

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119
--	--

(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
R0000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: March 7, 8, 9, 2012</p> <p>Facility Number: 012161 Provider Number: 012161 AIM Number: NA</p> <p>Survey Team: Avona Connell, RN TC Dorothy Navetta, RN</p> <p>Census Bed Type: Residential: 58 Total: 58</p> <p>Census Payor Type: Other: 58 Total: 58</p> <p>Sample: 07 Supplemental sample: 16</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/13/12 by Suzanne Williams, RN</p>	R0000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/09/2012	
NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119			
(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			
R0144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on record review, observation and interview, the facility failed to ensure the facility was free from heavy dust on the wood frames on 45 of 50 dining room chairs. This had the potential to affect 50 of 58 residents served at breakfast, lunch and dinner.</p> <p>Findings include:</p> <p>On 3/7/2012 at 2:00 p.m., during initial tour, it was observed that the dining room chairs had heavy dust on the wood frames.</p> <p>On 3/9/2012 at 1:00 p.m., during an interview with the Business Office Manager (BOM), she indicated that dietary was responsible for cleaning the dining room chairs. The BOM indicated that the Dietary Manager had indicated that the chairs were last cleaned on 3/2/2012.</p> <p>On 3/9/2012 at 1:30 p.m., record review of the daily dietary department cleaning schedules indicated, but was not limited to, "clean chairs."</p>	R0144	<p>R144-Sanitation and Safety I. The wood frames of all chairs in the dining room and piano were dusted: II. Other areas/furniture throughout the facility was also inspected for potential dust build up. III. As a means to ensure ongoing compliance with maintaining a clean environment, the cleaning schedule was reviewed and updated to include dusting at least twice weekly. IV. As a means of quality assurance, the Administrator shall monitor to ensure that the revised schedule is sufficient to maintain a clean environment. Should concerns be noted, staff will be addressed and/or the schedule amended as necessary.</p>	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/09/2012	
NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119			
(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			
R0192	<p>410 IAC 16.2-5-1.6(p) Physical Plant Standards - Nonconformance (p) The facility shall have a janitor's closet conveniently located on each resident occupied floor of the facility. The janitor's closet shall contain a sink or floor receptacle and storage for cleaning supplies. The door to the janitor's closet shall be equipped with a lock and shall be locked when hazardous materials are stored in the closet.</p> <p>Based on observation, record review and interview, the facility failed to ensure 1 of 2 janitor's closets was closed when chemicals were present. This had the potential to affect 19 residents with diagnoses of dementia and/or Alzheimer's of 58 residents. (Resident #2) (Resident #3) (Resident #5) (Resident #8) (Resident #9) (Resident #10) (Resident #11) (Resident #12) (Resident #13) (Resident #14) (Resident #15) (Resident #16) (Resident #17) (Resident #18) (Resident #19) (Resident #20) (Resident #21) (Resident #22) (Resident #23)</p> <p>Findings included:</p> <p>On 3/8/2012 at 1:56 p.m., during observation, the door to the janitor's closet was propped open with a 30 gallon black garbage can. Chemicals present inside the janitor's closet included, but were not limited to:</p> <p>8-Spray scents 7 oz. (ounce) cans 8-Febreze air effects spray cans 9.7 oz. 2-Clorox toilet bowl cleaner 24 oz.</p>	R0192	<p>R192-Physical Plant Standards-Nonconformance</p> <p>I. Upon discovery, the unlocked door to the mechanical room was again secured.</p> <p>II. In an effort to determine if any other secured areas were unsecured, facility rounds were conducted to affirm all secured areas/chemicals remain, in fact, secured.</p> <p>III. As a means to ensure ongoing compliance, immediate in-service training was</p>	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/09/2012	
NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119			
(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			
	<p>6-Crew cling toilet bowl cleaner 946 ml (milliliters) 1-Clorox wipes 11 lb (pound) 7 oz. 3-Suma Cal detergent 1 gallon 6-Suma premium soap 50 fluid oz. 8-Suma diverpak machine dish detergent 9 lb 1-Shine up lemon furniture polish 1 qt. 3-Mold armour-mold blocker 32 fluid oz.</p> <p>On 3/8/2012 at 2:15 p.m., in an interview with the Corporate Manager, she indicated the door was supposed to be closed.</p> <p>On 3/8/2012 at 2:45 p.m., in an interview with the Administrator, she indicated "I've just got nothing to say about door being opened."</p> <p>On 3/9/2012 at 11:20 a.m., in an interview with Administration, she indicated they have two janitor closets that they store chemicals in.</p> <p>On 3/9/2012 at 12:00 p.m., review of the policy on storage of chemicals indicated, but was not limited to: "...ensuring that doors to restricted areas remain locked/secured" "...ensuring that chemicals are either within visual range of the staff using the chemical or properly locked/secured."</p>		<p>initiated to ensure that each staff member would receive training in regard to secured doors/chemicals prior to the beginning of his/her next tour of duty.</p> <p>IV. As a means of quality assurance, the Administrator shall be responsible to conduct daily rounds on scheduled days of work to confirm continued compliance of securing hazardous chemicals/securing doors following re-education provided. Should non-compliance be noted, re-education and disciplinary action shall be taken as warranted.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>On 3/9/2012 at 12:10 p.m., review of the Material Safety Data sheets for the chemicals named included, but was not limited to:</p> <p>"Eye contact: Corrosive. Causes permanent eye damage, including blindness."</p> <p>"Skin contact: Corrosive. Causes permanent skin damage."</p> <p>"Indigestion: Corrosive:: Causes burns to mouth, throat and stomach."</p> <p>"Inhalation: ....may be harmful or fatal..."</p> <p>"Ingestion Acute Exposure Effects: Liquid can be corrosive to the mouth and throat, mucous membranes and stomach. Swallowing can burn the tissues, cause abdominal pain, nausea, vomiting, circulatory collapse, confusion, delirium, coma and collapse. Swallowing large quantities can cause death."</p> <p>On 3/8/2012 at 3:00 p.m., documentation provided by the Administrator included a list of 19 residents who had a diagnosis of dementia and/or Alzheimer's (Resident #2) (Resident #3) (Resident #5) (Resident #8) (Resident #9) (Resident #10) (Resident #11) (Resident #12) (Resident #13) (Resident #14) (Resident #15) (Resident #16) (Resident #17) (Resident #18) (Resident #19) (Resident #20) (Resident #21) (Resident #22) (Resident #23).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119
--	--

(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
	<p>On 3/9/2012 at 12:25 p.m., review of Resident #12's record indicated, but was not limited to, diagnosis of dementia.</p> <p>During observation of Resident # 12 on 3/8/2012 at 1:56 p.m., he was sitting in the lounge area approximately 42 feet from janitor's closet.</p> <p>During observation of Resident # 12 on 3/8/2012 at 2:35 p.m., he was independently walking.</p> <p>On 3/9/2012 at 12:40 p.m., review of Resident # 19's record indicated, but was not limited to, diagnosis of dementia.</p> <p>During observation of Resident #12 on 3/8/2012 at 1:56 p.m., she was sitting in the lounge area approximately 44 feet from the janitor's closet.</p>			