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 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIAR VILLAGE	8800 SPOON DR INDIANAPOLIS, IN 46219

(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
R 0000 Bldg. 00	This visit was for State Residential Licensure Survey. This visit included Investigation of Complaint IN00196958. Complaint IN00196958- Substantiated. No deficiencies related to the allegations are cited. Survey dates: April 12, 13 and 14, 2016. Facility number: 011799 Provider number: 011799 AIM number: N/A Census bed type: Residential: 95 Total: 95 Census payor type: Medicaid: 23 Other: 72 Total: 95 Sample: 10 These State deficiencies are cited in accordance with 410 IAC 16.2-5. Quality review completed by 30576 on April 15, 2016.	R 0000	The plan of correction is submitted as required under State and Federal law The submission of the Plan of Correction does not constitute an admission on the part of Greenbriar Village as to the accuracy of the surveyors' findings or the conclusions drawn there from Submission of this Plan of Correction also does not constitute a deficiency or that the scope and severity cited are correctly applied Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis The Community submits this plan of correction with the intention that it be inadmissible by any third party in an civil or criminal action again the Community or any employee, agent, officer, direction, attorney or shareholder of the Community or affiliated companies We respectfully request a desk review of this plan of correction	

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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R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff person on each shift with first aid certification. This had the potential to affect 95 of 95 residents residing at the facility. Findings include:	R 0117	R117-Personnel - Deficiency Staff shall be sufficient in number, qualifications, and trainingin accordance with applicable state laws and rules to meet the twenty-four (24)hour scheduled and unscheduled needs of the residents and services provided.The number, qualifications, and training of staff shall depend on skillsrequired to	05/27/2016

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	The worked schedule, dated 3/27/16 through 4/9/16, was provided by the Director of Wellness on 4/13/16 at 9:03 a.m. The schedule indicated the following positions were without a staff person certified in first aid: 3/27/16= 3rd shift, 3/28/16=2nd shift, 3/29/16=3rd shift, 3/30/16=3rd shift, 3/31/16=2nd and 3rd shifts, 4/1/16=2nd and 3rd shifts, 4/2/16=1st and 2nd shifts. A document was provided by the Assisted Living (AL) Coordinator, on 4/13/16 at 10:50 a.m. The document indicated there was no staff certified in First Aid during the above shifts. During an interview with AL Coordinator, on 4/13/16 at 10:50 a.m., the AL Coordinator indicated the facility was aware there were shifts that were not covered by staff that were certified in First Aid and they were going to initiate training. A policy titled, First Aid, no date, was received from the Wellness Director on 4/13/16 at 2:18 p.m. The policy indicated, "...All Employee Partners should receive training in first-aid within 90 days of their date of hire...."		provide for the specific needs of the residents. A minimum of one(1) awake staff person, with current CPR and first aid certificates, shall beon site at all times. If fifty (50) or more residents of the facility regularlyreceive residential nursing services or administration of medication, or both,at least one (1) nursing staff person shall be on site at all times.Residential facilities with over one hundred (100) residents regularlyreceiving residential nursing services or administration of medication, orboth, shall have at least one (1) additional nursing staff person awake and onduty at all times for every additional fifty (50) residents. Personnel shall beassigned only those duties for which they are trained to perform. Employeeduties shall conform with written job descriptions. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficient practice? No resident was name as being affected by this deficient practice. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what correctiveaction will be taken? All residents have the potential to be affected by this deficient practice. 3.What measures will be put into place or whatsystemic changes the facility will make to	

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			ensure that the deficient practicedoes not recur? Public SafetyTraining and Supply will conduct first aid and CPR training by a certificated CPR instructor for all licensed staff by the date of compliance. Upon hire, all licensed staff will receivefirst aid and CPR training within the first 90 days of hire. DON or designee will ensure that there is a CPR/First Aidcertified employee is scheduled on each shift 1x week on an ongoing basis. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? Executive Directoror designee will monitor certification 1x week for 8 weeks, 1x every other weekx 8 weeks and 1x per month on an ongoing basis. Executive Director or designeewill monitor schedule to ensure that each shift has a certified CPR/First aideemployee for 2x weeks for 4 weeks, 1x week x 4 weeks and 1x every other weekfor 8 weeks and 1 x a month for 8 weeks Results will be reviewed in QA meeting monthlyduring the first six months. 5.Date of Compliance: 5-27-16	
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities			

