STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155802	A. BUILDING 00 B. WING	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 1, 2, 3, 4, and 5, 2016 Facility number: 003624 Provider number: 155802 AIM number: 200429840 Census bed type: SNF/NF: 63 Residential: 33 Total: 96 Census payor type: Medicare: 16 Medicaid: 39 Other: 8 Total: 63 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/10/16 by 29479.	F 0000		
F 0323	483.25(h)			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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SS=E Bldg. 00	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain water temperatures of less than 120 degrees F (Fahrenheit) to prevent potential burns to skin in the bathroom sinks in 11 of 35 resident bathrooms observed for unsafe water temperatures (Residents #71, #38, #12, #15, #47, #106, #61, #41, #44, #30, #91, #80, #56, and #37). Findings include: On 2/1/16 at 11:20 a.m., during hot water observations with Maintenance employee # 14, the following was observed: a). At 11:26 a.m., the bathroom in room #111 had a sink faucet with a water temperature of 127.5□ F (one hundred twenty-seven point five degrees Fahrenheit). The resident who resided in the room did not independently access the bathroom. Review of Resident #71's Quarterly Minimum Data Set (MDS) assessment dated 11/13/15, indicated the resident had	F 0323	**F 323** The facility will ensure that theresident environment remains as free of accidents hazards as is possible; andeach resident receives adequate supervision and assistances devices to preventaccidents. The facility will maintainwater temperatures of less than 120 degrees in the bathroom sinks in residentrooms. **CORRECTIVEACTION:** Thehot water temperatures in rooms 101, 103, 107, 108, 111, 112,114, 123, 130,131and 132 have been corrected and the water is under 120 degrees; these roomswill be checked every day for the next 30 days to ensure compliance and after30 days these rooms will be on the regular schedule. **FUTUREASSURANCE of COMPLIANCE:** Theemployee responsible for water temperatures has been relieved of that duty andassigned to another area outside Providence Health Care. A new maintenance man began on February 22,2016 The Water Temperature Policyrequires every room to be checked at least once a week by the maintenance man. If the temperature is above 120 degrees, he willnotify the nurse	02/17/2016

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	severe cognitive deficit and required extensive assistance of one person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. During an interview on 2/1/16 at 12:30 p.m., LPN #15 indicated Resident #71 (Room # 111), did not access the bathroom independently and required assistance of one staff with toileting and bathing. b). At 11:30 a.m., the bathroom utilized by room #130 had a sink faucet with a water temperature of 128.2□ F. The residents residing in room #130 were assisted by staff to access the bathroom and did not turn on the faucet independently. Review of Resident #12's Quarterly Minimum Data Set (MDS) assessment dated 12/23/15, indicated the resident had severe cognitive deficit and required extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. Review of Resident #38's Quarterly Minimum Data Set (MDS) assessment dated 11/05/15, indicated the resident had severe cognitive deficit and required		supervisor, the nurse, nurse aides and the maintenance menwill shut off all values under the sinks in room affected by the hotwater. The shower rooms have doors that lock;until the hazard has been corrected the shower room doors will remainlocked. After securing the rooms and neutralizingthe threat of hot water to the the residents, Facilities Management will benotified to fix the problem. The Facility Management employeewill document the time of arrival, action taken to correct the hot waterproblem. He will notify the nursesupervisor when the water is safe and notify the Assistant Administrator. The maintenance man assign to checkwater tempts will follow the facility procedure for checking water temperaturesand keep a record of the water temperatures. The Assistant Administrator will reviewthe water temperatures at the end of each week to ensure at least all rooms,shower rooms and kitchen areas have been checked. A review by the Assistant Administrator of allwork done on water tempts by Facility Management will be conducted at the endof the month. A report will be given at thebi-monthly Risk Management Committee meeting and the Quarterly QualityAssurance Committee meeting.	

