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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00103830. Complaint IN00103830 - Substantiated. State residential deficiency related to the allegation is cited at R0089. Survey dates: February 13, 14, 15, 16, & 17, 2012 Facility number: 010667 Provider number: 010667 AIM number: N/A Survey team: Vicki Manuwal, RN-TC Susan Bruck, RN Bobbie Costigan, RN (2/13, 2/14, 2012) Census bed type: Residential 36 Total: 36 Census payor type: Other 36 Total: 36 Sample: 7 Supplemental sample: 3 These state residential findings are cited	R0000	**The following is the Plan of Correction with addendum for Sterling House of South Bend in regards to the Statement of Deficiencies for the annual survey and complaint surveys completed on 2-17-2012, and the addendum request received on 3-13-12. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.**	

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.

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in accordance with 410 IAC 16.2. Quality review completed 2/24/12 by Jennie Bartelt, RN.			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0029	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on observation, interview and record review, the facility failed to ensure dignity was maintained for 1 of 7 residents in a sample of 7 reviewed for a dignified dining experience. Resident # 16 Findings include: The clinical record for Resident #16, reviewed on 2/12/12 at 11:45 A.M., indicated diagnoses of, but not limited to: terminal diagnosis of dementia, hypertension, venous insufficiency, and anxiety. During lunch meal observation on 2/13/12 at 12:20 P.M., CNA # 1 was observed standing beside Resident # 16 feeding her applesauce. A second observation on 2/16/12 at 12:35 P.M., CNA # 1 was observed standing while feeding Resident #16 several bites of her lunch meal. During interview on 2/16/12 at 3:20 P.M., the Health Wellness Director indicated the staff are to sit while feeding residents.	R0029	**R 029 410 IAC 16.2-5-1.2 (d) Resident Rights-Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · C.N.A. # 1 has received corrective action and re-education on the appropriate procedure for maintaining resident dignity while providing assistance with meals. · Resident #16: Personal Service Plan and Care Profile have been updated to include the appropriate procedure for assisting this resident with meals. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents who require mealtime assistance of caregivers have the potential to be affected by the alleged deficient practice, but an audit completed by the HWD revealed no additional residents at this time.· For this reason, caregivers have been re-educated by the Executive Director Designee/ Health and Wellness Director on resident rights, dignity, and the expectations regarding provision of assistance to residents who	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			require dining assistance. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Residents who require caregiver assistance have had their Personal Service Plans and Care Profiles updated to include the appropriate instructions for dining assistance to be provided with dignity. · An audit tool was developed for use by community managers/designees to document observations and corrective actions taken regarding the above issue. · A community manager/designee will be assigned on a rotating basis to audit the dining room for compliance. All three meals will be audited daily by a manager/designee for 30 days, then daily in an ongoing manner. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Community managers will report audit findings to the Health and Wellness Director/Designee on a daily basis. · Results of these audits are to be provided to the Executive Director/Designee on a weekly basis. · In the event deviations from expectations are noted, the manager will be authorized to immediately counsel associates and correct any issues identified that may	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			impact the resident's experience with the dining process. ***By what date will these systemic changes be implemented?