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	that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review the facility failed to ensure a Certified Nurse Aide (CNA) did not work with an expired license, as a nurse aide, for 1 of 51 employees whose licenses were reviewed. (CNA #9) Findings include: The Employee Records form and employee licenses were reviewed on 4/13/16 at 2:00 p.m. The form indicated CNA #9 began working at the facility on 6/11/15. The license for CNA #9 indicated her license as a Certified Nurse Aide expired on 7/25/15. An interview was conducted with the Director of Wellness on 4/14/16 at 11:50 a.m. She indicated CNA #9 was sent home on this day, due to her expired license, and the facility should follow state regulations regarding CNA certifications. The Administrator provided a statement on 4/14/16 at 12:10 p.m., indicating, "Since 7/27/15 (name of CNA #9) has worked an average of 32-40 hours a	R 0118	R118-Personnel- Deficiency Any unlicensed employee providing more than limited assistancewith the activities of daily living must be either a certified nurse aide or ahome health aide. Existing facilities that are not licensed on the date ofadoption of this rule and that seek licensure within one (1) year of adoptionof this rule have two (2) months in which to ensure that all employees in thiscategory are either a certified nurse aide or a home health aide 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficient practice? CNA #9 has a current and activecertification effective date of 4/15/16 with an expiration date of 7/25/17. 2.How will the facility identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken? All resident could be affected by this deficient practice. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice doesnot recur? A complete audit of all CNA certifications was	05/27/2016

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	week. She was on maternity leave for six weeks in Oct (October) - Nov (November) 2015."		completed and all CNAs have a current certification.Binders will be created for all licensed staff members with their licenses/certifications. Nurses and QMAs will be reminded of their renewal dates one month prior to renewal. CNAs will be kept in a binder according to month of renewal. CNAs will be reminded one month before renewal date. All licensed/certifiedstaff will be required to show proof of renewal, before their last day before renewal, to be able to continue working. Business Office Manager or designee will review monthly on an ongoing basis. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? Executive Directoror designee will monitor binders 1x week for 8 weeks, 1x every other week for 8weeks, and 1x month on an ongoing basis. Results will be reviewed in QA meetingmonthly. 5.Date of Compliance: 5/27/16	
R 0121 Bldg. 00	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,			

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	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 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 interview and record review, the facility failed to ensure timely second step tuberculin (tb) skin tests were completed for 2 of 5 employees whose personnel files were reviewed. (Cook #10 and CNA (Certified Nurse Aide) #11)	R 0121	R121-Personnel - Noncompliance A health screen shall be required for each employee of a facilityprior to resident contact. The screen shall include a tuberculin skin test,using the Mantoux method (5 TU, PPD), unless a previously positive reaction canbe documented. The result shall be	05/27/2016

