

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2015
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NAME OF PROVIDER OR SUPPLIER  SENIOR SUITES AT THE LELAND, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177605.</p> <p>Complaint IN00177605-Substantiated. State residential deficiencies related to the allegations are cited at R091 and R120.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: August 13, 14 and 17, 2015</p> <p>Facility number: 012497 Provider number: 012497 AIM number: N/A</p> <p>Census bed type: Residential: 79 Total: 79</p> <p>Census Payor type: Medicaid: 57 Other: 22 Total: 79</p> <p>Sample: 4</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of and state law.</p> <p>Senior Suites at the Leland maintains that the alleged deficiencies do not individually or collectively jeopardize the health and/or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Senior Suites at the Leland asserts that it is in substantial compliance with regulations governing the operation of assisted living facilities, and this Plan of Correction in its entirety constitutes this provider's credible allegation of compliance and, thereby, we request resurvey to verify such as of October 12th, 2015 Further, we request desk review (paper compliance) for compliance, if acceptable. Completion dates are provided for procedural processing purposes to comply with state regulations, and correlate with the most recent contemplated or accomplished</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R 0091 Bldg. 00	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to ensure the facility's policies regarding resident's rights and personnel were implemented in that two former employees files reviewed for abuse prohibition and resident's rights education did not have this information documented for annual education in their employee files. (Former Director of Nursing [DON] and Former Assistant Director of Nursing [ADON])</p> <p>Findings include:</p> <p>1. During the review of the facility's personnel records of the Former DON on</p>	R 0091	<p>corrective action. These do not necessarily chronologically correspond to the date that Senior Suites at the Leland is under the opinion that it was in compliance with the requirements of participation or that corrective action was necessary.</p> <p>It is the policy of this provider to have in place policies regarding organized in-service education. <u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> As the files noted were former employees, no action is required. It should be noted that after the survey was</p>	10/12/2015	

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	<p>8-17-15 at 10:00 a.m., the records indicated an absence of a criminal background check upon employment on 4-1-13, or since that date. There was an absence of annual staff education in the year prior to leaving employment on 7-7-15 related to resident's rights, including abuse/abuse prohibition. In an interview with the Current DON on 8-17-15 at 1:10 p.m., she indicated she was unable to locate a criminal background check for the Former DON, nor could locate annual staff education in the year prior to leaving employment on 7-7-15 related to resident's rights, including abuse/abuse prohibition.</p> <p>2. During the review of the facility's personnel records of the Former ADON on 8-17-15 at 10:00 a.m., the records indicated an absence of annual staff education in the year prior to leaving employment on 7-24-15 related to resident's rights. In an interview with the Current DON on 8-17-15 at 1:10 p.m., she indicated she was unable to locate annual staff education in the year prior to leaving employment on 7-24-15 related to resident's rights.</p> <p>On 8-17-15 at 2:00 p.m., the Current DON provided a copy of a policy entitled, "Elder Abuse Information and Policy." This policy was undated, but</p>		<p>completed, the background check on the former DON was located and placed in her closed employment file. <u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as none. The facility audited all employee files and verified that in-service education, including Resident Rights, were present. The same records were audited for a background check and no others were found to be lacking. <u>3. What measures will be put into place or what systemic changes will be made to</u></p>	

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	<p>indicated to be the current policy utilized by the facility. This policy indicated, "[Name of facility] prohibits abuse, neglect and financial exploitation of its residents. The community will not knowingly employ an individual who has any criminal history that indicates behavior that is potentially harmful to our residents, documented through either a criminal history records check or criminal background check."</p> <p>On 8-17-15 at 2:00 p.m., the Current DON provided a copy of a policy entitled, "Ongoing Staff Training." This policy was undated, but indicated to be the current policy utilized by the facility. This policy indicated, "...Attendance at educational offerings and in-services will be recorded for each employee and kept on file. All employees will need to fulfill the state's mandated number of training hours through our online training, [name of program used by facility]. All employees must complete a monthly in-service...A record of all educational offerings and in-services offered to the employees will be maintained by the Manager..."</p> <p>On 8-17-15 at 2:15 p.m., the Executive Director provided a copy of an untitled policy. This policy was undated, but indicated to be the current policy utilized</p>		<p><u>ensure that the alleged deficient practice does not recur?</u>The current DON has developed an ongoing in-service program for nursing and non-nursing personnel. Binders for the documentation are assembled and in-service materials are assembled. Area ombudsman has been approached about presenting Resident Rights to staff and residents. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> Bimonthly, the DON, BOM or designee will review the files of employee in-services for the previous period to assure that each file has the required items in place. A report will be given to the Executive Director, monthly, who</p>	

