

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 03/07/2012
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NAME OF PROVIDER OR SUPPLIER MCKINNEY HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 HIGH STREET RD LOGANSPORT, IN 46947
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 5, 6, 7, 2012</p> <p>Facility number: 004441 Provider number: 004441 AIM number: NA</p> <p>Survey team: Tim Long, RN-TC Julie Wagoner, RN</p> <p>Census bed type: Residential: 36 Total: 36</p> <p>Census Payor type: Other: 36 Total: 36</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on March 14, 2012 by Bev Faulkner, RN</p>	R0000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or, that this Statement of deficiency was coprrctely cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who draft or may be discussed in the Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
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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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R0006	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on record review and interview, the facility failed to discharge a resident and allowed the resident to remain in the facility who required extensive supervision to prevent elopement, and presented as a danger to self and others for 1 of 7 residents (#7) reviewed for appropriate placement.</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 03/05/12 between 10:35 A.M. - 11:00 A.M., QMA (Qualified</p>	R0006	We respectfully request that an informal disputed resolution conference be held regarding this citation. We would like to submit further information in support of our dispute with this citation. Resident #7 is moving to a locked unit on 3/30/2012 due to increased mental health decline. Current residents were at potential risk. The Residence Director (RD) will ensure a "sitter" is available if resident becomes agitated, The sitter will document activity on the resident's service notes. Elopement drills are in place to be conducted 2 times a year. Elopement assessments	03/30/2012			

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	<p>Medication Aide) #4 indicated Resident #7 had recently returned from an inpatient psychiatric hospitalization. She indicated the resident had been exit seeking but was better now. She indicated the resident was confused and ambulated independently.</p> <p>The clinical record for Resident #7 was reviewed on 03/06/12 at 1:45 P.M. Resident #7 had been admitted to the facility on 07/29/11 with diagnosis, including but not limited to, Alzheimer's dementia. Resident service notes, dated 01/18/12 at 12 noon, indicated the resident had refused to come to the dining room for breakfast. A service note, dated 01/18/12 at 9:00 P.M., indicated the resident was sitting in the hallway outside her apartment and refused to go in her apartment or to the dining room for supper. On 01/22/12 at 10:00 A.M., the resident had again refused to come to the dining room and was feeding her cat her breakfast meal in her apartment.</p> <p>A resident service note, dated 01/27/12 at 8:00 A.M., indicated the resident had been up knocking on other residents doors, yelling, swearing at staff, slamming doors, going in and out of other resident's apartments. The note indicated redirection had been repeatedly attempted and was not successful.</p>		are performed on admission and then every 3 months. High risk residents will b assigned a "sitter" until residents behavior changes to a non-elopment risk.The Regional Director of Quality and Care Management (RDQCM) will monitor resident service notes for sitter documentation weekly until resident #7's departure.				

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	<p>Further notes on 01/27/12 at 2:00 P.M., indicated the resident's physician had been notified of her behaviors. At 3:00 P.M., a physician's order for the antipsychotic medication, Abilify, was received.</p> <p>Nursing notes on 01/28/12 at 11:00 A.M., indicated the resident had refused to come to breakfast, and had then proceeded to throw items out of her apartment, stated it was not hers, and then started crying. The resident repeated the behavior on 01/28/12 at 5:00 P.M., and the resident's family took her to the local emergency room. The resident returned from the emergency room on 01/28/12 at 9:45 P.M., with diagnoses of a fecal impaction and a urinary tract infection. The resident had an order to receive an enema and an antibiotic.</p> <p>Resident service notes on 01/29/12 at 3:30 P.M., indicated the resident was bundling her personal items in her apartment and the Wellness Director was sitting with her. From 6:00 P.M. - 6:30 P.M., the resident's daughter was with her. After the daughter left the building, the resident then was noted to be going in and out of other resident's rooms, was verbally and physically aggressive with staff when they tried to redirect or intervene, was noted to be kicking, shaking, and hitting the front doors of the</p>			

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	<p>facility. She had to be physically held back while visitors exited the building and was also noted to be going in and out of storage areas near the dining room. At 7:00 P.M., the resident was found in another resident's room, pulling the resident's arm and attempting to take items from her room. The resident's daughter was called at the time and requested she come back in to the facility to sit with her mother. The Wellness Director was also notified and instructed the nurse to call the resident's physician. At 7:20 P.M., the resident's daughter returned the facility's call and indicated she would come back in to the facility. She also told the nurse she had already spoken with the resident's physician. At 7:30 P.M., the resident's physician called and gave an order to send the resident to the emergency room with her daughter. At 8:00 P.M., a resident whose room was close to Resident #7's called nursing staff because Resident #7 was heard yelling at her cat. However, staff noted the resident crying in her apartment with the cat on her lap. At 8:15 P.M., the resident's daughter entered the building, the nurse was at the front desk filling out transfer forms for Resident #7 when the local police department telephoned the facility and inquired if there was a resident by Resident #7's name. The police officer informed the facility the resident had been</p>						

