

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 03/28/2012
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NAME OF PROVIDER OR SUPPLIER MONROE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 S ADAMS RD BLOOMINGTON, IN 47403
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R0000	<p>This visit was for a State Residential Licensure Survey. This visit included the investigation of Complaint IN00106205.</p> <p>Complaint IN00106205 unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 27 & 28, 2012</p> <p>Facility number: 004016 Provider number: 004016 AIM number: N/A</p> <p>Survey team: Sharon Whiteman RN TC Susan Worsham RN</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Census payor type: Other: 37 Total: 37</p> <p>Sample: 05</p> <p>This State Residential finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/29/12 Cathy Emswiller RN</p>	R0000		

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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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review, the facility failed to ensure documentation in the clinical record was complete and accurate for 1 of 5 resident's clinical records reviewed. [Resident #3]</p> <p>Findings Include:</p> <p>The clinical record of Resident #3 was reviewed on 03/38/12 at 2:00 p.m. Resident #3's physician's orders, dated 02/27/12 included, but were not limited to, "Geriatric Psych Evaluation." The nurse's notes dated from 02/15/12 to 03/12/12 lacked documentation to indicate this physician order was received or that the geriatric psych evaluation had been scheduled.</p> <p>On 03/28/12 at 1:30 p.m., the facility Regional Nurse provided a note which indicated he called the resident's power of attorney [POA] who refused to send the resident to a behavioral unit due to</p>	R0349	<p>We respectfully disagree with the below citation and would like to introduce for your review the attached documentation. This is provided for your review by way of the face to face Informal Dispute Resolution in effort to overturn this ruling.</p> <p>Citation #1 R 349 410 IAC 16.2-5-8.1 (a) (1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>No residents were found to be affected. Resident #3's clinical record was reviewed by the Regional Director of Quality and Care Management and a late entry was provided based on a conversation with the son and Power of Attorney as to the physician order asking for a psyche evaluation being refused</p>	05/01/2012			

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	<p>"Behavioral Disturbances."</p> <p>The nurses notes dated 02/15/12 to 03/12/12 lacked documentation of this contact by the facility Regional Nurse or the POA's response."</p> <p>The facility policy and procedure for "Documentation" was provided by the facility Regional Nurse on 03/28/12 at 3:05 p.m., and was reviewed at that time. The policy and procedure included, but was not limited to, "Resident Service Notes....It is essential that staff document observations and occurrences accurately....#13 B Emotional State."</p>		<p>by him (see attached). The Regional Director of Quality and Care Management consulted with the local Indiana State Department of Health spokesperson Debbie Beardsly for state guidelines as to acceptable Indiana state practice and regulations regarding late entries and discovered no such regulation. The Regional Director also has attached a copy of our policy and procedure regarding documentation with no such time frame as to when a late entry can be made.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director, Residence Director, and staff were re-educated to our policy and procedure regarding resident change of condition and documentation. The Wellness Director and/or Designee will be responsible for ensuring continued compliance going forward.</p>				

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			<p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Wellness Director and/or Designee will perform a random weekly audit of residents experiencing a change of condition to ensure appropriate documentation occurs within the resident's service notes for a period of six months to ensure continued compliance. Audits will be reviewed through our Monroe House QA process and reviewed after six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan.</p> <p>By what date will the systemic changes be completed? March 1, 2012</p>		