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R 0120  Bldg. 00	<p>by the facility. This policy indicated, "[Name of facility] prohibits abuse, neglect and financial exploitation of its residents. The community will not knowingly employ an individual who has any criminal history that indicates behavior that is potentially harmful to our residents, documented through either a criminal history records check or criminal background check...All new employees will receive Elder Abuse/Residents Rights training in new employee orientation and annually thereafter."</p> <p>This Residential tag relates to Complaint IN00177605</p> <p>5.1-3(h)(2) 5.1-3(h)(3)</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4)</p>		will determine compliance.				

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	<p>hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure the facility's policies regarding resident's rights and personnel were implemented in that two former employees files reviewed for abuse prohibition and resident's rights education did not have this information documented for annual education in their employee files. (Former Director of Nursing [DON] and Former Assistant Director of Nursing [ADON])</p> <p>Findings include:</p> <p>1. During the review of the facility's personnel records of the Former DON on 8-17-15 at 10:00 a.m., the records</p>	R 0120	<p>It is the policy of this provider to have in place policies regarding updating service plans and assessments every sixmonths. <u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Both Resident D and E were discharged from the facility prior to the survey being conducted. Thus, no action is necessary <u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Other residents with the propensity to be affected by the same alleged deficient</p>	10/12/2015

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R 0214  Bldg. 00	<p>"[Name of facility] prohibits abuse, neglect and financial exploitation of its residents. The community will not knowingly employ an individual who has any criminal history that indicates behavior that is potentially harmful to our residents, documented through either a criminal history records check or criminal background check...All new employees will receive Elder Abuse/Residents Rights training in new employee orientation and annually thereafter."</p> <p>This Residential tag relates to Complaint IN00177605</p> <p>5.1-4(d)(2)(B) 5.1-4(d)(2)(D) 5.1-4(d)(6)</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 4 residents, in a sample of 4, reviewed for service plans/evaluations had a minimum of semi-annual updates conducted of</p>	R 0214	<p>It is the policy of this provider to have in place policies regarding updating service plans and assessments every six months.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected</u></p>	10/12/2015

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	<p>their service plans. This deficient practice has the potential to adversely affect the care and services provided to each resident of the facility. (Resident #D and #E)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #D was reviewed on 8-17-15 at 9:10 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 9-17-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated she moved into the facility on 10-31-14. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on 8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on</p>		<p><u>by the alleged deficient practice?</u> Both Resident D and E were discharged from the facility prior to the survey being conducted. Thus, no action is necessary <u>2.</u> <u>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those coming into the facility as new admissions. Each new admission since the employment of the current DON has an evaluation/assessment in place before admission. Based on that assessment, a service plan is created and in place for each of the newly admitted residents. Current residents have been placed on a schedule of assessment, with each resident due to have a reassessment performed within 90 days. Based on that reassessment, a service plan will be updated with resident input. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> An audit checklist was created to assist personnel in assuring that assessments and reassessments are complete within a time frame as required. Such audits will be conducted on an ongoing basis. <u>4. How will the corrective actions be monitored to</u></p>				

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	<p>8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #D.</p> <p>2. The clinical record of Resident #E was reviewed on 8-17-15 at 9:20 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 2-16-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated he moved into the facility on 2-12-14. A second service plans/evaluation, dated 2-8-14, was present and signed by the Former DON only. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on 8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on</p>		<p><u>ensure that the deficient practice does not recur?</u> Monthly, the DON, BOM or designee will review the medical record of those residents on the schedule during that period to assure that each has the required item on the audit checklist. A report will be given to the Executive Director, monthly, who will determine compliance.</p>				

