

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2020
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NAME OF PROVIDER OR SUPPLIER FIVE STAR RESIDENCES OF LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 SHENANDOAH DRIVE LAFAYETTE, IN 47905
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00316825 and IN00316327.</p> <p>Complaint IN00316825 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00316327 - Substantiated. State Residential Findings are cited at R0052.</p> <p>Survey dates: February 4, 5, 6 and 7, 2020.</p> <p>Facility number: 014015</p> <p>Residential Census: 52</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed on February 13, 2020.</p>	R 0000		
R 0052 Bldg. 00	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to prevent an elopement of a cognitively impaired resident who was outside the facility building for an hour without the facility being aware for 1 of 1 resident reviewed for elopement (Resident B).</p>	R 0052	Resident 3 no longer resides in the community. Family remained with the resident until she left, placement was secured. Elopement risk assessment for the community residents were	03/07/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Finding includes:</p> <p>The record for Resident B was reviewed on 2/4/2020 at 1:08 p.m. Diagnoses included, but were not limited to, dementia, hyperlipidemia, hypertension and osteoporosis.</p> <p>An incident report, dated 1/3/2020, reported to the ISDH office indicated Resident B was found outside of the facility, at a shopping center, next door to the facility. The facility was notified by the shopping center of the residents location at the mall and the elopement protocol was then initiated by the facility. The resident was last seen at the facility after dinner at 6:00 p.m. in the hallway. The resident returned to the facility at 7:00 p.m. from the shopping center next door. The resident was assessed and no injuries were found. The family and physician were notified.</p> <p>The resident's service plan, dated 3/5/2019, indicated the resident was not a risk for elopement.</p> <p>An elopement risk assessment, dated 11/6/2019, indicated the resident was not an elopement risk.</p> <p>A Brief Interview for Mental Status (BIMS) score, on 11/6/2019, indicated the resident's score was a 4 which indicated a severe cognitive impairment.</p> <p>An elopement risk, dated 1/4/2020, was updated to indicate there was an elopement risk after the resident was found outside of the facility building.</p> <p>A nursing progress note, dated 1/3/2020, indicated the facility received a call from the</p>		<p>reviewed and appropriate interventions put in place. The nursing staff was trained on the elopement risks and interventions for elopement prevention. Elopement risk assessments are completed on admission and quarterly with intervention placed. The DRC/designee will audit the elopement risk assessment when completed to assure appropriate interventions are in place.</p>	

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R 0216 Bldg. 00	<p>shopping center's security and was informed a resident was found and was confused. The resident had identification which indicated she lived at the facility. Staff went to the shopping center and when they arrived the resident could not remember how she got to the shopping center, why she went to the center or where she lived. She was walked back to the facility by the staff.</p> <p>During an interview, on 2/6/2020 at 11:15 p.m., RN 3 indicated the resident was not an elopement risk, she was allowed to go outside the facility on leave with others and was not wearing a wanderguard. She indicated the facility did not have residents who required wanderguard's in their community. She indicated the staff was not aware the resident was missing until the facility was notified of her appearance at the shopping center.</p> <p>This state tag relates to complaint IN00316327.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p>			

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	<p>Based on interview and record review, the facility failed to follow the facility policy for conducting self medication administration assessments for 1 of 2 residents reviewed for self medications (Resident 3).</p> <p>Finding includes:</p> <p>The record for Resident 3 was reviewed on 2/4/2020 at 4:15 p.m. Diagnoses included, but were not limited to, anxiety, chronic kidney disease, stage 3, diabetic neuropathy, type 2 diabetes, hyperlipidemia and peripheral vascular disease.</p> <p>A physician's order, dated 1/25/2020, indicated the resident was able to administer her own medications.</p> <p>A nursing assessment of the residents ability to perform this procedure was not found.</p> <p>During an interview, on 2/6/2020 at 11:15 p.m., RN 3 indicated the resident was administering her own medications and had a physician's order to self medicate. She indicated there was no nursing assessment for the resident to self medicate and there should have been an assessment prior to allowing the resident to self medicate.</p> <p>A current facility polity, titled "Resident Self-Administration of Medication," with an effective date of 1/4/2019 and received from the Executive Director on 2/5/2020 at 2:00 p.m., indicated "...A. If a resident wishes to self administer his/her medications, the Director of Resident Care, or designee, will assess the resident's ability to self-administer upon move-in or at the residents request. The assessment</p>	R 0216	<p>Resident 3 has had an evaluation completed for self-administration of medication.</p> <p>Current residents of the community have had self-administration of medication evaluations completed. Residents that were appropriate to self-administer have physician orders to self-administer. Nursing staff have been trained on completion of the self-administration of medication evaluation as well as the policy. The DRC/designee will audit residents that self-administer medications on admission and at least quarterly to assure the evaluation is completed.</p>	03/07/2020			