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	extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. c). At 11:31 a.m., the bathroom for room #132 had a sink faucet with a water temperature of 127.5□ F. The residents residing in room #132 did not independently access the bathroom Review of Resident #47's Quarterly Minimum Data Set (MDS) assessment dated 12/22/15, indicated the resident was cognitively intact and required extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. Review of Resident #15's Quarterly Minimum Data Set (MDS) assessment dated 10/28/15, indicated the resident had moderate cognitive deficit and required extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. d). At 11:32 a.m., the bathroom utilized by room #131 had a sink faucet with a water temperature of 128.2□ F. The residents residing in room #131 were assisted by staff to access the bathroom			

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	and did not turn on the faucet independently. Review of Resident #106's Quarterly Minimum Data Set (MDS) assessment dated 12/02/15, indicated the resident had severe cognitive deficit and required extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. Review of Resident #61's Quarterly Minimum Data Set (MDS) assessment dated 12/15/15, indicated the resident had severe cognitive deficit and required extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. e). At 11:37 a.m., the Maintenance employee # 14 checked the water temperature of the bathroom in Room # 114 and indicated the temperature was 127 degrees F per the facility's thermometer. The resident who resided in the room did not independently access the bathroom. Review of Resident #41's Quarterly Minimum Data Set (MDS) assessment dated 11/19/15, indicated the resident had severe cognitive deficit and required			

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	extensive assistance of one person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. During an interview on 2/1/16 at 12: 05 p.m., LPN #15 indicated Resident #41 (Room #114), did not access the bathroom independently and required assistance of one staff with toileting and bathing. At the same time, she indicated Resident #44 (Room #112), did not access the bathroom independently and required assistance of 2 staff with toileting and bathing. f). At 11:40 a.m., the Maintenance employee # 14 checked the water temperature of the bathroom in Room # 112 and indicated the temperature was 124.5 degrees F per the facility's thermometer. The resident who resided in the room did not independently access the bathroom. Review of Resident #44's Quarterly Minimum Data Set (MDS) assessment dated 11/3/15, indicated the resident had severe cognitive deficit and required extensive assistance of two person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. g). At 11:41 a.m., the bathroom for room			

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	#108 had a sink faucet with a water temperature of 127.0□ F. The resident residing in room # 108 did not independently access the bathroom. Review of Resident #30's Quarterly Minimum Data Set (MDS) assessment dated 12/23/15, indicated the resident was cognitively intact and required extensive assistance of one person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. h). At 11:42 a.m., the bathroom for room #123 had a sink faucet with water temperature of 125.5 degrees F. The resident residing in room #123 did not independently access the bathroom. Review of Resident #91's Quarterly Minimum Data Set (MDS) assessment dated 1/5/16, indicated resident had severe cognitive deficit and required extensive assistance of one person physical assist with transfer, walking in room, and corridor, and with toileting and personal hygiene. During an interview on 2/1/16 at 2:00 p.m., LPN # 16 indicated Resident # 91 (room # 123), did not access the bathroom independently and required assistance of one staff with toileting and			

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	bathing. i). At 11:44 a.m., the bathroom utilized by room #103 had a sink faucet with a water temperature of 122.5□ F. The resident residing in room #103 was assisted by staff to access the bathroom and did not turn on the faucet independently. Review of Resident #80's Quarterly Minimum Data Set (MDS) assessment dated 11/23/15, indicated the resident was cognitively intact and required extensive assistance of one person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. j). At 11:45 a.m., the bathroom utilized by room #101 had a sink faucet with a water temperature of 123.5□ F. The resident residing in room #101 was assisted by staff to access the bathroom and did not turn on the faucet independently. Review of Resident #56's Quarterly Minimum Data Set (MDS) assessment dated 11/23/15, indicated the resident was cognitively intact and required extensive assistance of one person physical assist with transfer, walking in room and corridor, and with toileting and			