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	<p>found behind the facility on an access road between a department store and Walmart and looked visibly "battered."</p> <p>Review of an hourly check for Resident #7 for 01/29/12 indicated the resident was noted to be in her apartment "upset" at 6:00 A.M., 7:00 A.M., and 8:00 A.M. At 12:00 P.M., the resident tried to leave the building. At 7:00 P.M., the resident was "upset and trying to escape." At 8:00 P.M., the resident was noted to be in her room.</p> <p>Review of the admitted psychiatric hospital consultation report, completed on 02/01/12, indicated the resident had been admitted to an acute care hospital after falling after she wandered away from the assisted living facility. The resident was noted to have a left orbital floor fracture (facial), left eye swelling and bruising to her face, left wrist, and forearm.</p> <p>The resident received inpatient psychiatric care from 02/01/12 - 02/06/12, when she returned to the assisted living facility. However, review of the plan for the psychiatric evaluation indicated for safety concerns with elopement he felt it was "reasonable" for the patient to be moved to a secured facility.</p> <p>Interview with the Administrator and</p>						

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	<p>Director of Nursing, on 03/07/12 at 9:15 A.M., indicated the following measures had been taken to ensure Resident #7 did not elope: the door alarms were checked to ensure they were functioning, staff were inserviced again on the need to respond to door alarms, a self locking door handle was placed on the conference room door to prevent exit through the exit door on the interior of the room, kitchen staff were instructed to lock the kitchen door when leaving the kitchen unattended, the front door code to unlock the door was changed and new signs were placed to advise visitors not to allow residents to leave, and Resident #7 was placed on 1/2 hour checks, and the 3rd staff member's hours on evenings were extended till 10:00 P.M..</p> <p>Review of the new service plan and elopement risk assessment for Resident #7 indicated she was a "red flag" for behaviors, but was not considered high elopement risk and was receiving "behavior management services."</p> <p>A fax to the physician, dated 02/26/12, indicated a request to increase the resident's antipsychotic medication, Seroquel, due to cursing and kicking at the exit doors.</p> <p>Review of the facility "behavior</p>						

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	management plan" for Resident #7, located in a staff communication book, indicated if the resident was agitated staff were to try to get her to color a picture from a coloring book, and were to reapproach with a different staff member if she refused to come to the dining room, or staff were to give her a task if she was agitated. There was no plan to increase the resident's supervision if she was agitated, attempting to exit the facility, or entering other resident's room in an agitated state.			

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R0090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be</p>						

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	<p>available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interviews, the facility failed to report timely to the Department of Health a resident elopement with significant injury. This affected 1 of 1 residents reviewed for elopements in a sample of 7. (Resident #7)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #7, conducted on 03/06/12 at 1:45 P.M., indicated on 01/29/12 between 8:00 P.M. - 8:20 P.M., the resident had eloped from the facility. The local police department had been notified by the public of the need for assistance for Resident #7 who was found on an access road behind the facility between shopping centers. The police department indicated the resident appeared "battered."</p> <p>The resident was transferred by ambulance to a local acute care facility and admitted with diagnosis, including but not limited to, left orbital floor fracture (facial) and urinary tract</p>	R0090	<p>Resident #7 received appropriate medical intervention and due to increased mental decline, is moving to a locked unit on 3/30/2012.No other residents were affected and there were no specific resident concerns.Residence Director and Welness Director were re-educated to company policy and stae regulations regarding when to report an incident to the State.Residence Director and Welness Director were re-educated to company policy and state regulations regarding accurate reporting.Regional Director of Quality and Care Management (RDQCM) review incident reports for state reporting requirements to ensure compliance.</p>	04/06/2012

