

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155815	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2016
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NAME OF PROVIDER OR SUPPLIER  CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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F 0000  Bldg. 00	<p>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the investigation of Complaints IN00195213, IN00194999, IN00194848, IN00193489, IN00192746, and IN00192640 completed on April 7, 2016.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00201304 and IN00197491.</p> <p>Complaint IN00195213-Corrected Complaint IN00194999-Corrected Complaint IN00194848-Corrected Complaint IN00193489-Corrected Complaint IN00192746-Corrected Complaint IN00192640-Corrected</p> <p>Survey dates: May 31, June 1 and 2, 2016</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Census bed type: SNF: 36 SNF/NF: 10 Residential: 24 Total: 70</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00197413) Survey on May 12, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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.

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F 0279 SS=D Bldg. 00	<p>Census payor type: Medicare: 24 Medicaid: 10 Other: 36 Total: 46</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on June 6, 2016</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under</p>			

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	<p>§483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident who used a catheter and was identified as having urinary incontinence, had a care plan to address these conditions for 1 of 3 residents reviewed for care plans. (Resident #184)</p> <p>Findings include:</p> <p>The clinical record for Resident #184 was reviewed on 6/1/16 at 9:30 a.m. The diagnoses for Resident #184 included, but were not limited to: hyperlipidemia. He was admitted to the facility on 4/26/16.</p> <p>The 5/3/16 Admission MDS (minimum data set) assessment indicated Resident #184 used an indwelling foley catheter. The date in section V0200B2 was 5/10/16.</p> <p>Regional Clinical Specialist (RCS) #4 provided a list of residents with urinary incontinence on 5/31/16 at 12:08 p.m. Resident #184 was on the list.</p> <p>An interview was conducted with Family Member #7, Resident #184's wife, on 6/1/16 at 2:45 p.m. She indicated</p>	F 0279	<p><b>F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #184 care plan was developed for Foley catheter and incontinence</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents who have a catheter, and display consistent documentation of urinary incontinence to ensure a Care Plan is in place. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted by the DHS or designee on 5 residents 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: resident Care Plans to ensure diagnosis of Foley catheters and consistent documentation of urinary</p>	06/14/2016

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	<p>Resident #184 just got his catheter taken out, as he'd had it for almost 6 weeks. She indicated since getting it taken out, he either used a urinal or was assisted to the restroom.</p> <p>There was no care plan in Resident #184's clinical record to address his use of a catheter, use of a urinal, or urinary incontinence.</p> <p>An interview was conducted with the MDS Coordinator on 6/1/16 at 2:54 p.m. She indicated she was behind on care plans. She indicated any resident who used a catheter or was incontinent of urine should have a care plan to address it.</p> <p>An interview was conducted with RCS #4 on 6/1/16 at 3:10 p.m. She indicated Resident #184 had a catheter until 5/27/16. She indicated there was an issue with care plans, and he should have had one to address his use of a catheter.</p> <p>The Guidelines For Care Plan Development policy was provided by RCS #4 on 6/2/16 at 12:13 p.m. It indicated, "Purpose: To ensure care plans are developed to communicate resident preferences and care needs." It indicated, "A care plan shall be developed no later than 21 days after</p>		<p>incontinence are in place The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F 0282 SS=D Bldg. 00	<p>admission, and no later than 7 days after the date in V0200B2 (found in the MDS assessment)..."</p> <p>3-1.35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow a resident's plan of care to monitor daily blood pressures, and to ensure a resident's geri sleeves were in place, as care planned, for 1 of 3 residents reviewed for unnecessary medications and 1 of 3 residents reviewed for accidents. (Residents #32 and #70).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #70 was reviewed on 6/1/16 at 9:25 a.m. The diagnoses for Resident #70 included, but were not limited to, hypertension, dementia, insomnia, and anxiety. A Nurse Practitioner (NP) Progress Note by NP #3, dated 5/18/2016 at 1:40 p.m., (recorded as Late Entry on 05/20/2016 at 1:41 p.m.) indicated to check "...BIP [sic-blood pressure] daily...."</p>	F 0282	<p><b>F 282</b> <b>F 282</b> <b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #70-BP monitoring orders implemented per order. Resident #32- Geri Sleeves were placed on resident</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all resident MD orders for past 14 days to ensure documentation is in place for any ordered blood pressure monitoring and will ensure residents with orders for Geri sleeves are wearing per order/care plan.</p> <p><b>Measures put in place and</b></p>	06/14/2016

