

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/11/2015
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NAME OF PROVIDER OR SUPPLIER  GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey.</p> <p>Survey dates: June 4, 5, 8, 9, 10, &amp; 11 2015.</p> <p>Facility number: 011187 Provider number: 155759 AIM number: 200838150</p> <p>Census bed type: SNF: 21 SNF/NF: 35 Residential: 27 Total: 83</p> <p>Census payor type: Medicare: 20 Medicaid: 24 Other: 12 Total: 56</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation or execution of this plan of correction does not constitute provider admission or agreement related to 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 State Law. The Plan of Correction is submitted in order to respond to the isolated deficiencies cited during Indiana State Department of Health Recertification and State Licensure survey June 11, 2015. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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 0154 SS=D Bldg. 00	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>Based on observation, interview and record review the facility failed to inform the residents and or family members of the side effects of anti-psychotic medications for 2 of 3 residents out of 5 residents who met the criteria for unnecessary medications.(Resident #86 &amp; #91)</p> <p>Findings include:</p> <p>1. Review of Resident #86's record on 6/8/15 at 9:45 a.m., indicated, diagnoses included but were not limited to, depression, coronary artery disease, edema, dementia, dry eyes and delusional disorder.</p> <p>Resident #86's Minimum Data Set(MDS) assessment dated, 6/6/15, indicated she was understood and had the ability to understand others.</p>			F 0154	<p><b>F154 INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENT</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #91 has been discharged. Resident #86 was provided education related to the antipsychotic medications she is currently taking.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents receiving an antipsychotic medication have the potential to be affected. The DHS or designee will review all residents with antipsychotic</p>		07/11/2015

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	<p>Physician's recapitulation orders dated 6/1/15 through 6/30/15, indicated Risperdal 0.25 milligrams(mg) at bedtime, was started on 3/2/15, for the diagnosis of delusional disorder.</p> <p>Review of Physician's progress notes since admission on 3/2/15, indicated no documentation of anti-psychotic medication review or monitoring.</p> <p>Review of nursing notes and social services notes since admission, indicated no documentation of resident or family members being educated on the side effects of anti-psychotic medications.</p> <p>An interview with the Social Services Director on 6/10/15 at 11:20 a.m., indicated "I spoke with the family in the care plan meeting related to side effects of her meds, but I did not document it."</p> <p>6/10/15 at 2:54 p.m., an interview with Resident #86 indicated, "no, nobody talked to me about Risperdal or any of the side effects, is that something I've been taking?"</p> <p>2. Review of Resident #91's record on 6/9/15 at 9:35 a.m., indicated, diagnoses included but were not limited to, pneumonia,dementia with Lewy Bodies,</p>		<p>medication ordered and ensure the resident and/or family member have been educated on the side effects of those medications.</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 Nursing Team on Psychotropic Medication Usage guidelines (Attachment A) and Psychotropic Medication Informed Consent (Attachment B).</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> All admissions and new medication orders will be reviewed during the Clinical Care Meeting five times weekly to ensure resident and family are provided education on the side effects of using anti psychotic medications. Audits (Attachment C) for five (5) residents will be completed by the DHS or designee two (2) times per week for eight (8) weeks; then monthly for five (5) months to ensure compliance.</p> <p>The results of the audit</p>		

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	<p>depression, hypertension, left hip fracture and atypical psychosis.</p> <p>Resident #91's Minimum Data Set(MDS) assessment dated, 5/12/15, indicated she was understood and had the ability to understand others.</p> <p>Physician's recapitulation orders dated 6/1/15 through 6/30/15, indicated, Seroquel 25 mg at bedtime for diagnosis of atypical psychosis, started 3/17/15.</p> <p>Review of Physician's progress notes since admission on 3/17/15, indicated no documentation of anti-psychotic medication review or monitoring.</p> <p>Review of nursing notes and social services notes since admission, indicated no documentation of resident or family members being educated on the side effects of anti-psychotic medications.</p> <p>An interview on 6/10/15 at 11:25 a.m., with Social Services Director indicated, Resident #91's "daughter fills the resident's medications from an outside pharmacy and flyers related to the side effects are with the medication, we have talked about Seroquel, but I did not document the conversation. The resident was on Seroquel before she came here, I'm sure someone prior to her admission</p>		<p>observations will be reported, reviewed and trended for compliance through the campus Quality Assessment and Assurance Committee for 6 months then randomly thereafter for further recommendation.</p>		