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	Findings include: The Employee Records form and personnel files for Cook #10 and CNA #11 were reviewed on 4/13/16 at 2:00 p.m. The form indicated Cook #10 started working at the facility on 12/2/15, and CNA #11 started working at the facility on 3/4/16. The personnel file for Cook #10 included a form entitled Employee Health Screening/TB Testing. This form indicated her first tb test was given on 12/1/15 and her second test was given on 12/30/15. The form also indicated, "A second test administered between one and three weeks after the initial test is required..." The personnel file for CNA #11 included the form entitled Employee Health Screening/TB Testing. This form indicated her first tb test was given on 2/18/16 and her second test was given on 3/18/16. This form also indicated, "A second test administered between one and three weeks after the initial test is required..." An interview was conducted with the Director of Wellness on 4/13/16 at 3:05 p.m. She indicated there was no verification Cook #10 and CNA #11 had		recorded in millimeters of induration withthe date given, date read, and by whom administered. The facility must assurethe following: (1) At the time of employment, or within one (1) month prior toemployment, and at least annually thereafter, employees and nonpaid personnelof facilities shall be screened for tuberculosis. The first tuberculin skintest must be read prior to the employee starting work. For health care workerswho have not had a documented negative tuberculin skin test result during thepreceding twelve (12) months, the baseline tuberculin skin testing shouldemploy the two-step method. If the first step is negative, a second test shouldbe performed one (1) to three (3) weeks after the first step. The frequency ofrepeat testing will depend on the risk of infection with tuberculosis. (2) Allemployees who have a positive reaction to the skin test shall be required tohave a chest x-ray and other physical and laboratory examinations in order tocomplete a diagnosis. (3) The facility shall maintain a health record of eachemployee that includes reports of all employment-related health screenings. (4)An employee with symptoms or signs of active disease, (symptoms suggestive ofactive tuberculosis, including, but not limited to, cough, fever, night sweats,and	

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	their second step tb tests completed timely. The Mantoux Testing policy was provided by the Director of Wellness on 4/14/16 at 9:05 a.m. It indicated, "The second test should be performed one to three weeks later."		weight loss) shall not be permitted to work until tuberculosis is ruled out. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficient practice? No residents were identified to be affected by this deficient practice. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and whatcorrective action will be taken? All residents have the potential to be affected by this deficient practice. 3.What measures will be put into place or whatsystemic changes the facility will make to ensure that the deficient practicedoes not recur? A complete audit of all employees for TB testing was completed and all current employees have up todate TB tests. All first step TB skin tests will be given and read priorto beginning employment. Second step PPDs will be tracked by the DON or designee foreach calendar month and respective department directors will receive advancednotice of their respective personnel and be responsible to ensurecompliance. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? The Director	

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			ofNursing or designee will review the TB binder 1x per week for 8 weeks, 1x everyother week for 8 weeks and monthly on an ongoing basis. Results will be present in QA meeting monthly. 5.Date of Compliance: 5/27/16	
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the kitchen cooler and ice chest were kept in a cleanly manner. This had the potential to affect 95 of 95 residents in the facility. Findings include: A tour of the kitchen was conducted with the Dietary Manager (DM) on 4/13/16 at 11:30 a.m. The floor of the walk-in cooler was observed with debris, including a juice lid, onion peels, an orange, and a mini orange, underneath the racks of food. The DM indicated the cooler floors were cleaned once a month. The top of the ice chest was observed with a significant amount of a white, dry	R 0154	R154-Sanitationand Safety Standards - Deficiency The facility shall keep all kitchens, kitchenareas, common dining areas, equipment, and utensils clean, free from litter andrubbish, and maintained in good repair in accordance with 410 IAC 7-24. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficientpractice? No resident was named as being affected bythis deficient practice. 2.How will the facility identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken? All residents have the potential to beaffected by this deficient practice. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient	05/27/2016

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	looking substance, appearing to be limescale. The DM indicated it was lime scale. She indicated there was a cleaning schedule for wiping down equipment. On 4/14/16 at 9:05 a.m., the DM provided the A.M., and P.M., Cook Cleaning Lists. They indicated the kitchen was to be swept and mopped daily, and the cooler was to be cleaned out/organized weekly. The lists did not indicate cleaning of the ice chest. The Kitchen Cleaning policy was provided by the DM on 4/14/16 at 9:05 a.m. It indicated, "This policy is to ensure that all sanitation requirements are met regarding food service."		practicedoes not recur? Sweeping and mopping cooler was added tothe cleaning list in addition to cleaning/organizing, to make clears that it isincluded as cleaning. Cleaning and de-limingthe ice chest added to the PM cook's weekly cleaning. DietaryManager or designee will check daily to ensure that cleaning was completed onan ongoing basis. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assurance programwill be put in place? Executive Directoror designee will monitor the daily cleaning sheets 2x week for 8 weeks, 1x aweek for 8 weeks, and 1x every other week for 8 weeks. Results will be presented in QA meetingmonthly. 5.Date of Compliance: 5/27/16	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			

