing on 12/21/16 at 9:45 a.m., Cook #1 was observed to wash his hands for 15 seconds.<br><br>During an interview with the Executive Director, Executive Chef and the Dining Manager on 12/21/16 at 2:00 p.m., the Executive Chef indicated he had seen the policy regarding "first in, first out" dating policy, but did not have staff to comply. He also stated he did not have the policy book outlining all corporate policies. He indicated he was aware of the policy regarding dating and labeling frozen foods. During this interview, the Executive Director indicated employees had been inserviced on handwashing and labeling procedures.<br><br>A current policy titled "Storage of | | **- multiple container tray with tomatoes, onions, peppers, lettuce, mushrooms, green onions, not labeled or dated**<br>**- a carton of scrambled egg mix, opened and not dated**<br>**-a container of turkey burger patties with a preparation date of 12/14/16**<br>**Complete inspection of dry storage area was done immediately. All items with no received date or opened date were disposed of including:**<br>**-all canned goods did not have a received by date**<br>**-an opened bag of pasta, no opened date**<br>**-an opened bag of black eyed peas, no opened date**<br>**-an opened bag of long grain white rice, no opened date**<br>**- an opened bottle of vegetable oil, no opened date**<br>**-an opened container of chow mien noodles, no** | |

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| | Products" undated, received from the Dining Manager on 12/21/16 at 2:00 p.m., indicated "...Policy: All food shall be stored in a safe and sanitary manner... 4. Wrap, cover or seal all refrigerated foods and label the product with the preparation date...11. Left over and Prepared Food. Store prepared food in a container covered with a air-tight lid or cellophane, and label the container with the type of food and the date. Left-over foods which have not been frozen must be discarded after three days if not used...."<br><br>A current policy titled "Handwashing" undated, received from the Dining Manager on 12/21/16 at 2:00 p.m., indicated "...Policy: All food production and service personnel will follow proper handwashing practices to ensure the safety of food served to residents. 1. Wash hands (including under the fingernails) and forearms vigorously and thoroughly with soap and warm water (a temperature of at least 100 degrees Fahrenheit is recommended) for a total time of 20 seconds...." | | **opened date**<br>**-a bottle of vanilla extract, no opened date**<br>**- a jar of honey, no opened date**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**Kitchen staff will be in-serviced on "first in, first out" procedure, dating and labeling of frozen and other foods, storage of food items and proper handwashing procedure.**<br>**Executive Chef/Designee will monitor dry storage, refrigerators and freezers using an end of day labeling and dating checklist to ensure all received and stored food items are labeled and dated according to received date, opened date and clearly marked and any expired food item is disposed of immediately.**<br>**Executive Chef/Designee** | |

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| | | | **will review handwashing procedure with kitchen staff before each shift and enforce said policy through use of community's progressive discipline policy** | |
| R 0298<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(2)<br>Pharmaceutical Services - Deficiency<br>(2) A consultant pharmacist shall be employed, or under contract, and shall:<br>(A) be responsible for the duties as specified in 856 IAC 1-7;<br>(B) review the drug handling and storage practices in the facility;<br>(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;<br>(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and<br>(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.<br>Based on record review and interview, the facility failed to ensure a Consultant Pharmacist reviewed the drug regimen for 1 of 7 residents reviewed (Resident # 18).<br><br>Finding includes:<br><br>Resident #18's record was reviewed on 12/21/16 at 10:00 a.m. The resident was admitted on 08/29/16. There was no drug regimen reviews found in the chart. | R 0298 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same** | 01/18/2017 |

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| | During an interview on 12/21/16 at 4:45 p.m., the Director of Nursing indicated she had no further documentation to provide related to his pharmacy reviews.<br><br>No policy was provided. | | **deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. Audit of all Reflection resident's files to ensure a Consultant Pharmacist review form is included in all charts.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**DON will incorporate the Pharmacist Review Form into the chart audit/checklist of each new resident on admission.** | |
| R 0300<br><br>Bldg. 00 | 410 IAC 16.2-5-6(c)(4)<br>Pharmaceutical Services - Deficiency<br>(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.<br>Based on observation, interview and record review, the facility failed to ensure expired medications were discarded | R 0300 | **What corrective action(s) will be accomplished for those residents found to** | 01/18/2017 |