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	<p>infection.</p> <p>Interview with the Administrator, on 03/06/12 at 3:00 P.M., indicated he had reported the incident via an email to the Indiana State Department of Health on 01/31/12 at 11:36 A.M. He indicated the facility corporate staff had to "approve" of his report before he could submit it to the Department of Health. Review of the report submitted on 01/31/12 at 11:36 A.M., and confirmation from ISDH staff on 03/06/12 at 3:15 P.M., indicated only the following paragraph was submitted: "Brief Description of Incident: Subsequent to erratic behavior facility staff attempted to calm resident. The resident's daughter was contacted to visit the facility at approximately 5:30 P.M., and she attempted to calm the resident. The resident was initially calmed, but at 7:00 P.M., again evidenced erratic behaviors. The Wellness Director again contacted daughter, around 7:30 P.M., and both agreed the daughter would return as soon as possible to take the resident to hospital. The daughter arrived at the facility approximately 8:30 P.M."</p> <p>There was no account of the resident's elopement sent with the initial report.</p> <p>Interview with the Administrator on 03/06/12 at 3:00 P.M., regarding the</p>						

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	untimely reporting and circumstances of the report, the Administrator indicated again he had to have corporate approval and could only report what had been approved. There was no other explanation given as to why the report on 01/31/12 was untimely and did not include the actual elopement event documentation.				

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interviews, the facility failed to ensure a Qualified Medication Aide did not receive and implement a physicians order, which resulted in the QMA practicing outside of the scope of practice for a QMA and job description when caring for 1 resident in a sample of 7. (Resident #7)</p> <p>Finding includes:</p>	R0117	<p>Qualified Medication Aide (QMA) #10 received counseling on company policy and state regulations regarding taking a verbal doctor's order. Resident #7 was not adversely affected by the medication order. No other residents were affected. Wellness Director re-educated current clinical staff regarding scope of practice duties and exclusions The Regional Director Quality and Care Managemnt will review random physician orders for four</p>	03/12/2012

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	<p>1. Review of Resident service notes for Resident #7 for 01/28/12 at 6:00 P.M., indicated the following note written by QMA #10: "Dtr (daughter) here to take resident to ER (emergency room) (LMH) (initials of name of local acute care facility) for eval. Dtr called (physician's name) who spoke to me and gave one x [time] order for Ability at 6:30 P.M. Wd (Wellness Director) notified."</p> <p>Review of the physician's orders for Resident #7, for 01/27/12 - 01/29/12, indicated there was no one time order written for the one time Abilfy medication mentioned in the Resident Service note, dated 01/28/12 at 6:00 P.M. However, review of the Medication Administration Record for January 2012 for Resident #7 indicated QMA #10 gave 2 mg of Abilify at 6:30 P.M. on 01/28/12. The resident had already received a routine 2 mg dose of Abilify on 01/28/12 at 5:00 P.M.</p> <p>Interview with the Wellness Director, RN #1 , on 03/07/12 at 10:30 A.M., indicated she was notified of the order by QMA #10 and due to "special circumstances" had instructed the QMA to give the resident the medication.</p> <p>Review of the Qualified Medication Aide "Scope of Practice- 412 IAC 2-1-9,"</p>		months the quarterly thereafter to ensure licensed staff are receiving and transcribing verbal physician orders per company policy and state regulations.				

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	included the following: "(b) The following tasks shall not be included in the QMA scope of practice: (5) Assume responsibility for receiving in writing or receive a verbal or telephone order."			

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R0119	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on interview and record review, the facility failed to ensure facility managers received thorough training in duties for abuse procedures potentially affecting 36 of 36 residents in the facility.</p>	R0119	We respectfully request that an Informal Dispute Resolution conference be held regarding this citation. We would like to submit further information in support of our dispute with this citation.No	04/06/2012			

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	<p>Findings include:</p> <p>On 3/7/12 at 11:00 A.M., in an interview with the Administrator, he identified three staff who act as facility managers for weekends in the facility.</p> <p>An interview with Dietary Manager #1 on 3/7/12 at 11:15 A.M., indicated if she were acting as manager of the facility and an accusation of abuse was made towards a staff member she would call the Administrator or Director of Nursing (DN). She did not state she would send the staff member who was accused of abuse home. She stated she would have to see what the Administrator or DN told her to do with the staff member.</p> <p>An interview with CNA #2 on 3/7/12 at 11:20 A.M., indicated if she were acting as manager of the facility and an accusation of abuse was made towards a staff member she would call the Administrator or Director of Nursing (DN). She stated she would remove the staff member from the floor. She did not state she would send the staff member home during the investigation.</p> <p>An interview with Activity Director #3 on 3/7/12 at 11:30 A.M., indicated if she were acting as manager of the facility and</p>		<p>specific residents were affected. Employees #1, #2, and #3 were re-educated on duties of Weekend Manager on Duty Program and policy and procedures when there is an abuse allegation. Current Weekend Manager staff were re-educated relating to the duties of the Weekend Manager on Duty Program and policy and procedures when there is an abuse allegation. Resident Director will be responsible to ensure current staff is trained on Weekend Manager on Duty Program and policy on abuse. Regional Director of Operations (RDO) will audit employee files of Weekend Managers for four months, the quarterly thereafter to ensure compliance. The Regional Director of Operations (RDO) will make random weekend calls to weekend manager to validate understanding of duties and actions. The random calls will occur for 4 months and then quarterly thereafter to ensure compliance.</p>				