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	personal hygiene. k). At 11:47 a.m., the bathroom utilized by room #107 had a sink faucet with a water temperature of 127.5□ F. The resident residing in room #107 was assisted by staff to access the bathroom and did not turn on the faucet independently. Review of Resident #37's Quarterly Minimum Data Set (MDS) assessment dated 11/23/15, indicated the resident was cognitively intact and required extensive assistance of one person physical assist with transfer, walking in room and corridor, and with toileting and personal hygiene. During an interview on 2/1/16 at 11:15 a.m., maintenance employee #14 indicated the water temperature should have been less than 120□ F and indicated the prior week he had adjusted the water heater temperature, after he became aware of the water temperature in the East/West wing had been 121□ F. The maintenance employee #14 indicated he weekly checked random rooms every week on each resident hall for water temperatures. A "Water Temperature Maintenance Policy," undated, but identified by the			

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	Human Resource Director as current on 2/5/16 at 9:15 a.m., indicated, "...The facility should insure that plumbing fixtures that supply hot water and are accessible to the residents shall be thermostatically controlled so the water temperature at the point of use does not exceed on hundred twenty degrees Fahrenheit (120□ F). The water should be at a temperature range of one hundred degrees Fahrenheit to one hundred twenty degrees Fahrenheit (100□ F-120□ F). 3.1-45 (a)(1)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review the facility failed to ensure food was distributed in a safe and sanitary manner as evidenced by; a staff member was observed touching the residents' food with her bare hands for 3 random dining room observations. Findings include:	F 0371	**F 371** The facility will procure food fromsources approved or considered satisfactory by Federal, State, or localauthorities and store, prepare, distribute and serve food under sanitaryconditions. The facility will ensurefood is disturbed in a safe and sanitary manner as prescribed by the facilitypolicy. Corrective action for	02/06/2016

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	1). On 2/2/16 during the noon meal service in the East hall dinning room the following was observed: a). At 12:15 p.m., CNA # 1 touched Resident # 91's garlic bread and chocolate cookies with her bare hands while she removed them from the deli tissue. b). At 12:17 p.m., LPN # 2 touched Resident # 83's chocolate cookies with her bare hands while she removed them from the deli tissue. c). At 12:20 p.m., CNA # 3 touched Resident # 75's garlic bread and chocolate cookies with bare hands while she removed them from the deli tissue. 2). On 2/3/16 during the noon meal service in the North/South hall dinning room the following was observed: a). At 12:28 p.m., CNA # 3 touched Resident # 5's roll while she removed it from the deli tissue. 3). On 2/4/16 during the noon meal service in the East hall dining room the following was observed: a) At 12:23 p.m., CNA # 4 touched		residents#75,#5, #78 and #61on passing out food with bare hands has been taken afterbeing notified during the Exit Survey by the team leader that problem waspresent in our dinning service. Since all residentshave the potential to be affected, the corrections began on the day of theSurvey Exit on 2-5 and training again on 2-18-16 in mandatory staffmeetings. The DON and Unit Managers reviewedand updated the Nursing Policy on Hand Hygiene, **"Staff is not to handle food with bare hands as outlined in the IndianaRetail Food Establishment.** (See attachment) Attached is the initial staffeducation in the form of paper and verbal communications on 2-5-16. Another manadorty in-service was held on 2-18-2016. **FUTUREASSURANCE COMPLIANCE:** The following procedures will befollowed to ensure no future violations occur. The Director of Nursing or her designees will conduct improvement auditson the sanitary distribution of ready to eat foods (see attached audit tool) Each meal will be audited for 1week; then each meal will be audited for 3 days per week on randomly selecteddays for duration of 3 weeks; then 1 meal will be audited 3 times per weeks for6 months. Results of all audits are reportedto the bi-monthly Risk Management	