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	Based on interview and record, the facility failed to ensure admission and semi-annual weights were completed for 2 of 5 residents reviewed (Resident #12 & #16). Findings include: 1. The clinical record for Resident #16 was reviewed on 4/12/16 at 2:15 p.m. The diagnoses for Resident #16 included, but were not limited to, diabetes mellitus, chronic kidney disease, anxiety, and depression. Resident #16 was admitted on 2/22/16. No weights for Resident #16 were located in the clinical record. During an interview with the Assisted Living (AL) Coordinator, on 4/13/16 at 10:50 a.m., the AL Coordinator indicated the facility was unable to locate an admission weight for Resident #16. 2. The clinical record for Resident #12 was reviewed on 4/12/16 at 11:00 a.m. The diagnoses for Resident #12 included, but were not limited to: diabetes and chronic kidney disease. Resident #12 was admitted 1/2/15. A document, "Vitals Signs Record" indicated there was no admission weight obtained for Resident #12. It indicated	R 0216	R216-Evaluation – Noncompliance The scope and content of the evaluation shall be delineated in thefacility policy manual, but at a minimum the needs assessment shall include anevaluation of the following: (1) the resident's physical, cognitive, and mentalstatus. (2) The resident's independence in the activities of daily living. (3)The resident's weight taken on admission and semiannually thereafter. (4) Ifapplicable, the resident's ability to self-administer medications. (d) Theevaluation shall be documented in writing and kept in the facility. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficient practice? Weights were obtained for Residents #12 and#16 and documented in the clinical record. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to beaffected by this deficient practice. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practicedoes not recur? An in-service of all licensed personnelwill be conducted regarding proper procedure and recording of weights. The DON	05/27/2016

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GREENBRIAR VILLAGE	8800 SPOON DR INDIANAPOLIS, IN 46219

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	weights were obtained for Resident #12 on February 2015 and March 2015. There were no recorded weights for Resident #12 from April 2015 through March 2016. An interview was conducted with the Director of Wellness on 4/13/16. She indicated she is unable to locate any additional weights that were obtained for Resident #12. A policy, "HEALTH MONITORING AND INTERVENTIONS" was provided on 4/13/16 at 10:10 a.m. It indicated, "...Vital Signs...1. All Residents should be encouraged to have their vital signs taken once a month. This establishes a baseline for their health condition and enables the Wellness Director or their physician to more easily detect any changes from the baseline...2. On a monthly basis, the monthly vital sign readings for each Resident should be transferred to a Resident Vital Sign form. This form should be kept in the medication book behind the Resident's Medication Sheets and should be used to identify trends or changes in a Resident's condition (i.e.. weight loss or an increase in blood pressure)..."		or designee will monitor the weight log monthly and ensure that weights have obtained,documented and reweights obtained, documented and MD notified if indicated. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? Executive Director will review weight log 1x month for 6 months. Results will be presented in QA meeting monthly. 5.Date of Compliance: 5/27/16	

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to notify a physician of resident's blood sugars that were not within the parameters of the physician's orders for 2 of 5 residents records reviewed. (Resident #12) The facility also failed to ensure there was a Physician's order/notification to hold insulin for 1 of 5 residents reviewed. (Resident #89) Findings include: 1. The clinical record for Resident #16 was reviewed on 4/12/16 at 2:15 p.m. The diagnoses for Resident #16 included, but were not limited to, diabetes mellitus, chronic kidney disease, anxiety, and depression. Resident #16 was admitted on 2/22/16. An Individual Service Plan, dated March 2016, indicated a "current level of assistance...Resident receives accuchecks [blood glucose testing] daily...."	R 0240	R240- HealthServices - Deficiency Personalcare, and assistance with activities of daily living, shall be provided basedupon individual needs and preferences. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficientpractice? Physicians were all notified. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and whatcorrective action will be taken? All residents receiving glucose monitoring and/or those that are insulin dependent have the potential to be affected bythe deficient practice. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? The nursing staff will follow the parameterorders and notify the MD when blood sugar results fall within the parameters/call orders. The MD will be notified when an insulin	05/27/2016