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	<p>here informed the resident and her family."</p> <p>On 6/10/2015, 2:48 p.m., indicated, "no, I was not informed about any side effects of Seroquel."</p> <p>Review of a document provided by the Director of Health Services on 6/10/15 at 4:16 p.m., titled "Guidelines for Psychotropic Medication Usage and Gradual Dose Reductions indicated, Purpose: To ensure every effort is made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team. Definition: Psychotropic medications include: anti-anxiety/hypnotic, anti-psychotic. Procedure: 1. Residents shall receive psychotropic medications only if designated medically necessary by prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process. 2. Regular review for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident..."</p>			

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F 0280 SS=D Bldg. 00	<p>3.1-3(n)(2) 3.1-4(c)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure care plans were revised after a change in the resident's ambulatory status. This affected 2 of 15 reviewed for care plan revisions. (Resident #90 and Resident #110)</p> <p>Findings include:</p> <p>1. On 6/08/2015 at 1:49 p.m., Resident</p>	F 0280	<p><b>F 280 PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #90 &amp; #110 care plan interventions were reviewed and updated to reflect the current ambulation status.</p>	07/11/2015

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	<p>#90 was observed lying in bed and wore a t-shirt and sweat pants. The sweat pants were folded below both knees where his legs had been amputated. Resident #90 was alert, oriented, and able to make himself understood.</p> <p>Resident #90's record was reviewed on 6/08/2015 at 1:53 p.m. The record indicated Resident #90 had diagnoses that included, but were not limited to, end stage kidney disease, diabetes mellitus, high blood pressure, neuropathy, right and left below the knee amputation, and respiratory failure.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 2/26/15, indicated Resident #90 was cognitively intact - made decisions that were consistent and reasonable in cognitive skills for daily decision making, was transferred with extensive assistance of 2 or more staff, and did not walk.</p> <p>A care plan for activities of daily living (ADL's), last reviewed on 6/2/15, indicated, but was not limited to: "...I am at risk for falls due to generalized weakness from ESRD (end stage renal disease) [with] dialysis. My goal is to have no falls through the next review. Please remind me to use my call lite before getting up. I should use my</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 DHS or designee will review and update all care plan interventions related to the resident's current ambulation status.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The DHS or designee will educate the Interdisciplinary Care Plan Team on the Interdisciplinary Team Care Plan guidelines (Attachment D).</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b>Care Plans will be reviewed during the Clinical Care Meeting five times weekly to ensure residents are participating in planning and changing care and treatment. Audits (Attachment C) for five (5) residents will be completed by the DHS or designee two (2) times per week for eight (8) weeks; then monthly for five (5) months to ensure compliance.</p>	

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	<p>walker when walking...Please keep my room free of clutter. I need appropriate footwear on when up...I am weak and need assistance with my ADL's: bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene, and bathing. At present I require total assist for my care...."</p> <p>On 6/09/2015 at 1:14 p.m., Resident #90 was observed seated in his wheelchair eating lunch. He was alert and oriented and indicated his goal was to have a prosthesis made so he can learn to walk again and go home.</p> <p>During an interview, on 6/10/2015 at 3:16 p.m., the MDS coordinator indicated the footwear and walker shouldn't be on the care plan and that his care plan was not updated since he is no longer walking.</p> <p>2. Resident #110's record was reviewed on 6/08/2015 at 10:01 a.m. The record indicated Resident #110 had diagnoses that included, but were not limited to; stroke, weakness affecting the left side, difficulty walking, muscle weakness, speech/language deficit, high blood pressure, back pain, and debility.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/1/15, indicated</p>		<p>The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assessment and Assurance Committee for 6 months then randomly thereafter for further recommendation.</p>	