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R 0215 Bldg. 00	<p>8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #E.</p> <p>In an interview with the Executive Director on 8-17-15 at 2:15 p.m., he indicated the facility currently does not have any policy or procedure related to service plans. He indicated these policies and procedures are currently under development.</p> <p>5.1-2(a)</p> <p>410 IAC 16.2-5-2(b) Evaluation - Deficiency</p> <p>(b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 4 residents, in a sample of 4, reviewed for service plans/evaluations had a minimum of semi-annual updates conducted of their service plans. This deficient practice has the potential to adversely affect the care and services provided to each resident of the facility. (Resident</p>	R 0215	<p>It is the policy of this provider to have in place policies regarding updating service plans and assessments every six months.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u></p> <p>Both Resident D and E were discharged from the facility prior to the survey being conducted. Thus, no action is necessary <u>2.</u></p>	10/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/17/2015	
NAME OF PROVIDER OR SUPPLIER  SENIOR SUITES AT THE LELAND, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374			
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	<p>#D and #E)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #D was reviewed on 8-17-15 at 9:10 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 9-17-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated she moved into the facility on 10-31-14. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on 8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on 8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #D.</p>		<p><u>How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p> <p>Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those coming into the facility as new admissions. Each new admission since the employment of the current DON has an evaluation/assessment in place before admission. Based on that assessment, a service plan is created and in place for each of the newly admitted residents. Current residents have been placed on a schedule of assessment, with each resident due to have a reassessment performed within 90 days. Based on that reassessment, a service plan will be updated with resident input. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> An audit checklist was created to assist personnel in assuring that assessments and reassessments are complete within a time frame as required. Such audits will be conducted on an ongoing basis. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> Monthly, the DON, BOM or</p>				

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	<p>2. The clinical record of Resident #E was reviewed on 8-17-15 at 9:20 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 2-16-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated he moved into the facility on 2-12-14. A second service plans/evaluation, dated 2-8-14, was present and signed by the Former DON only. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on 8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on 8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #E.</p>		designee will review the medical record of those residents on the schedule during that period to assure that each has the required item on the audit checklist. A report will be given to the Executive Director, monthly, who will determine compliance.	

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R 0216 Bldg. 00	<p>In an interview with the Executive Director on 8-17-15 at 2:15 p.m., he indicated the facility currently does not have any policy or procedure related to service plans. He indicated these policies and procedures are currently under development.</p> <p>5.1-2(b)</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 4 residents, in a sample of 4, reviewed for service plans/evaluations had a minimum of semi-annual updates conducted of their service plans. This deficient practice has the potential to adversely affect the care and services provided to each resident of the facility. (Resident</p>	R 0216	<p>It is the policy of this provider to have in place policies regarding updating service plans and assessments every six months.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Both Resident D and E were discharged from the facility prior to the survey being</p>	10/12/2015

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	<p>#D and #E)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #D was reviewed on 8-17-15 at 9:10 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 9-17-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated she moved into the facility on 10-31-14. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on 8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on 8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #D.</p>		<p>conducted. Thus, no action is necessary <u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those coming into the facility as new admissions. Each new admission since the employment of the current DON has an evaluation/assessment in place before admission. Based on that assessment, a service plan is created and in place for each of the newly admitted residents. Current residents have been placed on a schedule of assessment, with each resident due to have a reassessment performed within 90 days. Based on that reassessment, a service plan will be updated with resident input. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u>An audit checklist was created to assist personnel in assuring that assessments and reassessments are complete within a time frame as required. Such audits will be conducted on an ongoing basis. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not</u></p>		

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	<p>2. The clinical record of Resident #E was reviewed on 8-17-15 at 9:20 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 2-16-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated he moved into the facility on 2-12-14. A second service plans/evaluation, dated 2-8-14, was present and signed by the Former DON only. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on 8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on 8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #E.</p>		<p><u>recur?</u>Monthly, the DON, BOM or designee will review the medical record of those residents on the schedule during that period to assure that each has the required item on the audit checklist. A report will be given to the Executive Director, monthly, who will determine compliance.</p>	

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R 0217 Bldg. 00	<p>In an interview with the Executive Director on 8-17-15 at 2:15 p.m., he indicated the facility currently does not have any policy or procedure related to service plans. He indicated these policies and procedures are currently under development.</p> <p>5.1-2(c)(1) 5.1-2(c)(2) 5.1-2(c)(4) 5.1-2(d)</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p>			