*** · 3-16-12	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify the physician of medications not being available for 1 of 7 residents (Resident # 29) in a sample of 7 and 1 of 3 residents (Resident # 28) in a supplemental sample of 3 reviewed for physician notification. Findings include: 1. The clinical record for Resident # 28, reviewed on 2/14/12 at 11:40 A.M., indicated diagnoses of, but not limited to: Lewy Body Disease, reflux esophagitis, and hypertension. A physician order, dated 1/14/12, indicated, "...Tylenol c (with) Codeine #3 - 1 p.o. qd BID... Colace 100 mg 1 po qd..." Review of January 2012 MAR indicated Resident # 28 did not receive the scheduled Tylenol with Codeine #3 on the	R0036	**R 036 410 IAC 16.2-5-1.2 (k) (1-2) Resident Rights Deficiency** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident # 28: Physician was notified of the need to provide a legal prescription for the pharmacy in order to obtain the controlled substance. This prescription was then provided to pharmacy and the meds were administered as ordered. The Pharmacy, responsible party and physician have been notified of the missed medications due to meds unavailable. · Resident # 29: The Pharmacy, responsible party and physician have been notified of the missed medication on 1-11-12 and 1-12-12 by the Health and Wellness Director/Designee. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents who require medication administration services have the potential to be affected by the alleged deficient practice. · For this reason, nurses have	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following dates: 1/18/12 at 8:00 A.M. and 8:00 P.M. 1/19/12 at 8:00 A.M. and 8:00 P.M. 1/20/12 at 8:00 A.M. and 8:00 P.M. 1/21/12 at 8:00 A.M. and 8:00 P.M. 1/22/12 at 8:00 A.M. and 8:00 P.M. 1/23/12 at 8:00 A.M. and 8:00 P.M. 1/24/12 at 8:00 A.M. and 8:00 P.M. 1/25/12 at 8:00 A.M. and 8:00 P.M. 1/26/12 at 8:00 A.M. and 8:00 P.M. 1/27/12 at 8:00 A.M. The January 2012 MAR further indicated, "...1/17/12 Tylenol w (with) codeine 8 A.M. not available...1/18/12 Tylenol w codeine 8 P.M. not available...1/19/12 Tylenol c (with) codeine 8 P.M. not available - pharmacy did not deliver yet...1/20/12 Tylenol c codeine 8 P.M. med (medication) unavailable...1/21/12 Tylenol c codeine 8 P.M. unavailable pharmacy aware...1/22/12 Tylenol c codeine...unavailable pharmacy aware...1/24/12 Tylenol c codeine 8 P.M. pharmacy aware med O (not) available...1/25/12 Tylenol c codeine 8 P.M. pharmacy aware med O available...1/26/12 Tylenol c codeine 8 P.M. pharmacy aware med O available...." The clinical record lacked documentation of physcian notification of the above medication not being administered as		been re-educated on Medication Administration and the process for handling medications when not available. · This training has been provided by the Health and Wellness Director/Designee. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · A Medication Administration Record audit will be completed on each shift by the nurse responsible for medication administration to audit for medications not available. · These audits will be documented on the Change of Shift form for controlled substances . **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Health and Wellness Director/Designee will be responsible for reviewing the audit tool 3 x weekly, and taking corrective action where indicated. · Results of audits will be available for ED/Designee review on a weekly basis. ***By what date will these systemic changes be implemented?*** · 3-16-12	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ordered. During interview on 2/15/12 at 10:30 A.M., the Health Wellness Director indicated she would need to do some follow up as to why Resident # 28 did not receive his medications as ordered by the physician. 2. The clinical record for Resident # 29, reviewed on 2/15/12 at 1:45 P.M., indicated diagnoses of, but not limited to: dementia, transient cerebral ischemia, hypothyroidism and osteoporosis. A physician order dated, 12/10/11, indicated, "...Aricept 5 mg 1 tab (tablet) po qd..." Review of January 2012 MAR indicates resident did not receive the scheduled Aricept on 1/11/12 and 1/12/12. The January 2012 MAR further indicated "...1/11/12 Aricept unavailable pharmacy aware...1/12/12 Aricept on order...." The clinical record lacked documentation of physician notification of the above medications not being administered as ordered. During interview on 2/15/12 at 10:50 A.M., LPN # 2 indicated if a medication			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	is not given to a resident for any reason, an explanation would be written on back of MAR. Review of a facility policy titled "BAIRS (Brookdale Automated Incident Reporting System)Incident Reporting Policy", dated April 1, 2010, indicated, "...In the event that a resident...experiences an occurence such as, but not limited to:...medication error...In most cases, the nurse, the physcian and the resident's emergency contact should be notified of reported incidents..."			