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
	155780		01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH CARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaints IN00190558, IN00190612, IN00190668. Survey dates: January 10, 11, 12, 13, 14, and 15, 2016. Facility number: 012225 Provider number: 155780 AIM number: 200983560 Census bed type: SNF/NF: 84 Total: 84 Census payor type: Medicare: 10 Medicaid: 62 Other: 12 Total: 84 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 14466 on January 25, 2016.	F 0000		

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.

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F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review, and interview, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments accurately reflected the	F 0278	Submission of this plan of correction does not constitute an admission by Madison Health Care Center or their Management companies that the allegations	02/14/2016

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	status of a resident's range of motion for 1 of 3 residents who met the criteria for review of range of motion. (Resident #9) Findings include: The clinical record of Resident #9 was reviewed on 1/15/16 at 5:12 p.m. Diagnoses for the resident included, but were not limited to, muscle spasm. An observation on 1/11/16 at 4:00 p.m., indicated Resident #9 had severe contractures in both hands. A contracture is a condition of fixed high resistance to passive stretch of muscle. A quarterly MDS assessment dated 10/21/15, indicated the resident had no impairment in range of motion to her upper extremities and was signed by Registered Nurse (RN) #4, verifying accuracy of the assessment. A quarterly MDS assessment dated 7/14/15, indicated the resident had no impairment in range of motion to her upper extremities, and was able to make a fist with or open her left and right hands. This MDS was signed by RN #5, verifying accuracy of assessment. On 1/15/16 at 4:30 p.m. the MDS Coordinator indicated Resident #9 did		contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of the survey allegations. F278 483.20(g) Accuracy of Assessment. The assessment must accurately reflect the resident's status. It is the practice of Madison Health Care Center to ensure that each Resident receives a Minimum Data Set (MDS) assessment which reflects an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the Resident's status, needs, strengths, and areas of decline. I. Resident #9 MDS range of motion assessments dated 10/21/15 and 7/14/15 were modified to accurately reflect Resident #9 range of motion assessment upon surveyor's findings. II. All Madison Health Care Center Residents who have Minimum Data Set (MDS) range of motion assessments completed have the potential to be affected. III. Madison Health Care Center has a policy regarding Minimum Data Set (MDS) assessments and submission. Nursing staff re-educated on Minimum Data Set (MDS) assessment policy and range of motion assessment. Nurses responsible for Minimum Data Set (MDS) data input and transmission have been re-educated on assessment and	

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	have severe contractions in both hands. She indicated the MDS range of motion assessments dated 10/21/15 and 7/14/15 were in error. 3.1-31(i)		submission policy. IV. Madison Health Care Center Minimum Data Set (MDS) and assessments have been reviewed. The MDS coordinator, or her designee, is conducting quality assurance audits to ensure the Residents Minimum Data Set (MDS) assessments due accurately reflect Resident's range of motion and coded as such on the Minimum Data Set (MDS). This QA audit will be completed 3 times per week for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative findings will add another four weeks of audits until 100% compliance is achieved.	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to provide laboratory services in accordance with each resident's written plan of care for 2 of 5 resident's receiving laboratory services. (Residents #36 & #18) Findings include: 1. The clinical record for Resident #36 was reviewed on 1/14/16 at 3:20 p.m.	F 0282	Submission of this plan of correction does not constitute an admission by Madison Health Care Center or their Management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of the survey allegations. F 282 483.20 (k)(3)(ii) SERVICES BY QUALIFIED	02/14/2016

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	Diagnoses included, but were not limited to, hypertension and depression. A care plan for Resident #36, created on 10/3/14, revised on 1/5/16, indicated a focus of, "Risk for fluid volume imbalance r/t [related to] diuretic therapy [medication which increases excretion of fluids and electrolytes]." Interventions included, "labs as ordered...." Laboratory test reports for Resident #36 were reviewed from April 1, 2015 through January 15, 2016. A report dated 5/26/15, indicated a comprehensive metabolic panel and a complete blood count test was completed. A report dated 10/8/15, indicated a protime-INR blood level test was completed. A report dated 11/24/15, indicated a comprehensive metabolic panel and a complete blood test was completed. A laboratory report dated 12/12/15, indicated a microalbumin and creatinine test was completed. A review of Physician's orders from April 1. 2015 through January 15, 2016, lacked orders for the laboratory testing completed on 5/26/15, 10/8/15, 11/24/15, and 12/12/15. On 1/15/15 at 7:37 p.m., the Director of Nursing (DON) indicated there were no Physician's orders found in Resident		PERSONS/PER CARE PLAN It is the practice of Madison Health Care Center to ensure that each Residents prescribed laboratory services are obtained in accordance with each Resident's written plan of care and as per physician order. I. Resident #18 and #36 laboratory services were obtained in excess of physicians order. Laboratory services are outlined in the Resident's care plan as the survey findings indicate. II. Madison Health Care Center Residents utilizing laboratory services all have the potential to be affected. III. Madison Health Care Center has a policy regarding ordering of laboratory services. Nursing staff has been re-educated on this practice. IV. All Madison Health Care Center Resident's information has been reviewed and changed, if necessary, in the laboratory services computer program. The DON, or her designee, is conducting quality assurance audits to ensure that residents requiring laboratory services will be obtained per physician orders and as outlined in the care plan. This QA audit will be completed 3 times per week for 30 days; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative findings will add another four weeks of audits until 100% compliance is achieved.	