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	<p>Resident #110 was cognitively intact; decisions consistent/reasonable in cognitive skills for daily decision making, was transferred with extensive assistance of 2 or more staff, and did not walk.</p> <p>A care plan, with a last review date of 6/5/15, indicated: "...Walk in hall: Non ambulatory. Hoyer lift for all transfers. I am at risk for falls due to generalized weakness. My goal is to have no falls through the next review. Please remind me to use my call lite before getting up. I should use my walker when walking...Please keep my room free of clutter. I need appropriate footwear on when up...Report any falls to my doctor and family. 2/3/15 two assist with transfers. 2/8/15 use gait belt with all transfers. I am weak and need assistance with my ADL's: bed mobility, transfers, walking, locomotion, dressing, toilet use...."</p> <p>On 6/10/2015 at 11:30 a.m., Resident #110 was observed being transferred from her bed to a wheelchair, then taken into the bathroom and transferred to the commode. CNA #3 and CNA #2 assisted Resident #110 using a gait belt. Resident #110 was able to stand with 2 assists and bear weight, and was not observed to move her legs or walk.</p>			

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F 0309 SS=D Bldg. 00	<p>During an interview, on 6/10/15 at 3:16 p.m., the MDS coordinator indicated when Resident #110 first came in, she was using a walker, and the information in the care plan about the walker should have been removed as she no longer uses a walker. She said Resident #110 does have times when she needs to use the hooyer lift; like at the end of the day when she is "so tired she can't help us", but during the day she can be transferred with 2 persons and a gait belt.</p> <p>On 6/10/15 at 1:00 p.m., the Director of Health Services provided a policy for "Guidelines for Care Plan Development", with an effective date of 6/2013. The policy indicated, but was not limited to, "Purpose: To ensure care plans are developed to communicate resident preferences and care needs...7. The care plan shall be updated as preferences and needs change...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to monitor a resident's shunt (artificial passage used for dialysis residents to access blood flow) for 1 of 1 resident's reviewed for dialysis (Resident #101).</p> <p>Finding include:</p> <p>Interview with Resident #101 on 6/8/15 at 9:15 a.m., indicated he had been on receiving dialysis (artificial process to clean the blood of waste) for over a year.</p> <p>Review of the record of Resident #101 on 6/9/15 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, end-stage renal disease, coronary artery disease, congestive heart failure, myocardial infarction, angina, hypertension, diabetes, weakness, debility and obesity.</p> <p>The physician recapitulation dated June 2015, Resident #101 was ordered to receive hemodialysis on Monday, Wednesday and Friday.</p> <p>Interview with RN #1 on 6/10/15 at 10:25 a.m., indicated Resident #101 did not have an assessment of his shunt on</p>	F 0309	<p><b>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The medical record of resident #101 was reviewed to ensure daily assessment of the shunt is documented.</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 DHS or designee will review the medical record of all residents and identify residents receiving dialysis services.</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 on the Monitoring Shunt: Hemodialysis Arteriovascular Access (AV)</p>	07/11/2015

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	<p>the Medication Administration Record or the Treatment Administration Record for June 2015. RN #1 indicated that is where the facility usually documented the assessment for dialysis residents with shunts.</p> <p>Review of Resident #101's record indicated no documentation of the resident's shunt for the following dates: 5/14/15, 5/18/15,5/19/15, 5/20/15, 5/23/15, 5/25/15, 5/27/15, 5/31/15, 6/1/15, 6/2/15, 6/3/15, 6/4/15, 6/5/15, 6/6/15, 6/8/15 &amp; 6/9/15. Requested from the facility for any documentation for these dates of an assessment for the resident's shunt.</p> <p>Interview with the Assistant Director of Health Services (ADHS) on 6/10/15 at 12:30 p.m., indicated she was unable to find assessments for Resident #101's shunt for 5/14/15, 5/18/15,5/19/15, 5/20/15, 5/23/15, 5/25/15, 5/27/15, 5/31/15, 6/1/15, 6/2/15, 6/3/15, 6/4/15, 6/5/15, 6/6/15, 6/8/15 &amp; 6/9/15.</p> <p>During observation on 6/10/15 at 10:55 a.m., RN #1 assessed Resident #101's shunt in the right arm with a stethoscope she listened for a bruit and indicated she heard a swoosh and felt for thrill and indicated it was present. RN #1 indicated the resident's skin felt normal and had no</p>		<p>(Fistula, Graft or Central Venous Catheter) guidelines (Attachment E).</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The medical record of residents receiving dialysis will be reviewed during the Clinical Care Meeting five times weekly to ensure there is daily assessment of the shunt. Audits (Attachment C) for five (5) residents will be completed by the DHS or designee two (2) times per week for eight (8) weeks; then monthly for five (5) months to ensure compliance.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assessment and Assurance Committee for 6 months then randomly thereafter for further recommendation.</p>	