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0089	410 IAC 16.2-5-1.3(e)(1-2)(f) Administration and Management - Noncompliance (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. Based on record review and interview, the facility failed to ensure a full time administrator was available to oversee the daily operations of the facility after the previous administrator vacated the position. This deficient practice had the potential to affect 36 of 36 residents who reside in the facility. Findings include: Upon entrance of the facility on 2/13/12 at 10:45 A.M., the Health Wellness Director (HWD) indicated the administrator was not available. She further indicated she would need to contact her backup. During interview on 2/13/12 at 11:55 A.M., the HWD indicated (Name of previous Administrator) was no longer here and he has been gone since	R0089	**R 089 410 IAC 16.2-5-1.3 (e) (1-2) Administration and Management - noncompliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · No residents were cited as affected by the alleged noncompliant practice. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · The state of Indiana was notified in writing on 12-22-11, that the previous Executive Director was no longer employed at the community. As required by the regulation, the letter further informed the state of its active recruiting process, as well as giving the name, in writing, of the individual authorized to act on the administrator's behalf. · Residents and family members were provided notification in a timely manner, and another Brookdale administrator was available 24/7 in the	03/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	December (2011). She further indicated there is an Interim Administrator. On 2/14/12 at 1:45 P.M., the Interim Administrator introduced herself and indicated she was helping out here. During daily exit on 2/14/12 at 3:45 P.M., the Interim Administrator indicated she is the Administrator of a sister facility. Review of a facility letter received on 2/15/12 at 4:15 P.M., addressed to the Indiana State Department of Health, dated 12/22/11, indicated, "...This letter is to advise you of a change in administrator effective December 22, 2011 for Sterling House of South Bend.... (Name of previous Administrator) will no longer serve as administrator. We are actively recruiting for this position. (Name of Director of Marketing), Director of Marketing and (Name of Interim Administrator), an Indiana Administrator, currently working at a sister community will oversee Sterling House of South Bend until such time another administrator is hired...." During interview with the HWD on 2/16/12 at 9:40 A.M., she indicated the Director of Marketing does not have an administrator's license. She further indicated the Interim Administrator is		event there was a need. · Brookdale provides a 24/7 contact number for visitors, associates or residents to call in the event there is a concern. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · The community has hired a new Executive Director, and a letter has been sent to the state advising them of the name and official start date (March 12, 2012) for the licensed administrator. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The community will continue to inform the state of any changes in administrator in an ongoing manner. ***By what date will these systemic changes be implemented?*** · 3-12-12	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	typically present in the facility on Mondays and Fridays. Interview on 2/16/12 at 3:20 P.M., the Director of Marketing indicated she does not have a provisional administrator's license. She further indicated she is not currently an administrator in training.			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure the required fire drills were conducted on each shift once per quarter as required. This deficient practice had the potential to effect 36 of 36 residents who reside in the facility. Findings include: Review of the facility conducted fire drill log received on 2/13/12 at 12:00 P.M., indicated fire drills were conducted on the	R0092	**R 092 410 IAC 16.2-5-1.3 (i) (1-2) Administration and Management-Noncompliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · No residents were cited as affected by the alleged noncompliant practice ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?***	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP CODE 17441 SR 23 SOUTH BEND, IN 46635	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	following days: First Quarter 2011 There was no record available of the January or February, 2011, fire drills. 