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	Resident # 78's bread with her bare hands while she removed it from the deli tissue. b) At 12:30 p.m., LPN # 5 touched Resident # 61's bread with her bare hands while she buttered the bread. During an interview on 2/4/16 at 1:55 p.m., CNA # 6 indicated staff shouldn't be touching food items with their bare hands. During an interview on 2/4/16 at 1:58 p.m., CNA # 7 indicated staff shouldn't touch residents food with bare hands. She further indicated staff could butter a residents bread without touching the piece of bread with bare hands. During an interview on 2/5/16 at 11:00 a.m., Dietary Manager indicated the facility follows the *Indiana Retail Food Establishment Manual* guidelines and staff shouldn't be touching food with bare hands. An undated policy, identified as current, titled, "Dietary Supervision and Foodborne Illness Training", provided by the Dietary Director on 2/5/16 at 1:05 p.m., included but not limited to, "...k. Staff prevent cross contamination of ready-to-eat foods from unwashed hands and properly use utensils such as deli		Committee and the quarterly Quality Assuranceand Performance Improvement Committee for compliance and additionalrecommendations.	

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	tissue, spatulas, tongs, disposable gloves, or dispensing equipment when such items can be used...." 3.1-21(i)(2)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure living environments were functional and comfortable for 4 of 4 nursing units reviewed for comfortable living environments (West Unit, East Unit, South Unit, and North Unit). Finding includes: On 2/05/16 at 1:00 p.m., during environmental rounds with the Administrator, DON (director of nursing) and Assistant Administrator #10, the following issues were observed: West Unit: a. The wall outside of room #112, was	F 0465	**F 465** **SAFE/FUNCTION/SANITARY/COMFORTABLE EVIRONMENT:** Thefacility will provide a safe, functional, sanitary, and comfortable environmentfor residents, staff and the public. A plan of correction will be implementedto ensure living environments will be functional and comfortable for 4 of 4living environments on West, East, South, and North Units. **CORRECTIVEACTION:** An outside painting firm has beencontracted to correct the deficiencies on the West, East, North and Southliving area. This includes the door on the South Hall shower room, the door tothe Oxygen room on North Hall and the door on the women's restroom on the EastHall. The company will repair	03/01/2016

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	observed to be marred with plaster showing in the area below the handrail. East Unit: a. In room #126, the wall behind the left side of the resident's bed was observed with a marred area. The area was observed by the Administrator to measure 14 inches in height and 12 inches in width. At the same time, Resident # 88, who resides in Room #126, indicated the area on the wall was unsightly. b. The door to the Women's restroom was observed with a gash across the width of the bottom portion of the door. South Unit: a. In room #173, the wall to the right of bathroom sink was observed to be chipped and marred. b. In room # 175, the wall behind the bedside table was observed to be chipped and marred. c. The South Hall shower room door molding was observed to be marred and the door had a deep gash across the width of the bottom portion of the door. North Unit:		and paint thehallway outside room # 112. They will clean, scrape, plaster and paint the wallsin rooms # 126, #173, #175, #180 as cited in the 2567. **FUTUREASSURANCE OF COMPLIANCE:** When damage to walls,doorframes and doors are noticed by the staff on the living areas, residentrooms, shower rooms and hallways by staff, the preventative maintenance workorder policy will be followed. There isa work order box at every nurses station, staff will complete the request andplace in the box. Prior to 8:30 AM in the morning andimmediately after lunch these boxes will be emptied and reviewed by the leadmaintenance man and the Assistant Administrator. Work orders will be prioritized and assignmentsmade to both maintenance employees. During the month, periodic reviewswill be made by the lead maintenance man, the Assistant Administrator andExecutive Director to ensure the quality of the work, as well, as timeliness. The Assistant Administrator andExecutive Director will conduct a walk through reviewing all projects assignedthat month for completeness and quality. Written documentation will be filed in the Assistant Administrator'sfiles. The lead maintenance	

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	155802	A. BUILDING 00 B. WING	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE HEALTH CARE CENTER	1 SISTERS OF PROVIDENCE SAINT MARY OF THE WO, IN 47876

