

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155381	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2016
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NAME OF PROVIDER OR SUPPLIER HARBOUR MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00202702.</p> <p>Complaint IN00202702 - Substantiated. Federal/State deficiencies related to these allegations are cited at F514.</p> <p>Survey dates: June 20 and 21, 2016</p> <p>Facility number: 000551 Provider number: 155381 AIM number: 100267400</p> <p>Census bed type: SNF/NF: 101 SNF:12 Total: 113</p> <p>Census payor type: Medicare: 17 Medicaid: 76 Other: 20 Total: 113</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on June 22,</p>	F 0000	This administrator respectfully request a desk review regarding this citation	

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

TITLE

(X6) DATE

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

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F 0514 SS=D Bldg. 00	<p>2016.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurate in regard for 1 of 4 residents reviewed for complete and accurate records. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 6/20/16 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, end stage renal disease, peritonitis, peritoneal dialysis, liver cirrhosis, viral hepatitis C, depression and diabetes mellitus type II.</p> <p>Review of the Physician orders for May,</p>			F 0514	<p>The plan of correction is to serve as Harbour Manor Health and Living Community's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Harbour Manor Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>F 514 483.75(l)(1) RES RECORDS-COMPLETE/ACCUR</p>		07/08/2016

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	<p>2016, indicated the following: "Novolog Flexpen (insulin aspart) Insulin pen; 100 unit/mL; Amount to Administer: Per Sliding Scale; If Blood Sugar is less than 70, call MD. If Blood Sugar is 151 to 200, give 2 units. If Blood Sugar is 201 to 250, give 4 units. If Blood Sugar is 251 to 300, give 6 units. If Blood Sugar is greater than 300, call MD." This order was dated May 6, 2016 and discontinued on June 12, 2016.</p> <p>Review of the Medication Administration Record for May 6, 2016 through May 31, 2016, indicated the following:</p> <p>May 6 at 5:00 p.m., no blood sugar nor reason for omission was documented.</p> <p>May 7 at 7:00 a.m., 12:00 p.m. and 5:00 p.m., no blood sugar nor reason for omission was documented.</p> <p>May 8 at 7:00 a.m., 12:00 p.m. and 5:00 p.m., no blood sugar nor reason for omission was documented.</p> <p>May 9 at 7:00 a.m., 12:00 p.m. and 5:00 p.m., no blood sugar nor reason for omission was documented.</p> <p>May 18 at 5:00 p.m., no blood sugar nor reason for omission was documented.</p> <p>May 25 at 7:00 a.m., no blood sugar nor</p>		<p>ATE/ACCESSIBLE</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the practice.</p> <p>Resident Bno longer resides in the facility</p> <p>II. The facility will identify other residents that may potentially be affected by the practice.</p> <p>Residents who reside at Harbour Manor Health and Living Community and have physician ordered accuchecks are being reviewed for complete and accurate documentation. Any identified concerns will be reported to the MD.</p> <p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur.</p> <p>Licensed nurses will be educated regarding the accurate and complete documentation of accucheck results. All residents with accucheck orders will be reviewed daily in the clinical stand up meeting (Monday through Friday) Any concerns will be addressed.</p> <p>IV. The facility will monitor</p>	

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	<p>reason for omission was documented.</p> <p>During an interview on 6/21/2016 at 9:18 a.m., the Clinical Support Specialist indicated the blood sugars should have been documented on the Medication Administration Record. The Clinical Support Specialist further indicated she was unable to locate the missing documentation .</p> <p>This Federal tag relates to Complaint IN00202702.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>		<p>thecorrective action by implementing the following measures.</p> <p>A CQlaudit tool will be utilized by the Director of Nursing or designee to audit thedocumentation of accucheck results daily for 30 days. If 100% compliance isattained, the Director of Nursing or designee will then audit the documentationof accucheck results weekly for 60 days. If 100% compliance is attained, theDirector of Nursing or designee will then audit the documentation of accucheckresults monthly for 180 days for a total of 12 months of monitoring.</p> <p>Theresults of these reviews will be discussed at the monthly facility QualityAssurance Committee meeting monthly for 3 months and then quarterly thereafteronce compliance is at 100%. Frequencyand duration of reviews will be increased as needed, if compliance is below100%.</p> <p>V. Plan of Correction completiondate.</p> <p>Date ofCompliance 07/08/2016 TheAdministrator will be responsible for ensuring the facility is in compliance bydate of compliance listed.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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