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	<p>redness. RN #1 applied lidocaine 2.5% on shunt site and wrapped the resident's arm with plastic wrap. RN #1 indicated this was done before his dialysis appointment to numb the shunt site.</p> <p>The guidelines for monitoring shunt policy provided by the Director Of Health Services (DHS) on 6/10/15 at 9:50 a.m., indicated the purpose was to effectively provide monitoring of vascular access utilized for hemodialysis. The facility was to monitor the shunt daily for "redness, swelling, signs and or symptoms of infections, complaints of pain, local warmth, exudate, tenderness, numbness, tingling, extremity swelling distal to access, list not all inclusive". The shunt will be monitored daily for thrill and bruit. The "thrill- is done by touch, "bruit-sound via stethoscope "whooshing sound" (if sound changes to a whistle like sound it could indicate a clot and narrowing." "If this occurs, notify physician." Document assessment findings in resident medical record nursing notes and or in designated area on treatment administration record (TAR)." "If abnormal bleeding is noted apply pressure to area and call 911 for transfer to the hospital."</p> <p>3.1-37(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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F 0329 SS=D Bldg. 00	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</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 observation, interview and record review the facility failed to provide documentation and monitoring for the continued use of an anti-psychotic medication for 2 of 3 residents reviewed for unnecessary medications out of 5 who met the criteria.(Resident #86 &amp; #91)</p> <p>Findings include:</p> <p>1. Review of Resident #86's record on 6/8/15 at 9:45 a.m., indicated, diagnoses</p>	F 0329	<p><b>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUG</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> A request to the physician for resident #86 to review their anti-psychotic medication for Gradual Dose Reduction (GDR) or to support clinical contraindication for GDR</p>	07/11/2015

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	<p>included but were not limited to, depression, coronary artery disease, edema, dementia, dry eyes and delusional disorder.</p> <p>Resident #86's Minimum Data Set(MDS) assessment dated, 6/6/15, indicated she was understood and had the ability to understand others.</p> <p>Physician's recapitulation orders dated 6/1/15 through 6/30/15, indicated Risperdal 0.25 milligrams(mg) at bedtime, was started on 3/2/15, for the diagnosis of delusional disorder.</p> <p>Review of Physician's progress notes since admission on 3/2/15, indicated no documentation of anti-psychotic medication review or monitoring.</p> <p>On 6/9/15, at 2:30 p.m., review of "Mood and Behavior Report" indicated Resident #86 had no mood or behavior problems since her admission.</p> <p>2. Review of Resident #91's record on 6/9/15 at 9:35 a.m., indicated, diagnoses included but were not limited to, pneumonia,dementia with Lewy Bodies, depression, hypertension, left hip fracture and atypical psychosis.</p> <p>Resident #91's Minimum Data Set(MDS)</p>		<p>will be completed. Resident #91 has been discharged.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents receiving an antipsychotic medication have the potential to be affected. The DHS or designee will review the medical record of all residents and pharmacy consultant reports to identify unnecessary drug regimens.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The DHS or designee will educate the IDT Team and Licensed Nurses on Psychotropic Medications Usage and Gradual Dose Reduction guidelines (Attachment F).</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The medical record of residents will be reviewed during the Clinical Care Meeting five times weekly to monitor for unnecessary drug regimens and referrals to the physician for Gradual Dose Reduction. Audits (Attachment C) for five (5) residents will be completed by the</p>				

