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	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
JOURNEY SENIOR LIVING OF VALPARAISO	74 E JOURNEY WAY VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 an Initial State Residential Licensure Survey. Survey dates: April 18, 2018. Facility number: 014081 Residential Census: 5 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/19/18.	R 0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility is also requesting a desk review for compliance in these areas.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (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			

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

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	director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to ensure the Dementia Care Director had completed 12 hours of required Dementia training within 3 months upon hire for 1 of 5 employee records reviewed. (Dementia Care Director) Finding includes: On 4/18/18 at 2:56 p.m., the employee records were reviewed. The Administrator had a start date of 12/18/17. She was acting as the Dementia Care Director, and had only completed 6 hours of Dementia training since her start date. Interview with the Administrator, on 4/18/18 at 3:50 p.m., indicated she was acting as the Dementia Care Director until the new one started. She had only completed 6 hours of Dementia training. Interview with the Business Office Manager, on 4/18/18 at 4:20 p.m., indicated she was unaware the Memory Care Director needed 12 hours of Dementia training within 3 months of hire. She indicated staff only required 6 hours of Dementia training. A job description titled, "Memory Care Coordinator/Resident Assistant", was provided by the Director of Nursing on 4/18/18. The job description indicated, "...18. Complete 12 hours of	R 0095	Corrective Action: A.) Memory Care Director has taken the remaining 6 hours of the required 12 hours of dementia training for a memory care unit (Attachment A). Completed 4/24/18 B.) Policy implemented for Dementia staff training (Attachment B). Policy will be added to the new hire orientation paperwork. All current staff in-serviced on policy. Completed 4/24/18. C.) Executive Director will audit all new hire training to ensure proper hours pertaining to each position is completed and that all staff sign off on new dementia training policy. This will be conducted for 6 months. (Attachment C). Monitoring on going.	04/24/2018

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	dementia specific training within 90 day period from date of hire...." 410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (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. (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. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of			
R 0121 Bldg. 00				

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	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. Based on record review and interview, the facility failed to ensure employees received a second step Tuberculosis (TB) test upon hire for 2 of 5 employee records reviewed. (Administrator & Director of Nursing) Findings include: On 4/18/18 at 2:56 p.m., the employee records were reviewed. 1. The Administrator had a start date of 12/18/17. A TB test was completed on 5/6/17. The record lacked any documentation a second step TB had been completed. 2. The Director of Nursing (DON) had a start date of 2/5/18. A TB test was completed on 1/5/18. The record lacked any documentation a second step TB had been completed. Interview with the Business Office Manager, on 4/18/18 at 4:20 p.m., indicated the staff members did not have a completed second step TB test upon hire. A policy titled, "Mycobacterium Tuberculosis (TB)", was provided by the DON on 4/18/18. The policy indicated, "...Indications for two-step tuberculin skin test (TST)... Situation: Previous negative TST result (documented) less than 12 months prior to employment. Recommended Testing: Single TST needed for baseline testing; this test will be the second step...."	R 0121	Corrective Action: A.) Executive Director and Director of Nursing 1st step of two step TB test done 4/23/18. With completion of 2nd step to be read 5/9/18. (Attachment D). B.) Executive Director/ Business Office Manager/ Director of Nursing will review all new hires to ensure TB tests are completed first scheduled work date. C.) Staff completion, monitoring in place.	04/23/2018

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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 standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in accordance with safe food handling standards related to the lack of internal thermometers in the walk in cooler and refrigerator, use of non-pasteurized eggs, food and drinks uncovered in the refrigerator, and handling food and non-food items with same gloved hands. This had the potential to affect the 5 residents who resided in the facility. (Kitchen, Kitchenette, and CNA 1) Findings include: A tour of the Kitchen and Kitchenette with the Dietary Director was completed on 4/18/18 at 8:45 a.m. The following was observed. 1. The walk in cooler and refrigerator in the Kitchen did not have internal thermometers. 2. The walk in cooler in the Kitchen contained 7 containers of eggs. The eggs did not indicate they were pasteurized. 3. The Kitchenette refrigerator contained 3 containers of drinks and 2 containers of gelatin. These foods and drinks were uncovered. Interview with the Dietary Manager during the observations, indicated he was unaware there needed to be internal thermometers since they had a thermometer on the outside of the doors. The	R 0273	Corrective Action: A.) Internal thermometers were immediately placed in the kitchen's walk-in cooler and refrigerator while surveyor was present. Completed 4/18/18. Dietary Supervisor will add these thermostats to his daily audit log (Attachment E). B.) Executive Director contacted the company Goldhen eggs to inquire if they are pasteurized. Company responded that they are not (Attachment F). Eggs present in kitchen were immediately pllled from being utilized. Pasteurized eggs were purchased for meals going forward. Dietary staff and Executive Director also inserviced by the Dietary Consultant (Attachment G). Completed 4/19/18. C.) Items that were uncovered in the refrigerator on memory care were removed. Staff was re-educated about ensuring all items are to be covered at all times to avoid contamination (Attachment H). Executive Director/ Director of Nursing will ensure training for staff is ongoing. Completed 4/19/18. D.) A new Single-Use Glove	04/19/2018

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	food and drinks should have been covered in the refrigerator and he was unsure if the eggs were pasteurized or not.4. During a lunch observation on 4/18/18 at 11:40 a.m., the following was observed: CNA 1 washed her hands, donned gloves, used tongs and a gloved hand to place a hamburger with its bun on a plate. With the same gloved hands, she then removed the top bun, removed plastic wrap from the container with cheese, removed the cheese from its individual wrapper and placed it on the hamburger. Then, with the same gloved hands, picked up the ketchup bottle and applied ketchup to the hamburger, used the spoon and placed green beans on to the resident's plate, then served that plate to the resident. Without removing her gloves, CNA 1 proceeded to get another hamburger with its bun, and placed it onto a plate with the same gloved hands and tongs. Interview with CNA 1 at that time, indicated she should have changed her gloves and washed her hands after touching the food. Policy titled, "G. Cleanliness," was provided by the Director of Nursing, on 4/18/18 at 5:25 p.m. This current policy indicated, "...Hand washing Procedure...Change gloves when: They become soiled or torn, before beginning a new task, after handling raw meat and before handling cooked or ready-to-eat food...."		specific policy was created to ensure all staff know the procedures on handling food and non-food items when serving meals. (Attachment I). All staff was in-serviced on the policy and all new hires will have the policy given to them during orientation. Completion date 4/19/18. Monitoring ongoing.	