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	a. In room #180, the wall above the baseboard behind the resident's bed was observed to be chipped and marred. The wall outside to the left of the bathroom door was marred and the wall under the bathroom sink was observed to be chipped and marred. On 2/5/16 at 11:00 a.m., the DON provided a current policy titled, "Reporting Repair & Safety Needs," dated 8/1/08. The policy indicated, "Policy: Mother Theodore Hall...were created to be a...comfortable and safe homelike environment...Procedure: 1. Each nurse station...will have a file box on the counter that is marked repairs...3. On a daily basis (Mon-Fri), the environmental services tech will check each file box. He will remove any completed form from the file box and add the new repair problem to his ongoing repair list...4. The environmental services tech and manager will review on a weekly basis the status of all repair requisitions... On 2/5/16 at 11:30 a.m., the DON provided a current policy titled, "Maintenance Policy," undated. The policy indicated "Purpose: To ensure that the building (interior and exterior)...are maintained in a safe and operable		man will reportto the bi-monthly Risk Management Committee and the Quarterly Quality AssuranceCommittee the number of projects, scope of work completed, approximate cost andtime to complete the project	

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	manner...Standards: 5. Preventative Maintenance Programs shall include the periodic inspection, general maintenance procedures and repairs of at least the following: g. Interior...finishes of the building... 3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 33 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IC 16.2-2.5. Quality review completed 2/10/16 by 29479.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (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: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions,			

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	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. (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 shall be documented with the names and signatures of the personnel present.			
	Based on record review and interview, the facility failed to ensure quarterly fire drills were performed on each shift as indicated on the facility policy for fire drills. Findings include: A request was made on 2/4/16 at 11:00 a.m. to review the fire drills performed in the past 12 months. A "Fire Drill Report", dated 1/5/16 at 10:15 a.m. was provided on 2/4/16 at 12:00 p.m. by the Residential Director. During an interview with the Residential Director on 2/4/16 at 12:00 p.m., she indicated this "Fire Drill Report" was the only one she could find.	R 0092	**R092 ADMINISTRATRATION and MANAGEMENT –Non-compliance** Thefacility will maintain a written fire and disaster preparedness plan to assure continuityof care of residents in cases of emergency. Twelve (12) drills will be heldevery year and the drills will be conducted at least one every shift. **CORRECTIVEACTION:** Thefacility had conducted one fire drill for the first quarter. The drill was on the day shift on 1-5-16. The staff from each shift was in-serviced onfire disaster drill procedure the next week. A fire disaster for the first quarter was conducted on 2/4/16 for dayshift, 2/18/16 on evening shift. A coded announcement fire disaster wasdone on 2/24/16 for the night shift. TheEnvironmental Service	02/24/2016

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	During an interview with the HR (Human Resources) Director on 2/5/16 at 9:16 a.m., she indicated she and Maintenance Director #13 had looked all through his office and were unable to find any other fire drills. She also indicated at that time she did not know how the facility was able to pass the Fire Marshall inspection or Life/Safety inspection last year without the fire drills. She indicated Maintenance Director #13 was the one responsible for doing the fire drills and keeping the records. Maintenance Director #13 was not available for interview. No other fire drill records were provided by the time of the final exit conference on 2/5/16 at 2:30 p.m. An undated current facility policy, titled "Fire And Disaster Policy" was provided by the DON (Director of Nursing) on 2/5/16 at 9:10 a.m.. The policy indicated: "Purpose: To ensure the facility has an acceptable written plan in operation with training and implementation procedures to be followed in the event of fire, natural and/or man-made disaster.... Standards: 1. The facility shall comply with fire and safety standards, including the rules of		Director is initiating a fire disaster drill inconjunction with the local fire department by June 30th, 2016. The bi-monthly Risk ManagementCommittee will review these findings to ensure awareness of this AssistedLiving requirement. The findings willalso be reviewed by the Quarterly Quality Assurance Committee. The Assistant Administrator in conjunctionwith the facility security team will schedule, conduct and monitor fire disasterdrills for compliance with Resident Living Communities.	