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	A Physician's Order, dated 2/25/16, indicated blood glucose testing to be completed twice daily and to notify the Physician of a blood glucose reading less than 80 or greater than 240. The March 2016 MAR (medication administration record) indicated the following blood glucose results: 3/2/16 at 5:00 p.m.=300, 3/4/16 at 5:00 p.m.=386, 3/18/16 at 5:00 p.m.=276. The Capillary Blood Glucose Monitoring Tool indicated the following blood glucose results: 3/19/16 at 4 p.m.=253, 3/20/16 at 6 a.m.=262, 3/20/16 at 4 p.m.=242. Physician notification of the above blood glucose results was not located in the clinical record. During an interview with the Assisted Living (AL) Coordinator, on 4/13/16 at 12:40 p.m., she indicated the Physician was not notified of the above blood sugars as ordered. The AL Coordinator further indicated there was a printing error on the MAR that left off the parameters for notification. 2. The clinical record for Resident #89		dosage is helddue to low blood sugar and or declining meals. An in-service will be conducted regarding the expectation of notifyingMD's regarding blood glucose parameters and notifying MD's if results fallwithin the call orders of these parameters and any occasion of withholdinginsulin as a nursing measure due to low glucose level or declining meals. DON or designee willmonitor the Glucose Log/MAR weekly on an ongoing basis. All new MARS/rewrites will be reviewedprior to the first of the month to ensure that the parameters areincluded/continued. 4.How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? Executive Directoror designee will monitor Glucose Log/MAR 1x week x 8weeks, 1x every other week for 8 weeks and 1x monthly for 8 weeks.Results will be reviewed at QA meeting monthly. 5.Date of Compliance: 5/27/16	

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	was reviewed on 4/13/16 at 10:15 a.m. The diagnoses for Resident #89 included, but were not limited to, diabetes mellitus, hypertension, and dementia. A Physician's Order, dated 3/24/16, indicated an order to change Humalog (insulin) to 6 units three times a day with meals. The Capillary Blood Glucose Monitoring Tool indicated on 4/4/16 at 4:30 p.m., Resident #89's blood glucose was 80 with a handwritten note, "held insulin did not eat." The tool also indicated MD (medical doctor) notified "No." The March 2016 MAR (medication administration record) indicated on 4/12/16 at 5 p.m., a handwritten note, "insulin held-did not eat enough dinner...." A Progress Note, dated 4/12/16 at 5 p.m., indicated, "Insulin held-did not eat enough [symbol for at] dinner...." A Physician notification/order to hold insulin on 4/4/16 at 4/12/16 was not located in the clinical record. During an interview with the Director of Wellness, on 4/13/16 at 12:35 p.m., she indicated there was no Physician's			

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	Order/notification to hold insulin for Resident #89, if she did not eat enough at meals and the nursing staff should've called the Physician to receive an order to the hold the insulin. 3. The clinical record for Resident #12 was reviewed on 4/12/16 at 11:00 a.m. The diagnoses for Resident #12 included, but were not limited to: diabetes and chronic kidney disease. Resident #12 was admitted 1/2/15. A physician order dated, 4/8/15, indicated Resident #12's blood sugar was to be checked three times a day before meals. The staff was to notify the physician if Resident #12's blood sugar was less than 80 mg/dl (milligrams/deciliters) or greater than 350 mg/dl. A document, "Capillary Blood Glucose Monitoring Tool" indicated Resident #12's blood sugars were not within the parameters as ordered for the following days: 4/3/16 at 4:00 p.m. blood sugar 61 4/4/16 at 6:00 a.m. blood sugar 57 4/5/16 at 4:00 p.m. blood sugar 74 4/8/16 at 6:00 a.m. blood sugar 67 4/9/16 at 6:00 a.m. blood sugar 70 4/12/16 at 6:00 a.m. blood sugar 40 4/12/16 at 4:00 p.m. blood sugar 76 There was no documentation the			