3/31/11 12:55 A.M. - night shift Second Quarter 2011 4/25/11 3:00 P.M. - evening shift 5/22/11 3:40 P.M. - evening shift 6/23/11 9:20 A.M. - day shift Third Quarter 2011 7/28/11 10:30 P.M. - evening shift 8/10/11 4:00 A.M. - night shift 9/30/11 4:00 A.M. - night shift Fourth Quarter 2011 10/15/11 11:00 A.M. - day shift 11/12/11 10:30 A.M. - day shift 12/26/11 10:30 A.M. - day shift First Quarter 2012 1/31/12 10:30 A.M. - day shift During interview with the Interim Administrator on 2/17/12 at 11:15 A.M., she indicated she implemented a rotating fire drill schedule in January as part of her		· Residents and associates may have the potential to be affected by the alleged non-compliant practice. · The Maintenance Tech has been re-educated on the existing policy and procedure for completion of fire drills on each shift at least quarterly. · Community associates have also been provided re-education on Fire Drills and Fire Safety. · The above re-education was provided by the ED Designee. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · A rotating fire drill schedule was implemented in January 2012 as part of its ongoing Quality Improvement process. · This information was presented to the surveyor at the time of the survey for review. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Executive Director/Designee will audit the Fire Drill Documentation on a monthly basis, and will schedule additional drills, if warranted, to meet policy guidelines and ensure fire safety preparedness for the community. ***By what date will these systemic changes be implemented?*** · 3-16-12	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	QI (quality improvement) because maintenance was not aware of the regulation. During interview on 2/17/12 at 11:35 A.M., the HWD (Health Wellness Director) indicated the day shift is from 6:00 A.M. to 2:00 P.M., evenings 2:00 P.M. to 10:00 P.M., and nights 10:00 P.M. to 6:00 A.M.			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure physician prescribed medications were available and administered as ordered by the physician for 1 of 7 residents (Resident # 29) in a sample of 7 and 1of 3 residents (Resident #28) in a supplemental sample of 3 and failed to assess the resident's blood pressure and pulse to determine the need for the medication as ordered by the physician for 1 of 3 residents (Resident # 11) in a supplemental sample of 3 reviewed related to following physician's orders for medications. Findings include: 1. The clinical record for Resident # 28, reviewed on 2/14/12 at 11:40 A.M., indicated diagnoses of, but not limited to: Lewy Body Disease, reflux esophagitis, and hypertension. A physician's order, dated 10/17/11, indicated, "...Ativan 0.5 mg (milligram) 1 p.o. (by mouth) qd (every day) BID (twice	R0241	**R 241 410 IAC 16.2-5-4 (e) (1) Health Services - Offense** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident # 28: Medications were obtained from the pharmacy and initiated as ordered. The physician, responsible party, and pharmacy were notified of the issue.· Resident # 29: Medications were obtained from the pharmacy and initiated as ordered. The physician, responsible party, and pharmacy were notified of the issue· Resident #11: The Resident Medication Administration Record has been updated to include clarification of physician orders obtained by the licensed nurse. In this resident's case, the physician has discontinued orders for daily blood pressure and pulse checks and the new order is to obtain vital signs on a monthly basis only. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient***	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily) ... Ambien 5 mg 1 po q (every) HS (bedtime)..." Review of the October 2011, MAR (Medication Administration Record) indicated Resident # 28 did not receive the scheduled Ativan on the following dates: 10/18/11 at 5:00 P.M. 10/19/11 at 9:00 A.M. and 5:00 P.M. 10/20/11 at 9:00 A.M. and 5:00 P.M. 10/21/11 at 9:00 A.M. and 5:00 P.M. The October 2011, MAR further indicated, "...10/18 - 5 P.M....Ativan 0.5 mg (milligrams)...unavailable...10/19 - 5 P.M....Ativan 0.5 mg...unavailable...10/20 - 5 P.M....Ativan 0.5 mg...unavailable..." Further review of the October 2011 MAR further indicated Resident #28 did not receive the scheduled Ambien on the following dates: 10/18/11 10/19/11 10/20/11 10/21/11 The October 2011, MAR further indicated, "...10/18 - 8 P.M....Ambien...med (medication) unavailable...10/20 - 8		***practice and what corrective action will be taken?*** · Residents who receive medication administration services have the potential to be affected by the alleged deficient practice. For this reason, all Medication Administration Records were audited for unavailable medications and undocumented vital signs, with no new residents identified with this issue.· Nurses have been re-educated on the appropriate process for handling of "unavailable" medications, including documentation of all attempts to contact the physician, responsible party, or pharmacy when meds are noted to be unavailable for any reason. This re-education was provided by the Health and Wellness Director/Designee.