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	#36's clinical record for laboratory tests completed on 5/26/15, 10/8/15, 11/24/15, and 12/12/15. The DON indicated there was no documentation found indicating a reason for those laboratory tests to have been completed. 2. The clinical record of Resident #18 was reviewed on 1/14/16 at 2:28 p.m. Diagnoses for the resident included, but were not limited to, bipolar disorder, coronary artery disease, high blood pressure, and hyperlipidemia (a condition of high levels of cholesterol). A care plan for Resident #18, dated 9/26/14 and current through 1/21/16, indicated he was a risk for complications due to his diagnosis of hyperlipidemia. Interventions included, "labs per orders." Another care plan, dated 9/26/14 and current through 1/21/16, indicated the resident was at risk for elevated blood pressure. Interventions included, "labs per orders." A physician's order dated 9/24/14, indicated Resident #18 was to receive valproic acid, a medication used to treat bipolar disorder, 2 times per day. A physician's order dated 4/16/15, indicated the resident was to have a laboratory blood test every 6 months to measure the			

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	level of valproic acid in her body. The resident's record indicated valproic acid levels were drawn on 5/5/15, 10/5/15, and 11/20/15. Recapitulated physician's orders for May, June, July, August, September, October, November, and December, 2015, indicated the resident was to have a lipid panel laboratory blood test drawn 1 time per year. The original date of the order was not available. A lipid panel is a blood test that measures fats and fatty substances in the body. The resident's record indicated a lipid panel was drawn on 5/5/15, 8/18/15, and 11/17/15. A physician's order dated 4/16/15, indicated Resident #18 was to have a comprehensive metabolic panel (CMP) every 6 months. Another physician's order dated 5/12/15, indicated the resident was to have a CMP in 3 months. The resident's record indicated a CMP was drawn on 5/5/15, 8/18/15, 10/5/15, and 11/17/15. A physician's order dated 4/16/15, indicated the resident was to have a complete blood count (CBC) drawn every			

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	6 months. The resident's record indicated a CBC was drawn 5/5/15, 8/18/15, 10/5/15, and 11/17/15. On 1/15/16 at 9:16 a.m., the Director of Nursing indicated, when the nurses were entering new laboratory blood draw orders into the computer, they were forgetting to cancel the old orders, and somehow the orders for the VPA level and lipid panel got mixed up with all the other orders, so the VPA, lipid panel, CBC, and CMP laboratory specimens were drawn more frequently than the physician ordered. 3.1-35(g)(2)			
F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was distributed to 2 residents under sanitary conditions (Residents #73 and #72).	F 0371	Submission of this plan of correction does not constitute an admission by Madison Health Care Center or their Management companies that the allegations contained in the survey report are a true and accurate portrayal of	02/14/2016

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	Findings include: An observation of the noon meal service in the main dining room was completed on 1/11/16. At 12:13 p.m., Licensed Practical Nurse (LPN) #1 was observed with non-gloved hands, picking up Resident #73's bread roll and then touching it again to place butter on the bread roll. At 12:15 p.m., LPN #1 was observed with non-gloved hands, picking up Resident #72's bread roll and then touching it again to place butter on the bread roll. On 1/15/16 at 5:57 p.m., the Administrator indicated the staff are not supposed to touch resident's food with ungloved hands. On 1/15/16 at 2:42 p.m., a policy for food service in the dining room was requested. No policy indicating correct food service distribution procedure in the dining room was provided by survey exit on 1/15/16 at 9:54 p.m. 3.1-21(i)(3)		the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of the survey allegations. F371 483.35(i)(2) - Store, prepare, distribute and serve food under sanitary conditions It is the practice of Madison Health Care Center to ensure food is distributed to Residents under sanitary conditions without food items being touched with an ungloved hand. I. Resident #73 and #72 noon meal observation in the main dining room was completed and observed to have bread roll touched with ungloved hand. II. Madison Health Care Center Residents whose meals are delivered via food service distribution procedure all have the potential to be affected. III. Madison Health Care Center has a policy regarding food service distribution. All staff participating in food service distribution have been re-educated on this practice. IV. Madison Health Care Center alternating meal service times have been reviewed. The DON, or her designee, is conducting quality assurance audits to ensure that Residents whose meals are delivered via food service distribution is not touched with an ungloved hand and distributed under sanitary conditions during alternating meal service times. This QA audit will be completed 5 times per week for 4 weeks; then	