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| | appropriately in 1 of 2 medication carts and in the medication storage refrigerator.<br><br>Findings Include:<br><br>During a medication storage review on 12/21/16 at 10:45 a.m., with LPN #1 in attendance the following observations were made:<br><br>a. In the narcotic locked drawer:<br>Lorazepam (a medication used to treat anxiety) 0.5 milligram (mg) tablet with an expiration date of 11/12/16.<br><br>b. In the medication storage refrigerator:<br>Acetaminophen (a non-narcotic pain medication) suppository 650 mg with an expiration date of 11/05/16.<br>Bisac-Evac (a laxative medication) suppository 10 mg with an expiration date of 11/09/16.<br><br>During an interview on 12/21/16 at 11:15 a.m., LPN #1 indicated her procedure included checking expiration dates prior to administering medications, if the medications were expired she discarded them in the appropriate manner or returned them to the pharmacy, if applicable.<br><br>A current policy titled "Drug Storage" | | **have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice.**<br>**DON audit of the two med carts. No expired medications found.**<br>**LPN's in serviced on Drug Storage and Medication Disposal.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**DON will do monthly audits of two med carts to ensure all expired medications have been disposed of according to company's policy and procedure.** | |

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| | undated, received from the Director of Nursing on 12/21/16 at 11:50 a.m., indicated "...9. Discontinued and expired medications should be removed from medication carts, refrigerators and cupboards promptly. Return drugs or destroy according to pharmacy and facility policies...."<br><br>A current policy titled "Medication Disposal" undated, received from the Director of Nursing on 12/21/16 at 11:50 a.m., indicated "...Procedure: Disposal of outdated, discontinued, and recalled medications shall occur no longer than seven days after the discontinuation...." | | | |
| R 0354<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(g)(1-7)<br>Clinical Records - Noncompliance<br>(g) A transfer form shall include the following:<br>(1) Identification data.<br>(2) Name of the transferring institution.<br>(3) Name of the receiving institution and date of transfer.<br>(4) Resident ' s personal property when transferred to an acute care facility.<br>(5) Nurses ' notes relating to the resident ' s:<br>(A) functional abilities and physical limitations; | | | |

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| | (B) nursing care;<br>(C) medications;<br>(D) treatment; and<br>(E) current diet and condition on transfer.<br>(6) Diagnosis.<br>(7) Date of chest x-ray and skin test for tuberculosis.<br><br>Based on interview and record review, the facility failed to ensure interfacility transfer documentation was completed for 1 of 1 resident reviewed for interfacility transfers (Residents #27).<br><br>Finding includes:<br><br>Resident #27's record was reviewed on 12/21/16 at 3:30 p.m. The resident was transferred to another facility and his record lacked a transfer form.<br><br>During an interview on 12/21/16 at 4:00 p.m., the Director of Nursing indicated a transfer form was not found in Resident #27's chart. | R 0354 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice. LPN's in-serviced on policy and procedures for inter-facility transfers.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**Upon any inter-facility** | 01/18/2017 |

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| | | | **transfer DON will ensure all required documentation is complete prior to transfer/discharge.** | |
| R 0357<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(j)(1-3)<br>Clinical Records - Noncompliance<br>(j) If a death occurs, information concerning the resident ' s death shall include the following:<br>(1) Notification of the physician, family, responsible person, and legal representative.<br>(2) The disposition of the body, personal possessions, and medications.<br>(3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death.<br><br>Based interview and record review, the facility failed to ensure documentation was completed when a resident passed away for 1 of 1 resident reviewed for death of a resident (Resident #26).<br><br>Finding includes:<br><br>Resident #26's record was reviewed 12/21/16 at 1:26 p.m. The resident's record lacked documentation of the disposition of her medications and her personal belongings after she passed away.<br><br>During an interview on 12/21/16 at 4:00 p.m., the Director of Nursing indicated | R 0357 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice.** | 01/18/2017 |