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R 0217 Bldg. 00	<p>involves an interview of the resident to determine his/her ability to identify, prepare and administer medications/treatments and is documented on the Self- Administration of Medication Assessment Form...."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure service plans were</p>	R 0217	Resident 8 no longer resides in the community.	03/07/2020

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R 0273 Bldg. 00	<p>signed by the resident or the resident's representative for 1 of 8 residents reviewed for service plans (Resident 8).</p> <p>Finding includes:</p> <p>The record for Resident 8 was reviewed on 2/4/2020 at 1:05 p.m. Diagnoses included, but were not limited to, dementia, hypertension, type 2 diabetes, hyperlipidemia, falls and contusion of the left foot.</p> <p>A service plan was not signed by the resident for 2019.</p> <p>During an interview, on 2/6/2020 at 11:15 p.m., RN 3 indicated the resident did have a service plan but it was not signed. The resident would sign the service plan when it was discussed with her or her family. She indicated the form should have been signed when it was discussed and it was not.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was labeled and dated in the refrigerator, freezer, open kitchen area, and dry storage area, the appliances and kitchen area was clean and free of dirt and debris and the food was temperature tested prior to serving meals in 1 of 1 kitchens. This deficient practice had the potential to affect 52 of 52 residents.</p>			R 0273	<p>Current residents have had their service plans updated, reviewed and signed.</p> <p>Nursing staff have been trained on completing service plans, updating service plans and the requirement of having them signed by the resident or responsible party.</p> <p>The DRC/designee will audit new admits and current residents quarterly to assure that they are updated and signed.</p> <p>Completed by 3/7/2020</p> <p>A detailed cleaning of the entire kitchen, walls, ceiling, floors, oven, garbage cans, dishwasher racks, condiment cabinets, walls, large sugar and flour containers, overhead fans, ice machine and overhead lights has been implemented. 3 level</p> <p>Food items in dry storage, coolers</p>		03/07/2020

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	<p>Findings include:</p> <p>During the tour of the kitchen, on 2/6/2020 at 10:35 a.m., with the Director of Food and Beverage the following observations were made:</p> <ol style="list-style-type: none"> 1. The dishwasher area floor, drains to the floor, 2 garbage cans, a 3 level cabinet chemical rack, the walls and 12 dishwasher racks were dirty with food, dirt and debris. 2. The refrigerator was observed to have dirty walls and floors with dirt and debris. 3. The freezer was observed to have the following: <ol style="list-style-type: none"> a. two packages of opened and not sealed french fries. b. one packet of 10 BBQ ribs open and not sealed. c. two packages of broccoli open and not sealed. d. one package of corn opened and not sealed or dated. e. one package of peas opened and not sealed or dated. f. one package of oriental vegetables opened and not sealed or dated. g. two packages of baby carrots opened and not sealed or dated. 4. The dry storage area had the following: <ol style="list-style-type: none"> a. two pudding packages opened and not sealed or dated. b. a rice crispy cereal container open, not sealed and not dated. c. a package of barley open, not dated and not sealed. 5. The open kitchen area was observed to have the following: 		<p>and freezers that were noted as being opened and not sealed or dated have been discarded. Proper wrapping, dating and storage procedures have been put in to place.</p> <p>All food items are being temped prior to serving at each meal.</p> <p>Temp logs for ready to serve foods and refrigeration equipment are to be monitored daily by the food and beverage director and cooks. The executive director does thorough kitchen audit and sanitation checklist weekly, forever. This audit must have a 95% score or better week after week. The monitoring will not stop and will be done weekly. The sanitation/food safety checklist covers cooking equipment, prep areas, serving areas, dish storage, staff hygiene, refrigerator and freezer storage, dish room, physical plant, pot wash and storage areas.</p>	