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			3 times per week for 4 weeks; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative findings will add another four weeks of audits until 100% compliance is achieved.	
F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except			

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	when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on interview and record review, the facility failed to ensure the controlled medication accountability record was completed for 4 of 6 controlled medication accountability records reviewed (Halls 400, 500, 600, and 700). Findings include: Review of facility controlled medication accountability records for December, 2015, and January, 2016, was completed on 1/15/16 at 6:30 p.m. 1. A review of the 400 hall controlled medication accountability record, lacked documentation for the following: a. 3rd shift oncoming: December 1, 2, 3, 5, 10, 13, 14, 15, 18, 20, 21, 24, 25, 26, 27, 28, and 29, 2015. January 1, 3, 4, 13, and 14, 2016. b. 3rd shift offgoing: December 1, 2, 3, 19, 20, 21, 24, 25, 26, 28, 29, and 31, 2015. January 1, 3, 4, and 14, 2016. c. 1st shift oncoming: December 1 and 18, 2015. January 1 and 8, 2016. d. 1st shift offgoing: & offgoing: December 1 and 18, 2015. January 1 and	F 0431	Submission of this plan of correction does not constitute an admission by Madison Health Care Center or their Management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of the survey allegations. F 431 483.60 (e) Storage of Drugs and Biologicals It is the practice of Madison Health Care Center to ensure that each controlled medication accountability record is complete. I. The controlled medication accountability records of 400, 500, 600 and 700 hall carts were presented as outlined in the survey findings. II. Madison Health Care Center controlled medication accountability records all have the potential to be affected. III. Madison Health Care Center has a policy regarding controlled medication accountability records. Licensed Nursing staff have been re-educated on this practice. IV. All Madison Health Care Center controlled medication accountability records have been reviewed. The DON, or her designee, is conducting quality assurance audits to ensure that controlled medication	02/14/2016

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	8, 2016. e. 2nd shift oncoming: December 25, 26, 27, and 31, 2015. January 1, 8, and 13, 2016. f. 2nd shift offgoing: December 25, 26, 27, and 31, 2015. January 1, 5, 8, 13, 2016. 2. A review of the 500 hall controlled medication accountability record, lacked documentation for the following: a. 3rd shift oncoming: December 7, 15, 16, 24, 25, and 31, 2015. January 1, 3, 4, 5, and 14, 2016. b. 3rd shift offgoing: 24, and 29, 2015. January 1, 3, 4, and 14, 2016. c. 2nd shift oncoming: December 8, 9, 22, 25, 26, 27, and 31, 2015. d. 2nd shift offgoing: December 8, 9, 17, 22, 25, 26, 27, and 31, 2015. 3. A review of the 600 hall controlled medication accountability record, lacked documentation for the following: a. 3rd shift offgoing: December 14, 15, 16, 18, 19, 20, 21, 24, and 25, 2015. January 14, 2016. b. 3rd shift oncoming: December 3, 16,		accountability records are being completed in its entirety. This QA audit will be completed 3 times per week for 30 days; then monthly for 6 months. Results of these audits will be reported at the QA committee monthly. Any negative findings will add another four weeks of audits until 100% compliance is achieved.	

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	19, 20, 21, 24, 28, and 29, 2015. January 14, 2016. c. 2nd shift oncoming: December 5, 2015. d. 3rd shift offgoing: 20, 26, 28, 29, and 31, 2015. e. 3rd shift oncoming: 6, 20, 25, 28, 29, and 31, 2015. 4. A review of the 700 hall controlled medication accountability record, lacked documentation for the following: a. 1 shift ongoing: January 1, and 15, 2016. b. 2nd shift oncoming: December 20, 2015. c. 2nd shift offgoing: December 20, 2015. d. 3rd shift oncoming: December 5 and 31, 2015. January 9, 10, 11, 12, 2016. e. 3rd shift offgoing: December 5 and 31, 2015. January 9, 10, 11, 12, 2016. During an interview on 1/15/16 at 8:38 p.m., the Corporate Nurse Consultant indicated nurses are supposed to sign the controlled medication accountability			

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MADISON HEALTH CARE CENTER	7465 MADISON AVE INDIANAPOLIS, IN 46227

(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
	record at the beginning of their shift and at the end of their shift. She also indicated that no nurses worked a double shift on the missing dates listed above. On 1/15/16 at 8:38 p.m., the Corporate Nurse Consultant provided an undated policy titled, "Medication Storage In The Facility" and indicated it was currently used by the facility. The policy indicated, "...D. At each shift change, a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses and is documented on the controlled medication accountability record per facility procedure...." 3.1-25(m)			