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	physician was notified when Resident #12's blood sugars were less than 80 mg/dl. An interview was conducted with the Assisted Living Coordinator on 4/13/16 at 1:50 p.m. She indicated the staff should have notified the physician Resident #12's blood sugars that were less than 80 mg/dl. The staff should have documented on either the blood glucose monitoring tool, progress notes, or the back of the Medication Administration Record if he or she has notified the physician. The Assisted Living Coordinator indicated she was unable to locate documentation the staff notified the physician regarding Resident #12's blood sugars. A policy titled, Communicating with Resident Physicians, no date, was received from the Director of Wellness on 4/13/16 a 2:21 p.m. The policy indicated, "...7. Document in the Resident's Service Notes all contact with the Resident's Physician and/or office nurse 8. As needed, the Wellness Director/ED should communicate the following information with the physician and/or his/her nurse in a positive manner...The need for written orders for all treatments and/or medications...."			

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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 dispose of spoiled food in the refrigerator. This had the potential to affect 1 of 7 residents in the facility. (Resident #17) Findings include: A tour of the kitchen was conducted with the Dietary Manager (DM) on 4/13/16 at 11:30 a.m. Upon observation of the walk-in cooler, a bag of tortilla shells, located on the top shelf, were observed green in color. The shells had no printed expiration date, but had a date of 1/18 (no year) written in black marker on the outside of the bag. At this time, the DM indicated the 1/18 represented the date the tortillas shells	R 0273	R273 Foodand Nutritional Services - Deficiency All foodpreparation and serving areas (excluding areas in residents ' units) aremaintained in accordance with state and local sanitation and safe food handlingstandards, including 410 IAC 7-24. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficient practice? Resident #17 had a gluten free item perphysician order. The item was discarded and the resident was informed. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. 3.What measures will be put into place or whatsystemic	05/27/2016

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	were purchased. The DM removed the shells from the refrigerator, and indicated the shells were purchased for Resident #17, because she was on a special diet. On 4/14/16 at 9:05 a.m., the DM provided the A.M., Cook Cleaning List. It indicated the cooler was to be cleaned out and organized weekly. The list indicated this task was completed on 4/6/16. An interview was conducted with the DM on 4/14/16 at 9:55 a.m. She indicated she didn't think staff looked on the top shelf of the cooler when they last cleaned it. The Food Storage-refrigerated policy was provided by the Director of Wellness on 4/14/16 at 9:30 a.m. It indicated, "Dietary Staff will check expirations dates on prepackaged foods and discard as needed.		changes the facility will make to ensure that the deficient practicedoes not recur? Dietary Managerwill in-service staff on the process for checking the open dates and expirationdates of all food items in the cooler and using provided step stool to checkdated/opened/expired items on the top shelf. This process was added tothe AM and PM cook's cleaning schedule. Dietary Manager will check the fooddates when putting away stock on Monday and Thursday on an ongoing basis to ensure that any outdated items and ensurethat they have been removed. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? Executive Directoror designee will monitor the weekly cleaning log 1x week for 8 weeks, 1x a week every other week for 8 weeks and 1x a month for 8 weeks. Results will be reviewed at QA meetingmonthly. 5.Date of Compliance: 5/27/16	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that			