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	<p>an accusation of abuse was made towards a staff member she would call the Administrator or Director of Nursing (DN). She did not state she would send the staff member who was accused of abuse home. She stated she did not know what she would do if she could not contact the Administrator or DN.</p> <p>Review of the facility policy "Suspected Abuse/Neglect/Exploitation" provide by the Administrator on 3/7/12 at 3:30 P.M., updated 2011 indicated: "5. Act quickly to gather pertinent information. If an employee is suspected of the abuse, the employee must be suspended pending the outcome of an investigation, for the employee's protection as well as the protection of the resident. A staff person suspected or accused of abuse, neglect or exploitation should not have access to any resident until the Residence investigates and takes action to assure resident safety."</p>				

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R0214	<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 record review and interview, the facility failed to ensure 1 resident with a possible change in condition (Resident #31) in a sample of 7 was accessed by a licensed nurse to ensure no injury had occurred.</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #31 was reviewed on 03/05/12 at 1:50 P.M. Resident #31 was originally admitted to the facility on 09/25/10. On 10/31/11, the resident fell in her apartment, fractured her hip, and was transferred to an acute care center. The resident was readmitted to the facility on 02/18/12.</p> <p>Interview with QMA #4 on 03/05/12 at 10:50 A.M., indicated Resident #31's hip was healing slowly because she was often non-compliant with partial weight bearing status and did not like to ask for or wait for assistance. She indicated at the skilled nursing facility and at this facility the resident was often noted to convince other</p>	R0214	Documentation of hip assessment in resident service notes for resident #31 was completed by Wellness Director. Wellness Director reviewed current residents' records for hip assessments and action plans. No other deficiencies were found. The Wellness Director re-educated current staff regarding reporting changes in resident condition through resident service notes, communication log and/or telephone call. Wellness Director will document post hospitalization assessments in Residents Service Notes after a resident returns to the facility. Wellness Director will review the communication log daily to ensure resident changes that are noted in the log are followed up with review and possible re-assessment as needed. The Regional Director of Quality and Care Management (RDQCM) will audit random resident files monthly for four (4) months and the quarterly thereafter for confirmation of compliance.	04/06/2012			

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	<p>residents to bring her wheelchair and/or walker to her despite repeated instructions to wait for nursing staff to assist her. QMA # 4 indicated the facility kept the resident's wheelchair from her to prevent her from transferring herself and toileting herself.</p> <p>Review of the Resident service notes for Resident #31 for 02/19/12 at 2:00 P.M., indicated the following: "Resident returned to facility 02/18/12. Had c/o (complaints) pain and discomfort during noc (night). Applied ice notified (wellness director's name) Wellness Director, (Nurse's name) administered pain medication, vs (vital signs) t (temperature) 98.4, p (pulse) 70, r (respirations) 16, b/p (blood pressure) 126/78." The note was signed by Certified Nursing Assistant #9.</p> <p>Review of the Resident service notes, from 02/19/12 - 02/27/12, the most recent note for Resident #31 as of 03/06/12, indicated there was no assessment of the resident's hip area to ensure if there were any concerns with swelling, redness, any dislocation or issues with the recent surgical site</p> <p>Interview with the Wellness Director and Administrator, during the daily exit conference, conducted on 03/06/12 at</p>						

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	4:15 P.M., indicated there was no further information or assessment documentation regarding the resident's hip.						