· A pharmacy representative has met with the ED Designee/Health and Wellness Director to address timely provision of medications, as well as communication to physicians, when physicians are required to provide a signed prescription for controlled substances. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · In order to identify situations where medications are unavailable, a Medication Administration Record audit will be completed on each shift	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M....Ambien...med unavailable...10/21 - 8 P.M....Ambien...on order..." A physician order, dated 1/14/12, indicated, "...Tylenol c (with) Codeine #3 - 1 p.o. qd BID... Colace 100 mg 1 po qd..." Review of January 2012, MAR indicated Resident # 28 did not receive the scheduled Tylenol with Codeine #3 on the following dates: 1/18/12 at 8:00 A.M. and 8:00 P.M. 1/19/12 at 8:00 A.M. and 8:00 P.M. 1/20/12 at 8:00 A.M. and 8:00 P.M. 1/21/12 at 8:00 A.M. and 8:00 P.M. 1/22/12 at 8:00 A.M. and 8:00 P.M. 1/23/12 at 8:00 A.M. and 8:00 P.M. 1/24/12 at 8:00 A.M. and 8:00 P.M. 1/25/12 at 8:00 A.M. and 8:00 P.M. 1/26/12 at 8:00 A.M. and 8:00 P.M. 1/27/12 at 8:00 A.M. The January 2012, MAR further indicated, "...1/17/12 Tylenol w (with) codeine 8 A.M. not available...1/18/12 Tylenol w codeine 8 P.M. not available...1/19/12 Tylenol c (with) codeine 8 P.M. not available - pharmacy did not deliver yet...1/20/12 Tylenol c codeine 8 P.M. med (medication) unavailable...1/21/12 Tylenol c codeine 8 P.M. unavailable pharmacy		DAILY by the nurse responsible for medication administration—this will be done in order to document the finding of any circled medications/medications not available for each shift, as well as any missing documentation of vital signs required by physician order. · These audits will be documented on the existing Change of Shift Controlled Substance form in the column marked “MAR Audit completed”. · In the event a nurse has noted a missing medication or missing documentation, the audit tool will indicate what additional actions were taken and the HWD will be notified through the use of the Shift Report. · A procedure has been developed whereby the pharmacy will improve turnaround time for new orders by providing the community with an “after-hours” number to call. The pharmacy will then be responsible for contacting the back-up pharmacy to deliver the new medication within 24 hours. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Director/Designee will be responsible for reviewing the Medication Administration Record and audit tool 3 x weekly, and taking corrective action where indicated.· Corrective action will include nurse	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	aware...1/22/12 Tylenol c codeine...unavailable pharmacy aware...1/24/12 Tylenol c codeine 8 P.M. pharmacy aware med O (not) available...1/25/12 Tylenol c codeine 8 P.M. pharmacy aware med O available...1/26/12 Tylenol c codeine 8 P.M. pharmacy aware med O available..." Further review of MAR indicated Resident # 28 did not receive the scheduled Colace on the following dates: 1/22/12 1/23/12 1/27/12 1/29/12 During interview on 2/15/12 at 10:30 A.M., the Health Wellness Director indicated she would need to do some follow up as to why Resident # 28 did not receive his medications as ordered by the physician. 2. The clinical record for Resident # 29, reviewed on 2/15/12 at 1:45 P.M., indicated diagnoses of, but not limited to: dementia, transient cerebral ischemia, hypothyroidism and osteoporosis. A physician order dated, 12/10/11, indicated, "...Aricept 5 mg 1 tab (tablet) po qd..."		re-education, counseling or disciplinary action as well as notification of the pharmacy when a problem has been identified with their delivery services.· Results of audits will be available for ED/Designee review on a weekly basis. ***By what date will these systemic changes be implemented?*** · 3-16-12	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of January 2012 MAR indicates resident did not receive the scheduled Aricept on 1/11/12 and 1/12/12. The January 2012 MAR further indicated "...1/11/12 Aricept unavailable pharmacy aware...1/12/12 Aricept on order...." Interview on 2/15/12 at 10:50 A.M., LPN # 2 indicated if a medication is not given to a resident for any reason, an explanation would be written on back of the MAR. 3. The clinical record for Resident # 11, reviewed on 2/14/12 at 11:50 A.M., indicated diagnoses of, but not limited to: dementia, hypertension, and hypercholesterolemia. A Physician Order, dated 8/22/11, indicated, "...Metoprol Tar Tab (high blood pressure medication) 25 mg (milligrams)...Take 1 tablet by mouth twice daily Hold if SBP (systolic blood pressure) < (less than) 100 & HR (heart rate) < 60...8 AM...8 PM..." Review of the October 2011, MAR (Medication Administration Record) indicated a lack of proper evaluation of the necessity of anti hypertensive medication on the following dates:			