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	<p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 4 residents, in a sample of 4, reviewed for service plans/evaluations had a minimum of semi-annual updates conducted of their service plans. This deficient practice has the potential to adversely affect the care and services provided to each resident of the facility. (Resident #D and #E)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #D was reviewed on 8-17-15 at 9:10 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 9-17-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated she moved into the facility on 10-31-14. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on</p>	R 0217	<p>It is the policy of this provider to have in place policies regarding updating service plans and assessments every six months.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Both Resident D and E were discharged from the facility prior to the survey being conducted. Thus, no action is necessary</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those coming into the facility as new admissions. Each new admission since the employment of the current DON has an evaluation/assessment in place before admission. Based on that assessment, a service plan is created and in place for each of the newly admitted residents. Current residents have been placed on a schedule of assessment, with each resident</p>	10/12/2015

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	<p>8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on 8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #D.</p> <p>2. The clinical record of Resident #E was reviewed on 8-17-15 at 9:20 a.m. A "Pre-Admission Assessment" form, also referred to as a pre-admission service plan, dated 2-16-14 was present. This form was signed and dated 9-17-14 by Resident #D and the Former Director of Nursing (DON). The face-sheet for Resident #D indicated he moved into the facility on 2-12-14. A second service plans/evaluation, dated 2-8-14, was present and signed by the Former DON only. No other service plans/evaluations could be located in the resident's clinical record.</p> <p>In an interview with the Current DON on</p>		<p>due to have a reassessment performed within 90 days. Based on that reassessment, a service plan will be updated with resident input. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u>An audit checklist was created to assist personnel in assuring that assessments and reassessments are complete within a time frame as required. Such audits will be conducted on an ongoing basis. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u>Monthly, the DON, BOM or designee will review the medical record of those residents on the schedule during that period to assure that each has the required item on the audit checklist. A report will be given to the Executive Director, monthly, who will determine compliance.</p>	

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	<p>8-17-15 at 9:20 a.m., she indicated around the time she began employment with the facility on 7-7-15, a computer memory stick was taken home by a staff member. She indicated this memory stick contained information related to resident assessments, evaluations and service plans which were conducted prior to her employment. She indicated, "When it was returned, it was blank."</p> <p>In an interview with the Current DON on 8-17-15 at 1:45 p.m., she indicated she was unable to locate any additional service plans/evaluations for Resident #E.</p> <p>In an interview with the Executive Director on 8-17-15 at 2:15 p.m., he indicated the facility currently does not have any policy or procedure related to service plans. He indicated these policies and procedures are currently under development.</p> <p>5.1-2(e)(1)(A) 5.1-2(e)(1)(B) 5.1-2(e)(1)(C) 5.1-2(e)(1)(D) 5.1-2(e)(2) 5.1-2(e)(3) 5.1-2(e)(4) 5.1-2(e)(5)</p>			

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R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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.</p> <p>Based on record review, the facility failed to fulfill a physician's written order to send all medications home with a resident discharged to home by destruction of several medications for 1 of 2 residents reviewed for transfer or discharge in a sample of 4 residents. This deficient practice has the potential to adversely affect the health and well-being of the resident. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 8-14-15 at 9:10 a.m. It indicated the resident was discharged from the facility, effective 5-11-15. A physician's telephone order form, dated 5-6-15, indicated, "Send all meds [sign for with] resident." A nursing note, dated 5-6-15, indicated the resident had been discharged that date from an area hospital to home and had moved in with a family</p>	R 0241	<p>It is the policy of this provider to have in place policies regarding medication storage and disposal.</p> <p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Resident C discharged from the facility prior to the survey being conducted. Thus, no action is necessary <u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will betaken?</u> Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those discharging from the facility with physician's order to discharge with medications. Each discharge since the employment of the current DON has been reviewed by the DON, to assure compliance with the d/c orders. All have so complied. <u>3. What measures will be put into place or</u></p>	10/12/2015			