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R0217	<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:</p> <p>(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.</p> <p>(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.</p> <p>(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> <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 record review and interview, the facility failed to update a service plan to include increased supervision provisions for 1 of 7 residents reviewed for elopement issues in a sample of 7. (Resident #7)</p> <p>Finding includes:</p>	R0217	Due to increased mental health decline, Resident #7 is being moved to a locked unit on 3/30/2012. Current residents were at potential risk. The Wellness Director revised the resident service plan to include supervision level, plan to prevent exiting the facility and plan to stop resident from enter other	04/06/2012			

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	<p>During the initial tour of the facility, conducted on 03/05/12 between 10:35 A.M. - 11:00 A.M., QMA (Qualified Medication Aide) #4 indicated Resident #7 had recently returned from an inpatient psychiatric hospitalization. She indicated the resident had been exit seeking but was better now. She indicated the resident was confused and ambulated independently.</p> <p>The clinical record for Resident #7 was reviewed on 03/06/12 at 1:45 P.M. Resident #7 had been admitted to the facility on 07/29/11 with diagnosis, including but not limited to, Alzheimer's dementia. Resident service notes, dated 01/18/12 at 12 noon, indicated the resident had refused to come to the dining room for breakfast. A service note, dated 01/18/12 at 9:00 P.M., indicated the resident was sitting in the hallway outside her apartment and refused to go in her apartment or to the dining room for supper. On 01/22/12 at 10:00 A.M., the resident had again refused to come to the dining room and was feeding her cat her breakfast meal in her apartment.</p> <p>A resident service note, dated 01/27/12 at 8:00 A.M., indicated the resident had been up knocking on other residents</p>		<p>resident's rooms in time of agitation. The Wellness Director will include, on the residents service plans to include supervision level, plan to prevent exiting the facility and plan to stop resident from entering other residents room. Service plans will include plan to prevent exiting the facility and plan to stop residents from entering other residents room on residents with elopment risks. The Rregional Director of Quality and Care Management will review resident's service plan weekly until resident #7's departure. The Regional Director of Quality and Care Management will monitor elopment risk residents for service plan for 4 months and then quarterly thereafter to ensure compliance</p>				

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	<p>doors, yelling, swearing at staff, slamming doors, going in and out of other resident's apartments. The note indicated redirection had been repeatedly attempted and was not successful.</p> <p>Further notes, on 01/27/12 at 2:00 P.M., indicated the resident's physician had been notified of her behaviors. At 3:00 P.M., a physician's order for the antipsychotic medication, Abilify was received.</p> <p>Resident service notes on 01/29/12 at 3:30 P.M., indicated the resident was bundling her personal items in her apartment and the Wellness Director was sitting with her. From 6:00 P.M. - 6:30 P.M., the resident's daughter was with her. After the daughter left the building, the resident then was noted to be going in and out of other resident's rooms, was verbally and physically aggressive with staff when they tried to redirect of intervene, was noted to be kicking, shaking, and hitting the front doors of the facility.</p> <p>She had to be physically held back while visitors exited the building and was also noted to be going in and out of storage areas near the dining room. At 7:00 P.M., the resident was found in another resident's room, pulling the resident's arm and attempting to take items from her</p>						

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	<p>room. The resident's daughter was called at the time and requested she come back in to the facility to sit with her mother. The Wellness Director was also notified and instructed the nurse to call the resident's physician. At 7:20 P.M., the resident's daughter returned the facility's call and indicated she would come back in to the facility. She also told the nurse she had already spoken with the resident's physician. At 7:30 P.M., the resident's physician called and gave an order to send the resident to the emergency room with her daughter. At 8:00 P.M. a resident whose room was close to Resident #7's called nursing staff because Resident #7 was heard yelling at her cat. However, staff noted the resident crying in her apartment with the cat on her lap.</p> <p>At 8:15 P.M., the resident's daughter entered the building, the nurse was at the front desk filling out transfer forms for Resident #7 when the local police department telephoned the facility and inquired if there was a resident by Resident #7's name. The police officer informed the facility the resident had been found behind the facility on an access road between a department store and Walmart and looked visibly "battered."</p> <p>The resident received inpatient psychiatric care from 02/01/12 - 02/06/12, when she</p>						

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	<p>returned to the assisted living facility. However, review of the plan for the psychiatric evaluation indicated for safety concerns with elopement he felt it was "reasonable" for the patient to be moved to a secured facility.</p> <p>Interview with the Administrator and Director of Nursing, on 03/07/12 at 9:15 A.M. indicated the following measures had been taken to ensure Resident #7 did not elope: the door alarms were checked to ensure they were functioning, staff were inserviced again on the need to respond to door alarms, a self locking door handle was placed on the conference room door to prevent exit through the exit door on the interior of the room, kitchen staff were instructed to lock the kitchen door when leaving the kitchen unattended, the front door code to unlock the door was changed and new signs were placed to advise visitors not to allow residents to leave, and Resident #7 was placed on 1/2 hour checks, a the 3rd staff member on evenings hours were extended till 10:00 P.M..</p> <p>Review of the new service plan and elopement risk assessment for Resident #7 indicated she was a "red flag" for behaviors but was not considered high elopement risk and was receiving "behavior management services."</p>						