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 02/17/2012
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF SOUTH BEND		STREET ADDRESS, CITY, STATE, ZIP CODE 17441 SR 23 SOUTH BEND, IN 46635	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/17/11 8:00 P.M. - lacked documentation of a pulse 10/18/11 8:00 A.M. - lacked documentation of a pulse 10/26/11 8:00 A.M. - lacked documentation of a blood pressure or pulse 10/28/11 8:00 A.M. - lacked documentation of a blood pressure or pulse 10/31/11 8:00 P.M. - lacked documentation of a pulse Review of the November 2011, MAR (Medication Administration Record) indicated a lack of proper evaluation of the necessity of anti hypertensive medication on the following dates: 11/24/11 8:00 P.M. - lacked documentation of a pulse Review of the December 2011, MAR (Medication Administration Record) indicated a lack of proper evaluation of the necessity of anti hypertensive medication on the following dates: 12/1/11 8:00 A.M. - lacked documentation of a pulse 12/1/11 8:00 P.M. - lacked documentation of a pulse 12/2/11 8:00 A.M. - lacked			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of a pulse 12/3/11 8:00 A.M. - lacked documentation of a pulse 12/4/11 8:00 A.M. - lacked documentation of a pulse 12/5/11 8:00 A.M. - lacked documentation of a pulse 12/6/11 8:00 A.M. - lacked documentation of a pulse 12/7/11 8:00 A.M. - lacked documentation of a pulse 12/8/11 8:00 A.M. - lacked documentation of a pulse 12/9/11 8:00 A.M. - lacked documentation of a pulse 12/10/11 8:00 A.M. - lacked documentation of a pulse 12/11/11 8:00 A.M. - lacked documentation of a pulse 12/12/11 8:00 A.M. - lacked documentation of a pulse 12/12/11 8:00 P.M. - lacked documentation of a pulse 12/13/11 8:00 A.M. - lacked documentation of a pulse 12/14/11 8:00 A.M. - lacked documentation of a pulse 12/15/11 8:00 A.M. - lacked documentation of a pulse 12/16/11 8:00 A.M. - lacked documentation of a pulse 12/16/11 8:00 P.M. - lacked documentation of a pulse 12/17/11 8:00 A.M. - lacked			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of a pulse 12/22/11 8:00 P.M. - lacked documentation of a blood pressure or pulse 12/23/11 8:00 A.M. - lacked documentation of a pulse 12/23/11 8:00 P.M. - lacked documentation of a pulse 12/24/11 8:00 A.M. - lacked documentation of a pulse 12/24/11 8:00 P.M. - lacked documentation of a pulse 12/25/11 8:00 A.M. - lacked documentation of a pulse 12/25/11 8:00 P.M. - lacked documentation of a pulse 12/26/11 8:00 A.M. - lacked documentation of a pulse 12/26/11 8:00 P.M. - lacked documentation of a pulse 12/27/11 8:00 A.M. - lacked documentation of a pulse 12/28/11 8:00 A.M. - lacked documentation of a pulse 12/28/11 8:00 P.M. - lacked documentation of a pulse 12/29/11 8:00 A.M. - lacked documentation of a pulse 12/30/11 8:00 A.M. - lacked documentation of a pulse 12/31/11 8:00 A.M. - lacked documentation of a pulse During the month of December 2011, the			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clinical record lacked documentation of the pulse 35 of 62 times and lacked documentation of the blood pressure 1 of 62 times. Review of the January 2012, MAR (Medication Administration Record) indicated a lack of proper evaluation of the necessity of anti hypertensive medication on the following dates: 1/1/12 8:00 A.M. - lacked documentation of a pulse 1/1/12 8:00 P.M. - lacked documentation of a pulse 1/2/12 8:00 A.M. - lacked documentation of a pulse 1/3/12 8:00 A.M. - lacked documentation of a pulse 1/3/12 8:00 P.M. - lacked documentation of a pulse 1/4/12 8:00 A.M. - lacked documentation of a pulse 1/4/12 8:00 P.M. - lacked documentation of a pulse 1/5/12 8:00 A.M. - lacked documentation of a pulse 1/5/12 8:00 P.M. - lacked documentation of a pulse 1/6/12 8:00 A.M. - lacked documentation of a pulse 1/6/12 8:00 P.M. - lacked documentation of a pulse 1/7/12 8:00 A.M. - lacked documentation			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of a pulse 1/8/12 8:00 A.M. - lacked documentation of a pulse 1/9/12 8:00 A.M. - lacked documentation of a pulse 1/10/12 8:00 A.M. - lacked documentation of a pulse 1/11/12 8:00 A.M. - lacked documentation of a pulse 1/12/12 8:00 A.M. - lacked documentation of a pulse 1/13/12 8:00 A.M. - lacked documentation of a pulse 1/14/12 8:00 A.M. - lacked documentation of a pulse 1/15/12 8:00 A.M. - lacked documentation of a pulse 1/16/12 8:00 A.M. - lacked documentation of a pulse 1/17/12 8:00 A.M. - lacked documentation of a pulse 1/18/12 8:00 A.M. - lacked documentation of a pulse 1/18/12 8:00 P.M. - lacked documentation of a pulse 1/19/12 8:00 A.M. - lacked documentation of a pulse 1/19/12 8:00 P.M. - lacked documentation