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F 0329	483.25(l)  A Vitals Report indicated Resident #70's blood pressure was last checked on 5/16/16 at 12:36 p.m. No other blood pressure readings were located in the clinical record. On 6/1/16, at 12:25 p.m., NP #3 indicated if she wrote in her Progress Note to check blood pressures daily, it usually was because the resident had a diagnosis of hypertension. During an interview with Regional Clinical Support (RCS) #4, on 6/1/16 at 11:33 a.m., RCS #4 indicated the facility was not able to locate any other blood pressure that were obtained for Resident #70. On 6/1/16 at 1:56 p.m., RCS #4 indicated the facility was able to review the NP Progress Notes as it was recorded above but there was a communication issue between the facility and the NP. At 11:18 a.m., on 6/2/16, RCS #4 indicated Physician Recommendations should be followed.		<b>systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus guideline: Physician Orders  <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of Physician orders to ensure documentation is in place for any ordered blood pressure monitoring and Geri Sleeves are on residents per MD order/Care Plan.  The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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SS=D Bldg. 00	<p><b>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to address a Psychologist's recommendations in a timely manner for 1 of 3 residents reviewed for unnecessary medications (Resident #70).</p> <p>Findings include:</p> <p>The clinical record for Resident #70 was reviewed on 6/1/16 at 9:25 a.m. The diagnoses for Resident #70 included, but were not limited to, dementia, insomnia, and anxiety.</p>	F 0329	<p><b>F 329</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The current Psychologist's recommendations for residents #70 have been followed up on.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> : DHS or designee will review residents</p>	06/14/2016

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	<p>A Progress Note, dated 5/17/16 at 6:03 p.m., indicated, "(late entry for 5/13/16)...was referred for a psychological assessment due to suspected depression...Impressions: [name of Resident #70} appears to have bipolar II disorder, most recent episode-depressed, and major neurocognitive impairment, etiology unspecified. In view of the above, Recommend:</p> <p>1. Consider discontinue daytime Aricept. She is presently already receiving the optimal dosages of both Aricept and Namenda [medications for Alzheimer's disease].</p> <p>2. Consider change [sic] her Seroquel [anti-psychotic medication] to 25 mg po [by mouth] daily (noon), 50 mg po nightly. This should afford her better energy during the day to pursue any activities that she may wish to do. The increased nightly dose should facilitate her sleep...</p> <p>4. [name of physician] may wish to consider slowly downwardly titrating her scheduled clonazepam (i.e., in increments of .25 mg) to prn (vs. scheduled) [lower dosage of anti-anxiety medication to as needed]. An upward titration of the Seroquel can be done if she exhibits increased mood swings and/or emotional lability during this process...Please feel</p>		<p>with Psychologist Recommendations within the last 14 days to ensure that all recommendations have been followed up on.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will educate the Licensed Nurses and Social Services on the following Guidelines 1). Psychological Recommendations</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audit and/or observation for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents with Psychologist's recommendations to ensure they have been followed up on</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>free to contact me if you have any questions about this report...."</p> <p>The Physician's Orders, MAR (medication administration record), Nurse Practitioner/Physician Progress Notes, Nursing Progress Notes, or any other part of the clinical record did not indicate the above recommendations were addressed.</p> <p>During an interview with the Social Services Director (SSD), on 6/1/16 at 10:28 a.m., the SSD indicated she will look into if the recommendations were addressed.</p> <p>A Progress Note by the SSD, dated 6/01/2016 at 10:30 a.m., indicated, "This writer spoke with family today in regards to recommendations from [name of above psychologist]. Family states they are taking resident to neurologist [name of neurologist] on 6-22-16, and do not want to proceed with recommendations until she is seen by neurologist. Nurses aware of upcoming appointment and transportation set...."</p> <p>At 11:03 a.m., on 6/1/16, the SSD indicated she just spoke with Family Member #2 and Family Member #2 indicated she did not want any "psych" drugs changed until the Resident #70 saw</p>			