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	<p>A fax to the physician, dated 02/26/12, indicated a request to increase the resident's antipsychotic medication, Seroquel due to cursing and kicking at the exit doors.</p> <p>Review of the facility "behavior management plan" for Resident #7, located in a staff communication book, indicated if the resident was agitated staff were to try to get her to color a picture from a coloring book, and were to reapproach with a different staff member if she refused to come to the dining room, or staff were to give her a task if she was agitated. There was no plan to increase the resident's supervision if she was agitated, attempting to exit the facility, or entering other resident's room in an agitated state.</p> <p>Interview with the Wellness Director, on 03/07/12 at 10:00 A.M., indicated she had revised and completed a new service plan for Resident #7 when she had returned from the inpatient psychiatric hospital.</p>						

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R0241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review and interview, the facility failed to administer a physician ordered medication (Novolog ) and obtain a physician's ordered laboratory test for 1 of 7 residents (#20) reviewed for physician's orders in a sample of 7.</p> <p>Findings include:</p> <p>1. Resident #20's clinical record was reviewed on 3/6/12 at 10:00 A.M. and indicated the resident was admitted to the facility on 1/31/12 with diagnoses including Diabetes Mellitus. The resident's physician's orders on admission and current physician's orders from 2/28/12 indicated the resident was to receive Novolog insulin, 10 mg IM before meals.</p> <p>On 3/6/12 at 11:45 A.M., Resident #20 was observed administering her own Humalog insulin intramuscular (IM) injection. The administration of the Humalog was supervised by Qualified</p>	R0241	Resident #20 HbBA1C has been obtained. Laboratory orders have been reviwed in current resident files, and no other residents were indentified at rick. The Regional Director of Quality and Care Management re-educated the Wellness Director on company policy and state regulations regarding receiving and confirming lab tests are documented and completed. Tkhe Wellness Director wiill review physician orders weekly to ensure compliance. The Wellness Director and/or Residence Director re-educated current staff on utilizing the communication log and service notes to identify new order when they come in and to confirm lab tests are completed as ordered. The Regional Director of Quality and Care Management will monitor physician orders monthly for four (4) months and then quarterly thereafter for confirmation of compliance.	04/06/2012			

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	<p>Medication Aide (QMA) #4. The resident checked her blood glucose and administered 3 units of Humalog per physician's orders for a blood glucose of 222.</p> <p>An interview with QMA #4 on 3/6/12 at 11:40 A.M., indicated the resident receives 2 IM injections in the morning before breakfast, and only one before lunch. QMA #4 indicated Resident #20 gives herself Lantus 58 units routinely and Humalog coverage for blood glucose level before breakfast and only Humalog coverage for blood glucose before lunch. QMA #4 indicated Novolog 10 units three times daily before meals, which was on the Medication Administration Record (MAR) was never given to the resident.</p> <p>An interview with the Director of Nursing (DN) on 3/6/12 at 11:45 A.M., indicated the resident's routine Novolog was never given. The DN indicated a lab for a HgBA1c was completed and the physician discontinued the Novolog and she forgot to take the medication off the MAR and the physician's orders sheet.</p> <p>Review of a fax dated 2/7/12, sent to Resident #20's physician, indicated the request: "Please check med list to see if it is correct for 'Resident #20' and fax back to me, she is not taking the Novalog [sic]</p>						

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	<p>insulin, can it be Dc'd?" The response from the physician was "do a HgbA1C, probably needs the insulin."</p> <p>An interview with the DN on 3/6/12 at 1:55 P.M., indicated the resident had never taken routine Novolog and that is why she faxed the physician on 2/7/12 to ask about whether the resident needed Novolog or not. The DN indicated the physician asked to obtain a lab, HgBA1C (which measures blood glucose levels over a long period of time). The DN indicated she never got a response from the physician after the HgBA1C was obtained ,but the DN said the lab level was good so the resident did not need the Novolog.</p> <p>Review of Resident #20's clinical record on 3/6/12 at 10:00 A.M. indicated on 2/7/12 a physician's order was received to obtain a lab for an HgBA1C which measures long term blood glucose levels.</p> <p>Review of the resident record did not indicate the resident had an HgBA1C lab completed.</p> <p>An interview with the DN on 3/6/12 at 2:45 P.M., indicated the HgBA1C lab was never obtained.</p>						

