

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140
---	--

(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
W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>This visit was done in conjunction with a post certification revisit (PCR) to the investigation of Complaint #IN00091975 completed on 7/15/11.</p> <p>Dates of Survey: November 14, 15, 16, 17 and 18, 2011.</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>Facility Number: 000846 AIM Number: 100243990 Provider Number: 15G328</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/30/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0210	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#3),</p>	W0210	<p>Within the last year, a new wheelchair was approved by Medicaid for Client #3, as it</p>	12/18/2011

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:  15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2011
NAME OF PROVIDER OR SUPPLIER  TANGRAM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140		
(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>and 1 additional client (#5), the facility failed to ensure the clients' positioning needs in regards to their diagnoses (scoliosis, kyphosis, hiatal hernia, cerebral palsy, arthritis, Gastro Esophageal Reflux Disease and dysphagia) were assessed.</p> <p>Findings include:</p> <p>During observations at the facility on the morning of 11/16/11 at from 6:00 AM until 11:30 AM, client #3 was observed to have limited usage of her arms and legs and used a wheelchair for mobility. The client was observed to have poor posture, she leaned forward and to her left while seated in the wheelchair. A tour of the client's bedroom indicated the client's bed had no adaptations to address proper positioning during sleeptime for her "severe reflux," posture and arthritis of her left hip.</p> <p>Client #5 was observed on 11/16/11 at 7:30 AM to walk with an awkward gait, to have difficulty articulating words and exhibited difficulty swallowing three 500 mg./milligram Oyster Shell (calcium supplement) tablets. The client's bedroom was observed to have no adaptations to her bed to address positioning for her scoliosis, kyphosis, hiatal hernia or GERD/Gastro Esophageal Reflux Disease.</p>		<p>worked better for her body and provided better support for her back. Client #3 uses this chair currently. On November 18, 2011, in response to the surveyor's recommendations, Client #3 was taken to her physician at American Health Network for an evaluation for referrals for a swallowing evaluation and bed adaptations. A letter dated November 18, 2011 from Client #3's physician states, "[Client] has had no swallowing issues, no recurrent pneumonias. I do not see a need for any swallowing evaluations or bed changes." Based upon this physician evaluation, Tangram is complying with the doctor's order. Client #5 has an appointment with her physician at Hancock Memorial on December 14, 2011 for evaluation and to obtain referrals for assessments related to this citation. Tangram will follow all doctor's orders in order to obtain the proper assessments for Client #5 as needed. Additionally, Client #5 was recently provided an order for a new walker that would assist client with her posture while walking. Tangram will work with the appropriate company to assure client gets this mobility device.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140
---	--

(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>Client #3's record was reviewed on 11/16/11 at 8:35 AM. The record review indicated a 9/07/11 Individual Program Plan/IPP which indicated the client's diagnoses included, but were not limited to, cerebral palsy, "severe reflux," and arthritis of left hip with pain. The record review indicated an occupational therapy consultation on 3/15/10 but the client's positioning needs during sleeptime to address her posture, arthritis and "severe reflux" had not been assessed during the consultation.</p> <p>Client #5's record was reviewed on 11/16/11 at 9:25 AM. The record review indicated a 9/06/11 IPP which indicated the client's diagnoses included, but were not limited to, cerebral palsy, scoliosis, kyphosis, awkward gait, hiatal hernia, GERD and dysphagia. The record review indicated the client's positioning needs in regards to her scoliosis and kyphosis had not been assessed. The record review indicated the client's positioning needs in regards to her risk of reflux and aspiration associated her hiatal hernia, dysphagia and GERD had not been assessed. The record review indicated the client's medications had not been evaluated in regards to their size and her difficulty in swallowing them.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140
---	--