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	<p>member. It indicated a member of Resident #C's family had come to the facility to pick up his medications and received all medications, including his narcotics. It indicated the family member signed for receipt of each narcotic.</p> <p>Review of Resident #C's "Controlled Count Sheet" for Norco 10/325 mg (milligrams) with directions for one tablet every 6 hours, indicated 3 sheets for this medication were present. Each form indicated 30 tablets had been received on 4-20-15. One form indicated 20 tablets were sent with the resident on 5-6-15, but had only the signature of Resident #C's family member and no facility staff member's signature present. Another form indicated 30 tablets were sent with the family on 5-6-15 and was signed by the Former DON and the family member. The third form indicated 30 tablets were "destroyed in facility" on 5-6-15 and was signed by the Former DON and the family member.</p> <p>Review of Resident #C's "Controlled Count Sheet" for diazepam (Valium) 5 mg with directions for one tablet every three times daily by mouth, indicated 3 sheets for this medication were present. Each form indicated 30 tablets had been received on 4-27-15. One form indicated 29 tablets were sent with the resident on</p>		<p><u>what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> An audit checklist was created to assist personnel in assuring that discharge orders of the physician are followed at discharge of the resident. Such audits will be conducted on an ongoing basis. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u> Monthly, the DON or designee will review the medical record of those residents being discharged during that period to assure that each has the required item on the audit checklist. A report will be given to the Executive Director, monthly, who will determine compliance.</p>				

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NAME OF PROVIDER OR SUPPLIER  SENIOR SUITES AT THE LELAND, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>5-6-15 was signed by the Former DON and the family member. A second form indicated 30 tablets were sent with the family on 5-6-15 and was signed by the Former DON and the family member. The third form indicated 30 tablets were "destroyed in facility" on 5-6-15 and was signed by the Former DON and the family member. Information related to the purpose of the release or destruction was not included on the forms.</p> <p>Review of Resident #C's "Controlled Count Sheet" for Morphine 30 mg with directions for one tablet by mouth every 8 hours as needed (for pain), indicated 3 sheets for this medication were present. Each form indicated 30 tablets had been received on 4-20-15. One form indicated 11 tablets were sent with the resident on 5-6-15 was signed by the Former DON and the family member. A second form indicated 30 tablets were sent with the family on 5-6-15 and was signed by the Former DON and the family member. The third form indicated 30 tablets were "destroyed in facility" on 5-6-15 and was signed by the Former DON and the family member. Information related to the purpose of the release or destruction was not included on the forms.</p> <p>On 8-17-15 at 1:30 p.m., the Executive Director provided an untitled policy with</p>			

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	<p>a development date of 7-9-15. It indicated, "This policy covers the disposal of discontinued controlled medication and/or controlled medications for a discharged resident. Procedure:</p> <ol style="list-style-type: none"> <li>1. The nurse who takes the order to discontinue a controlled medication will complete a "Discontinued Medication Form" and place in the Physician's Order box for the DON.</li> <li>2. The controlled medication <u>REMAINS</u> on the cart, until the DON (notified by step 1 above) removes the med from the cart.</li> <li>3. The controlled medication will remain in the control of the DON, who will dispose of it by notifying the Police Department who will dispatch an officer to acquire the controlled medication and remove it from the premises for incineration by the department.</li> <li>4. The Consulting Pharmacist and the Administrator may approve a deviation from this policy.</li> <li>5. Other medication will be returned to the pharmacy, as allowed by law.</li> <li>6. If a resident is discharged home, the medication may be discharged in the possession of a responsible family member. Such action shall be under physician order. The resident and the family member MUST sign a release of liability." </li></ol>			

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R 0306 Bldg. 00	<p>On 8-17-15 at 9:30 a.m., the Executive Director provided a copy of a policy entitled, "Discharge Resident Medication Policy: Medication Administration Residents." This policy had a start date of 8-1-15. This policy indicated, "...When a resident is discharged home, the medications may be sent home with the resident if the physician so orders. Absent a physician's order, the medication will be returned for credit."</p> <p>5-4(e)(1)</p> <p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure the</p>	R 0306	It is the policy of this provider to have in place policies regarding medication storage and disposal.	10/12/2015