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R0242	<p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents (#23) observed during medication pass was monitored for side effects during medication administration.</p> <p>Findings include:</p> <p>On 3/5/12 at 12:40 P.M., Resident #23 was observed receiving Albuterol 2.5 milligrams (mg) per 3 milliliters through a nebulizer inhaler. The medication was administered by the Director of Nursing (DN). The DN did not perform a pulmonary assessment or check any vital signs including pulse rate before, during or after the administration of the medication.</p> <p>An interview with the DN on 3/7/12 at 9:30 A.M., indicated the facility does not have a policy on administering nebulizer treatments for residents. The DN indicated the facility has a policy for assisting with nebulizer treatments. The DN provided the facility policy titled</p>	R0242	<p>We respectfully request that an informal Dispute Resolution conference be held regarding this citation. We would like to submit further information in support of our dispute with this citation. Resident #23 now has pulmonary assessments and pulse monitored before and after Albuterol aerosol therapy. No other residents were affected. Residents receiving Albuterol aerosol therapy will have pulmonary assessments and pulse monitored before and after Albuterol aerosol therapy. The Wellness Director will document residents pulmonary assessment and pulse before and after Albuterol aerosol therapy on resident service notes. the Regional Director of Quality and Care management will monitor Albuterol aerosol Treatment assessment documentation monthly for four (4) months and then quarterly thereafter for confirmation of compliance.</p>	04/06/2012			

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	<p>"General Procedure for Assisting with Nebulizer Medication," dated 6/2008. The policy did not include staff obtaining vital signs or pulmonary assessments.</p> <p>Review of the facility provided Nurse's Drug Handbook, 2008, indicated for Albuterol Nebulizer treatments under assessment section, #5: "Monitor pulmonary status (i.e. breath sounds, vital signs)."</p>			

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R0246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure medications ordered as needed (PRN) were authorized by a licensed nurse before administration for 2 residents (#38, 31) in a sample of 7 residents.</p> <p>Findings include:</p> <p>1. Resident #38's closed record was reviewed on 3/7/12 at 1:45 P.M.. The record indicated the resident had PRN medications which were administered by a Qualified Medication Aide (QMA) without authorization by a licensed nurse: On 2/21/12 at 11:30 A.M., Xanax 1.0 milligrams(mg) was administered; on 2/15/12 at 8:00 P.M., Tylenol 650 mg was administered; on 2/16/12 at 8:00 P.M., Tylenol 650 mg was administered and on 2/17/12 at 8:00 A.M., Tylenol 650 mg was administered.</p>	R0246	Residents #38 and #31 given PRN medication without authorization were assessed for side effects and none were found. Wellness Director reviewed Resident files to determine if any other resident was given PRN medication without authorization. No other residents were affected. Clinical staff were re-educated on corporate policy and state regulations regarding proper medication distribution and authorization. They were also re-educated as to documentation required when administering PRN medication. The Wellness Director will review MARS by-weekly for 4 months, then quarterly thereafter to ensure compliance.	04/06/2012			

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	<p>An interview with the Director of Nursing (DN) on 3/7/12 at 2:05 P.M., indicated the medications were not authorized by a licensed nurse before being given to Resident #38.</p> <p>2. The clinical record for Resident #31 was reviewed on 03/05/12 at 1:50 P.M. Resident #31 was originally admitted to the facility on 09/25/10. On 10/31/11, the resident fell in her apartment, fractured her hip, and was transferred to an acute care center. The resident was readmitted to the facility on 02/18/12.</p> <p>On 02/19/12 at 8:00 P.M., the resident was given a pain medication by QMA #8. The resident service note, dated 02/19/12 at 8:00 P.M., documented the resident's complaints of pain and the administration of the pain medication, but there was no documentation in the note of the authorization by a licensed nurse giving permission for the QMA to administer the medication. Review of the MAR (Medication Administration Record) for February 2012 indicated the Wellness Director, RN #1 had signed her initials next to the QMA's initials.</p> <p>The MAR for March 2012 for Resident #31 was reviewed on 03/05/12 at 2:45 P.M. The MAR indicated the resident was given as needed pain medication on 03/03 and 03/04, no specific time of day</p>						