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	<p>assessment dated, 5/12/15, indicated she was understood and had the ability to understand others.</p> <p>Physician's recapitulation orders dated 6/1/15 through 6/30/15, indicated, Seroquel 25 mg at bedtime for diagnosis of atypical psychosis, started 3/17/15.</p> <p>Review of Physician's progress notes since admission on 3/17/15, indicated no documentation of anti-psychotic medication review or monitoring.</p> <p>On 6/9/15 at 2:45 p.m., review of "Mood and Behavior Report" indicated Resident #91 had no mood or behavior problems since her admission.</p> <p>Review of a document provided by the Director of Health Services on 6/10/15 at 4:16 p.m., titled "Guidelines for Psychotropic Medication Usage and Gradual Dose Reductions indicated, Purpose: To ensure every effort is made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team. Definition: Psychotropic medications include: anti-anxiety/hypnotic, anti-psychotic. Procedure: 1. Residents shall receive psychotropic medications</p>		<p>DHS or designee two (2) times per week for eight (8) weeks; then monthly for five (5) months to ensure compliance.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assessment and Assurance Committee for 6 months then randomly thereafter for further recommendation.</p>	

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F 0514 SS=D Bldg. 00	<p>only if designated medically necessary by prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process. 2. Regular review for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident..."</p> <p>3.1-48(a)(3)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure a resident's inventory sheet was completed upon admission and discharge for 1 of 1</p>	F 0514	<b>F514 RESIDENT RECORDS - COMPLETE/ACCURATE/ACCE SSIBLE Corrective actions accomplished for those residents found to be affected by the alleged deficient</b>	07/11/2015			

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	<p>resident reviewed for complete and accurate records related to death. (Resident #89)</p> <p>Findings include:</p> <p>Resident #89's record was reviewed on 6/09/2015 at 1:53 p.m. The record indicated Resident #89 was admitted on 1/31/15 and was discharged on 2/20/15.</p> <p>Resident #89's inventory sheet was not filled out upon admission nor discharge, and was not signed by the family, resident nor a facility witness on admission or discharge.</p> <p>During an interview, on 6/10/2015 at 3:38 p.m., the Director of Health Services indicated Resident #89 did not have another inventory sheet, the CNA's are responsible for filling out the inventory sheets upon admission, and the family signs upon discharge.</p> <p>A document titled "Guidelines for Admission Audit Checklist" was provided by the Executive Director on 6/10/15 at 4:09 p.m. The document included, but was not limited to, "Purpose: To provide a mechanism to ensure all required admission tasks have been completed. Procedure: 1. New admission medical records will be</p>		<p><b>practice:</b> Resident #89 has been discharged. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents in facility have the potential to be affected by the same deficient practice. An audit of residents will be completed utilizing the Admission Audit Checklist (Attachment G) to ensure personal inventory sheets are complete. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> All nursing staff will be educated on resident record guidelines personal property and inventory at admission and discharge (Attachment H). <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Medical Records Director or designee will audit the personal inventory sheets of discharges and new admissions weekly to ensure completion. Audits (Attachment C) will be completed weekly for eight (8) weeks; then monthly for five (5) months to ensure compliance. The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assessment and Assurance Committee for 6 months then randomly thereafter for further recommendation.</p>	

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	<p>reviewed within 72 hours. 2. The Admission Audit Checklist should be utilized to review each admission task has been initiated and/or completed as required...5. Any areas of deficiency should be completed as soon as possible." A section of the "New Admission Chart Audit Checklist" indicated "Inventory - Inventory of personal items completed?" and had a section for "Yes", "No", and "Comment".</p> <p>A Policy and Procedure for "Guidelines for Medical Records Clinical Documentation", with an effective date of 9/25/14, was provided by the Executive Director on 6/10/15 at 4:09 p.m. The policy indicated, but was not limited to, "I. Policy Guidelines: The campus shall maintain a complete, ongoing, and organized resident record on each resident from the time of admission until termination of the resident's stay at the campus...The resident record complies with federal law, state law, professional standards of practice, and facility policy...."</p> <p>During an interview, on 6/10/2015 at 4:27 p.m., the Executive Director indicated they could not find a "New Admission Chart Audit Checklist" for Resident #89.</p>			

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R 0000  Bldg. 00	<p>3.1-50(a)(1) 3.1-50(j)(2)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 27</p> <p>Sample:7</p> <p>Glen oaks Health Campus was found to be compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000	<p>Preparation or execution of this plan of correction does not constitute provider admission or agreement related to 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 State Law. The Plan of Correction is submitted in order to respond to the isolated deficiencies cited during Indiana State Department of Health Recertification and State Licensure survey June 11, 2015. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>		