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	the Indiana Department of Fire and Building Services and NFPA [National Fire Prevention Agency], where applicable to health facilities.... ...7. The facility will conduct unannounced fire drills a minimum of one per shift, four ties a year, with at least (12) drills held per year. 8. The Environment Supervisor will be responsible for initiating these drills and will maintain documentation including names, signatures, and location of all personnel present during the drill and the report of the drill activity in the administrative office...."			
R 0408 Bldg. 00	410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to ensure new admissions to the Residential Unit had chest x-rays done within 6 months prior to their admission to the unit for 3 of 4 residents reviewed who were admitted during the previous year (Residents #33, #38, #51). Findings include:	R 0408	**INFECTIONCONTROL – Non-Compliance** Each resident will have a diagnosticchest x-ray completed no more than six (6) months prior to admission. **CORRECTIVEACTION:** Eachresident's medical record was audited by 2/19/16 to ensure that chest X-rayreports are on file, those residents who did not receive required screeningand/or have not received a chest x-ray since	02/24/2016

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	1. The record for Resident #33 was reviewed on 2/4/16 at 9:15 a.m. Her diagnoses included, but were not limited to, hearing loss and abdominal pain. Resident #33 was admitted to the facility on 8/5/15. Resident #33's record did not document a chest x-ray having been done. A chest x-ray was provided by the Medical Records Director on 2/4/16 at 11:00 a.m. that was dated in 2011. 2. The record for Resident #38 was reviewed on 2/3/16 at 3:15 p.m. Her diagnoses included, but were not limited to, heart failure and osteoarthritis. Resident #38 was admitted to the facility on 12/18/15. Resident #38's record did not document a chest x-ray had been done prior to admission. A chest x-ray was provided by the Medical Records Director on 2/4/16 at 11:00 a.m. that was dated in 2010. 3. The record for Resident #51 was reviewed on 2/4/16 at 2:11 p.m.		admission to the facility, will bescheduled for a chest x-ray by 2/24/16. It will be the responsibility of theMedial Records Coordinator to obtained chest x-rays reports upon notification ofupcoming admissions by the Assisted Living Manager. A comprehensive AdmissionChecklist has been implemented including the chest x-ray report on admission. Assisted Living staff wasin-serviced on 2/18/16 regarding the regulation and the process for using the comprehensivechecklist and the responsibility to report omitted chest x-ray during the admission process. Admissions occurring since February 5th have beenaudited and include x-rays reports in the Resident's Medical Record. Chest x-ray audit results ofadmissions each quarter to Assisted Living will be reviewed at the bi-monthlyRisk Management Committee and the Quarterly Quality Assurance Committee.	

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	Resident #51's diagnoses included, but were not limited to, congestive heart failure and hypothyroidism. Resident #51 was admitted to the facility on 11/21/15. Resident 51's record did not document a chest x-ray being done until 1/28/16. During an interview with the Residential Director on 2/4/16 at 2:03 p.m., she indicated no chest x-ray for Resident # 51 had been done until 1/28/16. During an interview with the DON (Director of Nursing) on 2/5/16 at 9:35 a.m., she indicated it was the Medical Records Director's responsibility to make sure the chest x-ray was present on admission, with the Residential Director being the back up auditor. The DON also indicated the new Medical Records Director and Residential Director had only had their positions for 2-3 months. She indicated the previous Medical Records Director was also the Interim Residential Director and she had obviously not backed herself up making sure admission records were in order. An undated current facility policy titled "Medical Record Policy" was provided by the DON on 2/5/16 at 9:05 a.m. The			

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	policy indicated: "...h. Chest X-Ray and Mantoux Testings [test for tuberculosis] and Immunizations - The dates and results of the pre-admission and annual chest x-ray and/or Mantoux test will be recorded in the resident's record on the Immunization Record. The diagnostic chest x-ray shall be completed no more than six (6) months prior to admission or upon admission...."			