(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
W0368	<p>Interview with client #5 at 7:35 AM on 11/16/11 indicated she had difficulty with and did not like taking the Oyster shell pills due to their size.</p> <p>Interview with staff #6 on 11/16/11 at 11:00 AM indicated client #3's bed had not been evaluated/adapted in regards to her positioning needs associated with her posture, arthritis and "severe reflux."</p> <p>Interview with staff #6 on 11/16/11 at 11:00 AM indicated client #5's bed/sleeptime positioning needs had not been assessed in regards to her scoliosis and kyphosis. The interview indicated her sleeptime positioning had not been assessed in regards to her risk of reflux/aspiration in association with her diagnoses of hiatal hernia, GERD and dysphagia. The interview indicated the client's difficulty with swallowing large pills had not been addressed.</p> <p>9-3-4(a)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 3 sampled clients (#1), and 2 additional clients (#4 and #6), the facility</p>	W0368	The employee involved in the incident with Client #6 no longer works with Tangram. However, in	12/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2011
NAME OF PROVIDER OR SUPPLIER  TANGRAM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140		
(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>failed to ensure the clients' medications were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>Review of the facility's reportable incidents on 11/16/11 at 1:30 PM indicated the following medications had not been given according to the physician's orders:</p> <p>On 8/25/11 client #6 was given the wrong dosage 500 mg./milligrams instead of 100 mg. of the seizure medication levetiraceta by staff #10.</p> <p>On 7/1, 2 and 3/2011, client #4 was given the dementia drug donepezil (dosage unknown) by staff #6 which had been discontinued by the physician on 5/27/2011.</p> <p>On 7/01/2011 client #1 had been given depakote (anticonvulsant given for behavior) 750 mg. by staff #11. The depakote had been discontinued by the physician three weeks prior to its administration.</p> <p>Interview with Administrator #1 on 11/16/11 at 2:00 PM indicated the staff had failed to administer clients #1, #4 and #6's medication according to the correct directions.</p>		<p>reponse to any medication error involving the administration of the wrong dosage of medication, including other medication errors. Tangram has a personnel policy that includes a progressive disciplinary process when staff make these errors. This progressive disciplinary policy involves probationary periods and mandatory retrainings for staff who make multiple medication administration errors. This policy is followed throughout the organization. With regard to the incidents that occurred with Clients #4 and #1, Tangram will institute a process to ensure that all medications that are discontinued by the physician are sent to the pharmacy and properly removed from the MARs/TARs. The QMRP/Program Manager will be responsible for auditing the client's charts to ensure that all doctor's orders have been communicated to the appropriate parties for follow-up. Additionally, the QMRP/Program Manager will ensure that the MARs/TARs and Physician's Orders properly match the doctor's orders that have been received regarding changes to any treatment and/or medication. The home's RN will be the back-up to review these records and ensure that all the information regarding treatments and/or medications is up to date.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2011
NAME OF PROVIDER OR SUPPLIER  TANGRAM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140		
(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	
W0382	<p>9-3-6(a)</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to ensure the clients' medications were securely stored (locked) when not being prepared for use.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 11/15/11 from 2:30 PM until 6:00 PM, the room where the clients' medications were stored was unlocked and open. During the observation period, clients #1, #2, #3, #4, and #6 had access to the unstaffed room. During the afternoon medication administration at 5:00 PM, the following medications were observed to be stored in an unlocked filing cabinet:</p> <p>Client #1's Prevident toothpaste (used for gingivitis), Client #2's Glipizide 10 mg./milligram used for diabetes, Client #3's Patanol eyedrops and Flonase nasal spray (both used for allergies), Client #4's Xopenex (used for shortness of breath), Dovonex cream (used for eczema) and her Clobetasol centrifugal</p>	W0382	On November 16, 2011, the medicine cabinet in the home was repaired so that all medications could be locked, except when being prepared for administration. All medications are now stored in this locked cabinet.	12/18/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140
---	--

(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>cream, Client #5's oxistat antifungal cream, cortisporin antibiotic ear drops, hydrocort skin cream, Neosporin antibiotic ointment, carmex lip salve, and her Oragel (used for mouth/gum irritation), Client #6's Flonase nasal spray (used for allergies), her Advair Diskus and Ventolin inhaler (both used for asthma).</p> <p>Interview with staff #6 on 11/15/11 at 5:00 PM indicated the clients' medications should have been locked.</p> <p>During observations at the facility on the morning of 11/16/11 at from 6:00 AM until 11:30 AM clients #1, #2, #3, #4, #5, and #6 were observed to have access to the facility's refrigerator. At 9:00 AM on 11/16/11, the facility's refrigerator contents were observed. The observation indicated four of client #2's Lantus Solostar (long acting insulin used for blood glucose control) injectable pens were unlocked and loose in the refrigerator's door. The observation indicated five of client #2's Humalog KwikPens (injectable fast acting insulin used to control blood glucose) were unlocked and loose in the refrigerator's door.</p> <p>Interview with staff #5 on 11/16/11 at 9:00 AM indicated the Humalog KwikPen</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140
---	--

(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
W0389	<p>and the Lantus Solostar pens were kept stored in the facility's refrigerator door unlocked.</p> <p>9-3-6(a)</p> <p>Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the client's insulin was labeled with the date when opened to ensure it was not used beyond the recommended expiration date of 28 days after opening.</p> <p>Findings include:</p> <p>During observations at the facility on the morning of 11/16/11 from 6:00 AM until 11:30 AM client #2's Humalog KwikPens (injectable fast acting insulin used to control blood glucose) were observed in the facility's refrigerator. The observation indicated five insulin pens; only one of which was opened and had been used. No date of opening was indicated on the KwikPen.</p>	W0389	<p>On November 16, 2011, the QMRP/Program Manager purchased a lock box that was placed inside the refrigerator with the insulin inside. The insulin, and other medications that will require refrigeration, will be stored in this lock box at all times, except when being prepared for administration. The lock box has a coded keypad entry so that a key is not accessible to clients. Additionally, Tangram has added to its Medication Storage and Destruction policy a requirement that staff immediately label a medication on the date it was opened to ensure that medication is not used after its expiration date. Staff will be given this policy and will receive training on proper medication storage and labeling.</p>	12/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/18/2011
NAME OF PROVIDER OR SUPPLIER  TANGRAM INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN46140		
(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>Review of client #2's 11/11 medication administration record/MAR on 11/16/11 at 8:00 AM indicated she received Humalog insulin injections via an injectable pen (KwikPen) on an as needed basis according to her blood glucose readings. The MAR review did not indicate the date her insulin KwikPen had been opened and put into service. Review of the patient information literature for the Humalog KwikPen on 11/17/11 at 11:00 AM indicated the KwikPen was to be discarded 28 days after opening regardless if it still held insulin.</p> <p>Interview with staff #5 on 11/16/11 at 9:00 AM indicated the Humalog Kwikpen had been used by client #2 but no date of its initial use or opening was documented on the pen or elsewhere in the facility.</p> <p>9-3-6(a)</p>				