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	<p>disposition of all medications utilized by residents of the facility are clearly documented to indicate in what manner the medications were provided to the resident or properly disposed of, upon discharge or transfer for 1 of 2 residents reviewed for transfer and discharge in a sample of 4. This deficient practice could potentially create an environment of mishandling of medications. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 8-14-15 at 9:10 a.m. It indicated the resident was discharged from the facility, effective 5-11-15. A physician's telephone order form, dated 5-6-15, indicated, "Send all meds [sign for with] resident." A nursing note, dated 5-6-15, indicated the resident had been discharged that date from an area hospital to home and had moved in with a family member. It indicated a member of Resident #C's family had come to the facility to pick up his medications and received all medications, including his narcotics. It indicated the family member signed for receipt of each narcotic.</p> <p>Review of Resident #C's "Controlled Count Sheet" for Norco 10/325 mg (milligrams) with directions for one</p>		<p><u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Resident C discharged from the facility prior to the survey being conducted. Thus, no action is necessary</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u> Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those discharging from the facility with physician's order to discharge with medications. Each discharge since the employment of the current DON has been reviewed by the DON, to assure compliance with the d/c orders. All have so complied. With respect to the disposal of medications NOT sent with residents at discharge, it should be noted that the facility reviewed the medication disposal procedure in effect at the hiring of the new DON. The procedure was reconstructed such that NO narcotics are destroyed on premises. in fact no medication at all are destroyed on premises. Narcotics that are d/c'd remain in the control of the DON only who notifies the local Police Department. Upon notification an officer is dispatched to acquire the medications from the facility</p>	

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	<p>tablet every 6 hours, indicated 3 sheets for this medication were present. Each form indicated 30 tablets had been received on 4-20-15. One form indicated 20 tablets were sent with the resident on 5-6-15, but had only the signature of Resident #C's family member and no facility staff member's signature present. Another form indicated 30 tablets were sent with the family on 5-6-15 and was signed by the Former DON and the family member. The third form indicated 30 tablets were "destroyed in facility" on 5-6-15 and was signed by the Former DON and the family member.</p> <p>Information related to the purpose of the release or destruction was not included on the forms.</p> <p>Review of Resident #C's "Controlled Count Sheet" for diazepam (Valium) 5 mg with directions for one tablet every three times daily by mouth, indicated 3 sheets for this medication were present. Each form indicated 30 tablets had been received on 4-27-15. One form indicated 29 tablets were sent with the resident on 5-6-15 was signed by the Former DON and the family member. A second form indicated 30 tablets were sent with the family on 5-6-15 and was signed by the Former DON and the family member. The third form indicated 30 tablets were "destroyed in facility" on 5-6-15 and was</p>		<p>(DON) for incineration by the law enforcement agency. The count is verified by the officer and the DON. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u> An audit is conducted by the consulting pharmacist during his normal routine visit to assure that the policy is being followed. Any deviation is reported to the Executive Director immediately for disciplinary action up to and including discharge if appropriate. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u>A report will be given to the Executive Director who will determine compliance.</p>				

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	<p>signed by the Former DON and the family member. Information related to the purpose of the release or destruction was not included on the forms.</p> <p>Review of Resident #C's "Controlled Count Sheet" for Morphine 30 mg with directions for one tablet by mouth every 8 hours as needed (for pain), indicated 3 sheets for this medication were present. Each form indicated 30 tablets had been received on 4-20-15. One form indicated 11 tablets were sent with the resident on 5-6-15 was signed by the Former DON and the family member. A second form indicated 30 tablets were sent with the family on 5-6-15 and was signed by the Former DON and the family member. The third form indicated 30 tablets were "destroyed in facility" on 5-6-15 and was signed by the Former DON and the family member. Information related to the purpose of the release or destruction was not included on the forms.</p> <p>Three pages of the May, 2015 medication administration record (MAR), listing the medications and their corresponding administration instructions was present in the clinical record, located with information related to Resident #C's discharge from the facility. Adjacent to each medication was hand-written information that was not clear as to its</p>			

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	<p>purpose. The third page also had a handwritten notation which indicated on 5-6-15, "Received" with the signature of the Former Director of Nursing and the family member of Resident #C.</p> <p>The Current DON and the Executive Director were each queried on 8-14-15 at 11:00 a.m. as to what this information meant. Each indicated they were unsure of exactly what this information meant, but could be related to the number of pills or tablets associated with a prescription number. Each emphasized they were confused with this documentation.</p> <p>The following information was present on the first page of the MAR:                      -amlodipine 10 mg, take 1 tablet by mouth in the morning. Handwritten to the right of the instructions was the encircled number "18" and a 10 digit number.                      -famotidine 20 mg, take one tablet by mouth daily. Handwritten to the right of the instructions was the encircled number "20" and a 10 digit number.                      -furosemide 40 mg, take one tablet by mouth daily. Two handwritten notations to the right of the instructions were the encircled numbers "20" and "25" and two different 10 digit numbers.                      -iprat-albuterol 0.5-3(2.5) mg/3 milliliters,</p>			