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	responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to maintain accurate documentation regarding blood sugar monitoring and insulin administration for 1 of 5 residents records reviewed. (Resident #12) Findings include: The clinical record for Resident #12 was reviewed on 4/12/16 at 11:00 a.m. The diagnoses for Resident #12 included, but were not limited to: diabetes and chronic kidney disease. A physician order dated, 4/8/15, indicated Resident #12's blood sugar was to be checked three times a day before meals. The staff was to notify the physician if Resident #12's blood sugar was less than 80 mg/dl (milligrams/deciliters) or greater than 350mg/dl. A physician order dated, 2/6/16, indicated the staff was to give Resident #12 humalog 100 units/milliliter by using a sliding scale of 150mg - 200mg = 4 units, 201mg - 250mg = 6 units, 251mg - 301mg = 8units, and greater than 300mg	R 0349	R349-Clinical Records - Noncompliance The facilitymust maintain clinical records on each resident. These records must bemaintained under the supervision of an employee of the facility designated withthat responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. 1.What corrective actions will be accomplished forthose residents who were found to have to been affected by the deficient practice? No negative outcomes were noted for Resident #12. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents receiving glucose monitoringand/or those that are insulin dependent have the potential to be affected bythis deficient practice. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? An in-service for licensed nurses will beconduced regarding accurate documentation of blood glucose	05/27/2016

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	= 10 units. A document titled, "Capillary Blood Glucose Monitoring Tool" indicated "Record each capillary blood glucose obtained, units of insulin given, and/or PRN (as needed) treatment. Notify MD (medical doctor) of all blood sugars as indicated by call orders or signs/symptoms of high or low blood sugar..." This glucose monitoring tool indicated boxes with the top row indicating the date, time, reading, units of SQ (subcutaneous) insulin, PRN treatment, MD(medical doctor) notified, and the nurse signature. The following are recorded dates, blood sugars and the amount of insulin given on the glucose monitoring tool: 3/1/16 - There was no recorded information, 3/27/16 - 6:00 a.m., no insulin amount recorded, and 11:00 a.m., no insulin amount recorded, 3/30/16 - 4:00 p.m., blood sugar 184mg recorded, The March 2016, Medication Administration Record (MAR), indicated the staff was to record Resident #12's blood sugars at 7:00 a.m., 11:00 a.m., and 4:00 p.m. The staff was to give Resident #12 humalog insulin using the sliding		results, amount ofinsulin administered and sites of insulin administration. The DON or designee will monitor the MARS's and documentationon a weekly basis for an ongoing basis to ensure accurate documentation. 4.How the corrective actions will be monitored toensure the deficient practice will not recur i.e. what quality assuranceprogram will be put in place? Executive Director or designee will monitor MARS and documentation 1x weekly x 8 weeks, 1x weeklyevery other week, and 1x monthly for 8 weeks. Results will be reviewed at QA meeting monthly. 5.Date of Compliance: 5/27/16	

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	scale at 9:00 a.m., 1:00 p.m., and 5:00 p.m. The staff was also to record the site used at each administration on the MAR using a numbered legend that identifies the part of the body used for the injection. The MAR indicated the following dates, times and blood sugars for Resident #12: 3/1/16 - 11:00 a.m., blood sugar 204mg, 4:00 p.m., blood sugar 250mg. 3/27/16 - 4:00 p.m., no recorded blood sugar. 3/30/16 - 4:00 p.m., blood sugar 174mg The following were recorded sites used to administer humalog insulin sliding scale: 3/1/16 - 1:00 p.m. - recorded site number 7, but no insulin amount documented, 5:00 p.m., recorded site number 8, but no insulin amount documented. 3/27/16 - 9:00 a.m., no site recorded, 1:00 p.m -no site recorded, 3/30/16 - 5:00 p.m., recorded 4 units - no site recorded. There was no documentation indicating the amount of insulin that was given on 3/1/16 on the MAR or glucose monitoring tool. There were insulin amounts recorded and no sites recorded on 3/27/16, and on 3/30/16 the blood sugar at 4:00 p.m., did not match on the MAR and the glucose monitoring tool, and it did not indicate the site used.			

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	An interview was conducted with the Assisted Living Coordinator on 4/13/16 at 9:30 a.m. She indicated Resident #12's MAR and "Capillary Blood Glucose Monitoring Tool" was documented inaccurately. She indicated staff would need to be educated on documentation.			