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| | the nurses filled out a pharmacy receipt when the medications were sent back to the pharmacy after a resident was deceased and the duplicate copy was placed in the resident's chart. The disposition of the resident's belongings were documented in the chart. She indicated the information for the disposition of Resident #26's medication and personal belongings was not found in her chart. | | **LPN's in-serviced on policy and procedures for drug disposition sheets.**<br>**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**Upon discharge/death DON will document the disposition of medications and personal belongings and keep a copy in the resident's chart.** | |
| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br>(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.<br>(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.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required | | | |

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| | to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>Based on interview and record review, the facility failed to perform first and second step Tuberculin skin testing (TB) (a test used to determine if a person had been exposed to Tuberculosis) in a timely manner for 4 of 7 residents reviewed for Tuberculin skin testing (Residents #12, #14, #15 and #18).<br><br>Findings include:<br><br>1. Resident #18's record was reviewed on 12/21/16 at 10:00 a.m.<br><br>A document titled "Resident Tuberculosis Screening Record" dated 12/05/16, indicated the resident was administered his first step Tuberculin skin test on 12/5/16. The area below the Date Administered indicated the date read, time, result and read by was blank. The "Admission 2nd Step Mantoux" (a test used to determine if a person had been exposed to Tuberculosis) area was completely blank.<br><br>During an interview on 12/21/16 at 4:45 p.m., the Director of Nursing indicated Resident #18 had received his first step TB test, but it had not been read and he had not received his second step TB test. | R 0410 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>**No resident was known to be affected by this deficient practice.**<br>**How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>**All residents have the potential to be affected by this deficient practice.**<br>**DON audit on all resident charts for PPD records.**<br>**All residents lacking proper documentation of completed Two step or Annual PPD will receive a complete Two step or Annual PPD and results recorded on the immunization form.**<br>**LPN's in-serviced on Resident PPD/immunization policy and procedure.** | 01/18/2017 |

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| | She indicated she had no further information to provide.<br><br>2. Resident #14's record was reviewed on 12/21/16 at 10:30 a.m.<br><br>A document titled "Resident Tuberculosis Screening Record" dated 05/29/16 and 12/05/16, indicated the resident was administered his first step Tuberculin skin test on 05/29/16 and 12/05/16. The area below the Date Administered on the document indicated the date read, time, result and read by was blank. The "Admission 2nd Step Mantoux" area was blank in all areas.<br><br>3. Resident #12's record was reviewed on 12/21/16 at 12:00 p.m.<br><br>A document titled "Resident Tuberculosis Screening Record" dated 04/01/16, indicated the resident's first step Tuberculin skin test was administered on 04/01/16 and it was dated and read on 04/03/16 as 0 millimeters (mm). The "Admission 2nd Step Mantoux" area was blank in all areas.<br><br>During an interview on 12/21/16 at 4:10 p.m., the DON indicated the admission dates were verified and she indicated there were no second step TB testing | | **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br>**DON/Designee will track all Reflections Resident's PPD/Immunization using audit form that tracks resident name, move in date, date of 1st step, 2nd step and date of annual due and reviewing audit form monthly.** | |

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| | located in the resident's record and a second step skin test was supposed to be completed.<br><br>4. Resident #15's record was reviewed on 12/21/16 at 12:51 p.m.<br><br>A document titled "Resident Tuberculosis Screening Record" dated 12/05/16, indicated the resident was administered an annual Tuberculin skin test on 12/05/16. The area below the Date Administered on the document indicated the date read, time, result and read by was blank.<br><br>A current policy untitled and undated, was received from the Executive Director on 12/21/16 at 4:00 p.m., indicated "...(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 preformed within one (1) to three (3) | | | |

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| | weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis...(h) All skin testing for tuberculosis shall be done using the Mantoux method (5TU [Tuberculin Unit], PPD [Purified Protein Derivative]) administered by persons having documentation of training from a department-approved course on instruction in intradermal tuberculin skin testing, reading, and recording...." | | | |