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	<p>use 1 vial in nebulizer every 4 hours, may keep at bedside. Handwritten to the right of the instructions was the encircled number "15" and phrase "3 packs."</p> <p>There was not a 10 digit number associated with this medication.</p> <p>-lisinopril 2.5 mg, take 1 tablet by oral route every day. Handwritten to the right of the instructions was the encircled number "19" and a 10 digit number.</p> <p>-mirtazapine 15 mg take 1 tablet by mouth in the evening. Handwritten to the right of the instructions were the encircled numbers "14" twice and "7" and and a 10 digit number.</p> <p>-mycophenolate 250 mg, take 1 tablet by mouth in the evening. Handwritten to the right of the instructions were the encircled numbers "12" twice and "14" and three different 10 digit numbers.</p> <p>The following information was present on the second page of the MAR:</p> <p>-mycophenolate 500 mg, take 1 tablet by mouth in the morning. Handwritten to the right of the instructions was the encircled number "3" and a 10 digit number.</p> <p>-omeprazole 20 mg, take 1 tablet by mouth every bedtime. Handwritten to the right of the instructions was the encircled number "26" and a 10 digit number.</p> <p>-pravastatin 10 mg, take 1 tablet by mouth daily. Handwritten to the right of</p>			

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	<p>the instructions was the encircled number "18" and a 10 digit number.</p> <p>-prednisone 10 mg, take 1 tablet by mouth in the morning, Handwritten to the right of the instructions were the encircled numbers "5, 7, 9, 28" and a 10 digit number.</p> <p>-Reno caps softgel, take 1 tablet by mouth in the morning, Handwritten to the right of the instructions were the encircled numbers "2" and "19" and a 10 digit number.</p> <p>-buspirone 7.5 mg, take 1 tablet by mouth twice daily. Handwritten to the right of the instructions were the encircled numbers "17" and "20" and two different 10 digit numbers.</p> <p>-ferrous sulfate 325 mg, take 1 tablet by mouth twice daily. Handwritten to the right of the instructions were the encircled numbers "14" and "19" and a 10 digit number.</p> <p>The following information was present on the third page of the MAR:</p> <p>-Symbicort 160/4.5 mcg (micrograms),inhale 2 puffs by twice daily, rinse mouth after use. Handwritten to the right of the instructions was the encircled number "2." A 10 digit number was not associated with this.</p> <p>-mycophenolate 250 mg, take 1 tablet by mouth in the morning with mycophenolate 500 mg, for total of 750</p>			

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	<p>mg. Handwritten to the right of the instructions was the encircled number "27" and a 10 digit number.</p> <p>-The lower portion of the third page had a handwritten notation which indicated on 5-6-15, "Received" with the signature of the Former Director of Nursing and the family member of Resident #C.</p> <p>A document with the heading of "Friday, May 8, 2015," and referring to Resident #C, indicated he or his family would be into the facility to pick up an identified medication "behind the desk (on the bottom cabinet). They are to sign the release form that is with the medication , whoever is at the desk is to sign it and date it and it is to go in [name of Marketing Staff member]'s mailbox." Accompanying this document was a form printed on the facility's letterhead. This document indicated, "On behalf of [name of Resident #C], I have received the small box from [name of a pharmaceutical company] a full box + 3 individual packages of Ipratropin Bromide and Albuterol Sulfate Inhalation Solution from [name of facility]. This document was signed by a family member of Resident #C and a facility staff member, dated 5-9-15.</p> <p>In an interview with the Marketing Staff member on 8-14-15 at 4:00 p.m., she</p>			

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	<p>indicated on 5-6-15, Resident #C had been to a local court, regarding a legal issue with the facility. She indicated after the hearing, the resident indicated he did not have enough oxygen in his oxygen tank to return to the facility to pick up his medications and he had authorized a family member to do this for him. She indicated there had been some medication overlooked when the family member came into the facility to pick up his medications. She indicated the overlooked medications were left at the front desk with the accompanying paperwork for the front desk staff to have completed when the family came in to pick up the medications.</p> <p>In an interview with the Executive Director on 8-14-15 at 4:20 p.m., he indicated that medications of any type should not have been left at the front desk. He indicated the front desk does have "limited access" by residents or the general public.</p> <p>On 8-17-15 at 1:30 p.m., the Executive Director provided an untitled policy with a development date of 7-9-15. It indicated, "This policy covers the disposal of discontinued controlled medication and/or controlled medications for a discharged resident. Procedure:</p> <ol style="list-style-type: none"> <li>1. The nurse who takes the order to</li> </ol>			

