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	11/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE CITY PLACE	425 CHINWORTH CT WARSAW, IN 46580

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 4, 2019 Facility number: 011389 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed on November 8, 2019.	R 0000		
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure authorizations for as needed medications administered by a qualified medication aide were documented in the medical record in 1 of 7 residents reviewed for medications. (Resident 3) Finding includes: A clinical record review was completed on 11/4/19	R 0246	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the*	12/04/2019

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

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	at 10:50 A.M., and indicated Resident 3 diagnoses included, but were not limited to: atrial fibrillation, spinal stenosis, chronic pain and hypertension. Resident 3's physician orders, dated 10/29/19, indicated he was receiving Oxycodone (a narcotic) 5/325 mg (milligrams) 1 tablet every 8 hours as needed for pain. A Medication Administration Record, dated 10/2019, indicated Resident 3 had received the narcotic medication on 10/12/19, 10/13/19 and 10/18/19 which were administered by a QMA (qualified medication aide). The nurses notes dated 10/12/19, 10/13/19 and 10/18/19 lacked documentation to show the time and date when the nurse was contacted for the authorization to give the medication. During an interview, on 11/4/19 at 3:12 P.M., the Director of Nursing indicated there should have been documentation in the medical record of the nurse being contacted. On 11/4/19 at 3:13 P.M. a policy was requested, but one was not provided. On 11/4/19 at 3:56 P.M., the Director of Nursing indicated the facility follows the state guidelines for medication administration.		*Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* R246 Health Services-Deficiency 1. The documentation for Resident 3 cannot at this time be fixed. 2. An audit of current resident's Medication Administration Record (MAR) will be completed by the Care Services Manager (CSM) on 11/25/2019 to identify like residents and any issues identified will be corrected. 3. The CSM was re-trained by Regional Director of Care Services (RDCS) on 11/5/2019 regarding the QMA scope of practice. The QMA was in-serviced by CSM on 11/5/2019 regarding the scope of practice 4. The CSM is responsible for sustained compliance. The CSM, or designee, will audit the MAR weekly x 2 months then monthly x 3 months to ensure compliance with QMA scope of practice. Results of the audit will be discussed in the monthly QI meetings. The QI Committee will	

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			determine if continued auditing is necessary based on 3 consecutive months of compliance. 5. Completion date: 12/4/2019	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure an emergency file was available for all residents residing in the facility. This effected 29 out of 29 residents in the facility. Finding includes: During an interview, on 11/4/19 at 2:55 P.M., an emergency binder was requested from the Director of Nursing. On 11/4/19 at 3:29 P.M., the Director of Nursing indicated she could not locate an emergency	R 0356	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of*	12/04/2019

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	binder with the required resident information. A policy on emergency resident information was requested on 11/4/19 at 3:30 P.M. On 11/4/19 at 3:56 P.M., the Director of Nursing indicated the facility follows the state guidelines for documentation required in an emergency.		*Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* R356 Clinical Records-Noncompliance 1. An emergency file was created for current residents on 11/19/2019 by the Care Services Manager (CSM) and designee. 2. An audit of the emergency file was completed on 11/20/2019 by CSM and any issues identified were corrected. 3. The Care Services Manager (CSM) was re-trained by the Regional Director of Care Services (RDCS) on 11/5/2019 regarding the emergency file regulation. Staff will be in-serviced on 12/4/2019 by CSM on the requirement to ensure the emergency file for residents is complete and immediately accessible to staff. 4. The CSM is responsible for sustained compliance. The CSM, or designee, will audit the emergency files for completion and accessibility to staff weekly for 4 weeks, the monthly for 3 months. Results of the audit will be discussed in monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.	

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			5. Completion date: 12/4/2019	
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 record review and interview, the facility failed to ensure residents receive timely Mantoux Tuberculosis screenings for 4 of 7 residents reviewed. (Residents 3, 8 & 7) Findings Include: 1. A clinical record review was completed on 11/4/19 at 10:50 A.M., and indicated Resident 3 was admitted on 2/18/19. His diagnoses included, but were not limited to: atrial fibrillation, spinal stenosis, chronic pain and hypertension.	R 0410	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiency was correctly cited, and is also NOT to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who drafted or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of*	12/04/2019

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	A Tuberculosis Testing/ Vaccines Consents/ Records form for Resident 3, indicated he received a Mantoux (skin test for tuberculosis) 1st step on 3/6/19, 7 days after admission into the facility. During an interview, on 11/4/19 at 2:05 P.M., the Director of Nursing indicated the Mantoux test should have been given on admission. 2. A clinical record review was completed on 11/4/19 at 12:40 P.M., and indicated Resident 8 was admitted on 2/25/19. Her diagnoses included, but were not limited to: dementia, hypertension and hyerlipidemia. A Tuberculosis Testing/ Vaccines Consents/ Records form for Resident 8, indicated she received a Mantoux (skin test for tuberculosis) 1st step on 3/6 /19, 9 days after admission into the facility. During an interview, on 11/4/19 at 1:45 P.M., the Director of Nursing indicated the Mantoux test should have been given on admission. 3. A clinical record review was completed on 11/4/19 at 2:25 P.M., and indicated Resident 7 was admitted on 10/13/17. His diagnoses included, but were not limited to: hypertension, depression, confusion and gout. A Tuberculosis Testing/ Vaccines Consents/ Records form for Resident 7 indicated she received a Mantoux (skin test for tuberculosis) 1st step on 10/17/17. The form lacked the documentation to show a 2nd step Mantoux had been administered to Resident 7. The next documentation of a Mantoux test being administered was on 12/12/17.		*Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* R410 Infection Control-Noncompliance 1. A tuberculin skin test was re-initiated on 11/20/2019 for Resident 3. Resident 8 and Resident 7 no longer reside in the community. 2. An audit of current resident tuberculin skin tests will be completed by 11/20/2019 by Care Services Manager (CSM) and any issues identified will be corrected. 3. The Care Services Manager (CSM) was re-trained by the Regional Director of Care Services (RDCS) on 11/14/2019 regarding the resident tuberculosis screening requirements. The CSM will in-services licensed nurses by 11/22/2019 on the tuberculosis screening requirements. 4. The Care Services Manager is responsible for sustained compliance. The CSM, or designee, will audit new resident tuberculin skin tests within 3 days of move in x 2 months then weekly x 3 months to ensure compliance with tuberculosis screening requirements. Results of the audit will be discussed in the monthly QI meetings. The QI Committee	

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	During an interview, on 11/4/19 at 3:10 P.M., the Director of Nursing indicated the 2nd step Mantoux should have been administered 1 to 3 weeks after the 1st step. On 11/4/19 at 3:14 P.M., the Director of Nursing provided the policy titled, "TB (Tuberculosis) Testing", dated 9/1/16, and indicated the policy was the one currently used by the facility The policy indicated"...TB testing will be completed per state regulations for residents, staff and volunteers...."		will determine if continued auditing is necessary based on 3 consecutive months of compliance. 5. Completion date: 12/4/2019	