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	<p>a. one package of 6 bagels opened and not sealed or dated.</p> <p>b. the ice machine was dirty with debris and syrup.</p> <p>c. there were 10 tea pitchers with dirt and tea stains.</p> <p>d. the temperature register mounting was dirty with food, debris and dust.</p> <p>e. the floors were dirty with dirt and debris.</p> <p>f. the cabinets with the condiments was dirty with debris.</p> <p>g. a liquid substance was dried and had ran down the walls, sides of the cabinet and floors.</p> <p>h. three garbage cans were dirty on the outside with dirt, a running liquid and the handles were caked with food.</p> <p>i. the large sugar and flour bins were dirty on the outside with liquid substances on the side and lids of the containers. j. the fryer had a dirty backsplash of grease.</p> <p>k. the oven was dirty inside and grease stained.</p> <p>l. the oven on the outside was caked with grease and debris.</p> <p>m. two over head fans were dirty with debris and dust (one located over the heating/serving tray).</p> <p>n. the overhead light near the outside door was dirty with debris and dead bugs.</p> <p>6. The salad bar area in the main kitchen was dirty with debris and liquids all round the outer edges. The salad bar refrigerator had a blue cheese dressing opened and not dated.</p> <p>7. The temperature logs for the food, at the three meals, during the week of 2/1/2020 through 2/6/2020 were reviewed and missing many item temperatures. Only two items were checked at the breakfast meal and six items at the dinner and lunch meal.</p>			

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R 0410 Bldg. 00	<p>During an interview, on 1/6/2020 at 11:45 a.m., the Director of the Food and Beverage indicated all open items should have been sealed and dated and the kitchen needed to be cleaned. The kitchen equipment needed to be replaced and deep cleaned. He indicated he thought it was "okay" to only check a few random temperatures and not every item on the serving trays were checked each meal.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to screen residents for Tuberculosis (TB) for 5 of 8 residents reviewed for Tuberculin skin tests (Resident 3, 4, 5, 6 and 8).</p>	R 0410	Resident's 3, 4, 5, 6, and 8 have had a TB skin test completed. Current residents have had their TB skin test completed per regulation. Nursing staff have trained on the	03/07/2020

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. A Mantoux (Tuberculin skin test) Test record for Resident 3 indicated the first and second step method TB skin test was not administered for the resident on admission. 2. A yearly Mantoux Test for Resident 4 was not found for the year 2019. 3. A yearly Mantoux Test for Resident 5 was not found for the year 2019. 4. A yearly Mantoux Test for Resident 6 was not found for the year 2019. 5. A yearly Mantoux Test for Resident 8 was not found for the year 2019. <p>During an interview, on 1/7/2020 at 4:00 p.m., RN 2 indicated no records could be found for Residents 4, 5, 6 and 8 for the recent 2019 skin TB testing. A risk assessment for Residents 4, 5, 6 and 8 were also not found. The TB testing should have occurred in 2019 or a risk assessment should have been completed. She indicated a 2 step TB test should have occurred with the admission of Resident 3.</p> <p>A current facility polity, titled "Tuberculosis Control Plan," with an effective date of 10/1/2017 and received from the Executive Director on 2/6/2020 at 1:38 p.m., indicated "...A. d. TB testing procedures to include: 1. Initial testing on new residents and readmitted residents to establish a baseline...B. Annual community Risk Assessments occur to determine if there is sufficient risk of TB in the community, based on and in accordance with CDC guidelines...."</p>		<p>TB testing requirements. Residents will have a TB test per regulation on admission and annually in February. The DRC/ designee will audit new admissions and annually for compliance in February for compliance.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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