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	<p>discontinue a controlled medication will complete a "Discontinued Medication Form" and place in the Physician's Order box for the DON.</p> <p>2. The controlled medication <u>REMAINS</u> on the cart, until the DON (notified by step 1 above) removes the med from the cart.</p> <p>3. The controlled medication will remain in the control of the DON, who will dispose of it by notifying the Police Department who will dispatch an officer to acquire the controlled medication and remove it from the premises for incineration by the department.</p> <p>4. The Consulting Pharmacist and the Administrator may approve a deviation from this policy.</p> <p>5. Other medication will be returned to the pharmacy, as allowed by law.</p> <p>6. If a resident is discharged home, the medication may be discharged in the possession of a responsible family member. Such action shall be under physician order. The resident and the family member <b>MUST</b> sign a release of liability."</p> <p>On 8-17-15 at 9:30 a.m., the Executive Director provided a copy of a policy entitled, "Discharge Resident Medication Policy: Medication Administration Residents." This policy had a start date of 8-1-15. This policy indicated,</p>			

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R 0349 Bldg. 00	<p>"...When a resident is discharged home, the medications may be sent home with the resident if the physician so orders. Absent a physician's order, the medication will be returned for credit."</p> <p>5-6(g)(3) 5-6(g)(4) 5-6(g)(5) 5-6(g)(6) 5-6(g)(7) 5-6(g)(8)</p> <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. Based on interview and record review, the facility failed to ensure 2 of 2 closed records of residents were complete, readily accessible and systematically organized. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. Resident #B's closed clinical record was requested of the Executive Director (ED) on 8-13-15 at 1:15 p.m. On the</p>	R 0349	<p>It is the policy of this provider to have in place policies regarding the organization of medical records, open, overflow and closed. <u>1. What corrective action(s) will be accomplished for the resident(s) found to be affected by the alleged deficient practice?</u> Residents B &amp; C discharged from the facility prior to the survey being conducted. Thus, no action is necessary <u>2. How will the facility identify other</u></p>	10/12/2015

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NAME OF PROVIDER OR SUPPLIER  SENIOR SUITES AT THE LELAND, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374			
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	<p>same date at 4:20 p.m., he indicated the closed clinical could not be located. On 8-14-15 at 10:30 a.m., the ED indicated the closed record had been located. He indicated Resident #B's clinical record had been located "under some other paperwork."</p> <p>Conduction of the record review for Resident #B was complicated by the lack of any organization of the record by topic or chronological order. In an interview with the ED on 8-14-15 at 10:30 a.m., he indicated "The charts are a mess. I cannot find any chart order for the charts."</p> <p>In an interview with the ED on 8-17-15 at 2:15 p.m., he indicated policies and procedures related to clinical records are currently under development.</p> <p>2. 1. Resident #C's closed clinical record was requested of the Executive Director (ED) on 8-13-15 at 1:15 p.m. On the same date at 4:20 p.m., he indicated the closed clinical could not be located. On 8-14-15 at 9:00 a.m., the ED indicated the closed record had been located.</p> <p>Conduction of the record review for Resident #C was complicated by the lack of any organization of the record by topic</p>		<p><u>residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</u></p> <p>Other residents with the propensity to be affected by the same alleged deficient practice would be those identified as those discharging from the facility. Beginning with the employment of the new DON, all discharged resident charts (records) will be organized in a systemic order as specified in policy. <u>3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?</u></p> <p>An audit is conducted monthly by the DON or designee to assure that the policy is being followed. <b>Such audits will be conducted on an ongoing basis.</b> Any deviation is reported to the Executive Director immediately for disciplinary action up to and including discharge if appropriate. <u>4. How will the corrective actions be monitored to ensure that the deficient practice does not recur?</u>A report will be given to the Executive Director who will determine compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2015
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