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F 0428 SS=D Bldg. 00	<p>her neurologist.</p> <p>On 6/1/16, at 12:25 p.m., Nurse Practitioner (NP) #3 indicated if above recommendations were addressed with her, she would've documented them in a Progress Note and she did not see any notation on her NP Progress Note, dated 5/18/2016 at 1:40 p.m. (recorded as Late Entry on 5/20/2016 1:41 p.m.). NP #3 further indicated the facility will sometimes have her review recommendations and she will sign off on them as needed, but she did not remember reviewing a Psychologist's recommendations.</p> <p>During an interview with Family Member #2, on 6/1/16 at 12:31 p.m., Family Member #2 indicated she was not contacted until that day regarding the above recommendations.</p> <p>3.1-48(a)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>			

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	<p>Based on observation, interview, and record review the facility failed to act timely on pharmacy recommendations for 1 of 3 residents reviewed for unnecessary medications. (Resident #32)</p> <p>Findings include:</p> <p>The clinical record for Resident #32 was reviewed on 6/01/2016 at 9:37 a.m. The diagnoses included, but were not limited to: major depressive disorder, cerebral palsy, muscle weakness, and cognitive communication deficit.</p> <p>The 5/6/2016 pharmacy Note to Attending Physician/Prescriber indicated, "Resident has the following psychotropic orders which are due for dosage reduction evaluations: Fluoxetine 20mg QD [daily] and Modafanil 200mg QD [daily] ....Please evaluate s/sx [signs and symptoms] of depression, narcolepsy, and determine if reduction may or may not be appropriate at this time. If resident is to continue current orders, please document risk v. [versus] benefit..." The response from the nurse practioner was signed on 5/9/2016 with a mark over the box labeled "AGREE."</p> <p>Progress notes and NP (Nurse Practioner) progress notes, from 5/07/16 forward, did not indicate any risk versus benefit documentation for the continued use of Fluoxetine or Modafanil.</p>	F 0428	<p><b>F 428</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The current pharmacy recommendations for resident #32 have been followed up on.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> The current pharmacy review recommendations for June 2016 have be reviewed and followed upon timely.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Clinical Support Nurse will educate the DHS (Director of Health Services) on the following campus guideline: Consultant Pharmacist</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted by the Clinical Support Nurse 1 time per month times 6 months to ensure compliance: review of the monthly pharmacy review reports to ensure it has been reviewed by DHS or designee and action</p>	06/14/2016

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	<p>There was no other risks versus benefit documentation located in the resident's clinical record.</p> <p>An interview was conducted with Regional Clinical Supervisor #4 on 6/01/2016 at 2:01 p.m. She indicated when the NP marks "AGREE" on the Note to Attending Physician/Prescriber form it indicates the medication is to be continued and the resident is referred to psych (psychiatric) services for follow up.</p> <p>An interview was conducted with Regional Clinical Supervisor #4 on 6/01/2016 at 3:09 p.m. She indicated she spoke with the NP on 6/01/2016 to confirm the recommendation for psychiatric services and got a verbal order from the NP to refer Resident #32 for psychiatric services and continue with current medications. She further indicated there was a delay due to the NP not documenting the risk versus benefit or the recommendations on the Note to Attending Physician/Prescriber form.</p> <p>A policy titled Documentation and Communication of Consultant Pharmacist Recommendations, dated 2/1/10, was provided on 6/2/2016 at 10:30 a.m. by Regional Clinical Supervisor #4. Policy indicated "...Procedures...B. Comments and recommendations concerning medication</p>		<p>items have been followed up on timely.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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NAME OF PROVIDER OR SUPPLIER  CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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(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
F 9999  Bldg. 00	therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the responsible physician or physician's designee is contacted by the consultant pharmacist or the facility, and prescribers response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record...."  3.1-25(i)	F 9999	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the	06/14/2016

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			<p>Statement of Deficiencies.</p> <p>The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00197413) Survey on May 12, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	