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	<p>indicated, by QMA #4. There was no documentation in the service notes for Resident #31, nor on the MAR record of any authorization by a licensed nurse. On 03/07/12 at 9:15 A.M., a copy of the MAR for March for Resident #31 was presented and the Wellness Director, RN #1, had initialed the form by QMA #4's initials. Interview with the Wellness Director, on 03/07/12 at 9:15 A.M., confirmed she had initialed the form on 03/06/12 before she made a copy. She indicated staff should be documenting the authorization information in the Resident service notes, identifying which nurse gave them authorization and then the nurse was supposed to initial beside the medication administration record for those medications for which he or she had authorized the QMA to administer.</p>			

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R0273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 nursing staff and 1 of 2 dietary staff handled food properly while serving the noon meal on 03/05/12. In addition, the facility failed to ensure beverages and tortillas were covered, labeled, and dated while being stored. This potentially affected all 36 residents in the facility.</p> <p>Finding includes:</p> <p>During the observation of the noon meal, conducted on 03/05 12 between 11:50 - 12:45 P.M., the Cook, employee #6, and two Certified Nursing Assistants, employees #2, and #7 were noted to do the following: Cook #6, who had donned gloves was noted to touch oven door handles, lids of pots, paper menus, handles of spoons, and place her gloved hands into potholders, and then used the same gloved hands to pick up orange slice garnishes and place them onto residents' dinner plates. CNA's #2 and #7 were noted to handle paper menus, plates, and then pick up biscuits and place them onto residents' dinner plates. CNA #2 asked</p>	R0273	<p>No specific resident was identified. Current residents were at potential risk. Dietary staff were re-educated on safe food handling practices related to gloved hands. Dietary staff were also re-educated on open storage requirements to include lids, labeling and dating. Dietary Manager and/or Dining Services Coordinator will monitor open storage for lids, labeling and dating. The Residence Director will perform random checks, different times of day and different days of the week, of kitchen to assure safe food handling standards are maintained and open storage has lids, labeling and a date. New employees will be orientated to procedure for safe food handling practices related to gloved hands and open storage requirements involving lids, dating, and labeling prior to food handling.</p>	04/06/2012			

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	<p>for tongs, but then was not noted to utilize the tongs but used her hands instead.</p> <p>During the dietary sanitation tour, conducted on 03/05/12 between 10:00 A.M. - 10:20 A.M., two pitchers of brown and pink colored liquids were noted to be stored without lids, unlabeled, and undated in the refrigerator. Both pitchers were partially covered with clear plastic wrap.</p> <p>During the observation of the noon meal preparation, on 03/06/12 at 11:50 A.M., there was one unlabeled pitcher of a dark pink liquid partially covered with plastic wrap stored in the refrigerator. In addition, there was an opened package of flour tortillas partially uncovered, unlabeled and undated stored in the refrigerator.</p> <p>Interview with the Administrator on 03/06/12 at 3:30 P.M., indicated the staff were to utilize tongs while serving meals. He indicated Cook #6 was new to the facility.</p>				

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R0410	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to provide a 2nd step Mantoux test for tuberculosis for a newly admitted resident for 1 of 7 residents reviewed for Mantoux tests in a sample of 7 residents. (Resident # 20)</p> <p>Findings include:</p> <p>Resident #20's clinical record was reviewed on 3/6/12 at 10:00 A.M.. The record indicated the resident was admitted to the facility on 1/10/12. The resident's "Tuberculosis Testing and Vaccine</p>	R0410	Resident #20's second step Mantoux was obtained. Current Residents files were reviewed to confirm there was a first step and second step Mantoux in the file. No other residents' were found out of compliance. Residence Director will re-educate staff on corporate policy and state regulations for TB skin testing. Residence Director will review new resident paperwork and confirm compliance. The Regional Director of Operations will audit random files Monthly for 4 months and quarterly thereafter to ensure compliance.	04/06/2012			

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	<p>Consents and Records" form indicated the resident received a Mantoux, step 1 on 1/10/12 and was read on 1/12/12. The results were 0 millimeters. The Mantoux Step 2 line was blank.</p> <p>An interview with the Director of Nursing on 3/6/12 at 1:50 P.M., indicated no 2nd step Mantoux was done and should have been completed.</p> <p>An untitled policy was received from the DN on 3/6/12 at 2:45 P.M. The policy indicated under resident guidelines: "1. Upon move-in, all Residents must have a two-step Mantoux method TB skin Test"; "3. Whenever possible, and as required by State Regulations, step one will be administered read and recorded prior to move-in. Skin tests must be administered, read and recorded within the first two weeks of move-in, unless otherwise defined by State Regulations."</p>						