of a pulse 1/20/12 8:00 A.M. - lacked documentation of a pulse 1/20/12 8:00 P.M. - lacked documentation of a pulse 1/21/12 8:00 A.M. - lacked			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of a pulse 1/21/12 8:00 P.M. - lacked documentation of a pulse 1/22/12 8:00 A.M. - lacked documentation of a pulse 1/23/12 8:00 A.M. - lacked documentation of a pulse 1/23/12 8:00 P.M. - lacked documentation of a pulse 1/24/12 8:00 A.M. - lacked documentation of a pulse 1/25/12 8:00 A.M. - lacked documentation of a pulse 1/26/12 8:00 A.M. - lacked documentation of a pulse 1/27/12 8:00 A.M. - lacked documentation of a pulse 1/28/12 8:00 A.M. - lacked documentation of a pulse 1/29/12 8:00 A.M. - lacked documentation of a pulse 1/29/12 8:00 P.M. - lacked documentation of a pulse 1/30/12 8:00 A.M. - lacked documentation of a pulse 1/31/12 8:00 A.M. - lacked documentation of a pulse During the month of January 2012, the clinical record lacked documentation of the pulse 42 of 62 times. The blood pressure parameter (values used to determine the necessity of a			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication) order was handwritten on the October 2011 and November 2011, MAR. The December 2011 and January 2012, MAR lacked documentation of the blood pressure parameter order. During interview with the Interim Administrator on 2/16/12 at 3:35 P.M., she indicated the pharmacy failed to carry over the blood pressure parameters orders, therefore, the nurses were handwriting the parameters on the MAR's but somehow those orders did not get written on the December 2011 and January 2012 MAR. She further indicated there was not a time when the nursing staff did take the blood pressure and pulse for Resident # 11 that he should not have gotten his medication because it fell below parameters.			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure physician prescribed medications were available for 1 of 7 residents (Resident # 29) in a sample of 7 and 1of 3 residents (Resident #28) in a supplemental sample of 3 reviewed for medication availability. Findings include: 1. The clinical record for Resident # 28, reviewed on 2/14/12 at 11:40 A.M., indicated diagnoses of, but not limited to: Lewy Body Disease, reflux esophagitis, and hypertension. A physician's order, dated 10/17/11, indicated, "...Ativan 0.5 mg (milligram) 1 p.o. (by mouth) qd (every day) BID (twice daily) ... Ambien 5 mg 1 po q (every) HS (bedtime)..." Review of the October 2011, MAR (Medication Administration Record) indicated Resident # 28 did not receive the scheduled Ativan on the following	R0297	**R 297 410 IAC 16.2-5-6 ©(1) Pharmaceutical Services-Noncompliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident # 28: Physician was notified of the need to provide a legal prescription for the pharmacy in order to obtain the controlled substance. This prescription was then provided to pharmacy and the meds were administered as ordered. The Pharmacy, responsible party and physician have been notified of the missed medications due to meds unavailable. · Resident # 29: The Pharmacy, responsible party, and physician have been notified of the missed medication on 1-11-12 and 1-12-12 by the Health and Wellness Director/Designee. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents who require medication administration services by community nurses have the potential to be affected by the alleged deficient practice. · For this reason, nurses have been re-educated on Medication Administration, The Medication Administration Record audit tool and the	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dates: 10/18/11 at 5:00 P.M. 10/19/11 at 9:00 A.M. and 5:00 P.M. 10/20/11 at 9:00 A.M. and 5:00 P.M. 10/21/11 at 9:00 A.M. and 5:00 P.M. The October 2011, MAR further indicated, "...10/18 - 5 P.M....Ativan 0.5 mg (milligrams)...unavailable...10/19 - 5 P.M....Ativan 0.5 mg...unavailable...10/20 - 5 P.M....Ativan 0.5 mg...unavailable..." The October 2011 MAR further indicated Resident #28 did not receive the scheduled Ambien on the following dates: 10/18/11 10/19/11 10/20/11 10/21/11 The October 2011, MAR further indicated, "...10/18 - 8 P.M....Ambien...med (medication) unavailable...10/20 - 8 P.M....Ambien...med unavailable...10/21 - 8 P.M....Ambien...on order..." A physician order, dated 1/14/12, indicated, "...Tylenol c (with) Codeine #3 - 1 p.o. qd BID... Colace 100 mg 1 po qd..."		documentation process for handling situations which may arise where medications may not available. · This training has been provided by the Health and Wellness Director/Designee. · A pharmacy representative has met with the ED Designee/Health and Wellness Director to address timely provision of medications, as well as communication to physicians, when physicians are required to provide a signed prescription for controlled substances. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · A Medication Administration Record audit will be completed on each shift by the nurse responsible for medication administration to audit for medications not available. · These audits will be documented on the Change of Shift form for controlled substances . · A procedure has been developed whereby the pharmacy will improve turnaround time for new orders by providing the community with an "after-hours" number to call. The pharmacy will then be responsible for contacting the back-up pharmacy to deliver the new medication within 24 hours. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Director/Designee will be responsible for reviewing the Medication Administration Record and audit tool 3 x weekly, and taking corrective action	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of January 2012, MAR indicated Resident # 28 did not receive the scheduled Tylenol with Codeine #3 on the following dates: 1/18/12 at 8:00 A.M. and 8:00 P.M. 1/19/12 at 8:00 A.M. and 8:00 P.M. 1/20/12 at 8:00 A.M. and 8:00 P.M. 1/21/12 at 8:00 A.M. and 8:00 P.M. 1/22/12 at 8:00 A.M. and 8:00 P.M. 1/23/12 at 8:00 A.M. and 8:00 P.M. 1/24/12 at 8:00 A.M. and 8:00 P.M. 1/25/12 at 8:00 A.M. and 8:00 P.M. 1/26/12 at 8:00 A.M. and 8:00 P.M. 1/27/12 at 8:00 A.M. During interview on 2/15/12 at 10:30 A.M., the Health Wellness Director indicated she would need to do some follow up as to why Resident # 28 did not receive his medications as ordered by the physician. 2. The clinical record for Resident # 29, reviewed on 2/15/12 at 1:45 P.M., indicated diagnoses of, but not limited to: dementia, transient cerebral ischemia, hypothyroidism and osteoporosis. A physician order dated, 12/10/11, indicated, "...Aricept 5 mg 1 tab (tablet) po qd..." Review of January 2012 MAR indicates		where indicated. · Corrective action will include nurse re-education, counseling or disciplinary action as well as notification of the pharmacy when a problem has been identified with their delivery services. · Results of audits will be available for ED/Designee review on a weekly basis. ***By what date will these systemic changes be implemented?*** · 3-16-12	

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident did not receive the scheduled Aricept on 1/11/12 and 1/12/12. The January 2012 MAR further indicated, "...1/11/12 Aricept unavailable pharmacy aware...1/12/12 Aricept on order..." During interview on 2/15/12 at 10:50 A.M., LPN # 2 indicated if a medication is not given to a resident for any reason, an explanation would be written on back of the MAR.			

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 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0351	410 IAC 16.2-5-8.1(c)(d) Clinical Records - Noncompliance (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on observation, the facility failed to protect medical records from possible water damage. This deficient practice had the potential to affect 36 of 36 residents who reside in the facility and an unidentified number of discharged residents. Findings include: During tour of the medical records room on 2/17/12 at 10:30 A.M., while accompanied by the Maintenance Technician, the following observations were made: Two 8.5 x 11 cardboard boxes containing resident records were located outside of the files cabinets directly below a sprinkler head.	R0351	**R 351 410 IAC 16.2-5-8.1 © (d)** **Clinical Records-Noncompliance** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · No residents were cited as affected by the alleged noncompliant practice. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Closed records for residents who no longer reside in the community were shredded according to the medical record destruction policy. · Non-resident information stored in cardboard boxes has been shredded according to the medical record destruction policy. · Medical records for current and former residents are currently stored in locked metal file cabinets. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Additional locking metal file cabinets have been made available for	03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF SOUTH BEND	17441 SR 23 SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			medical record storage in an area designated for medical records storage. · Existing records will be purged quarterly according the medical records destruction policy. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Executive Director/Designee will monitor the designated medical records storage areas on a monthly basis for compliance and will obtain additional storage devices when necessary. ***By what date will these systemic changes be implemented?*** · 3-16-12	