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| 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 08/05/2016 |
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| NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL | STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 |
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| R 0000 Bldg. 00 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 3, 4 and 5, 2016</p> <p>Facility number: 012309 Provider number: 012309 AIM number: N/A</p> <p>Census bed type: Residential: 42 Total: 42</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by 21662 on August 8, 2016.</p> | R 0000 | | |
| R 0092 Bldg. 00 | <p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and</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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| | <p>simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review, the facility failed to show documentation that they had attempted to hold a fire and disaster drills in conjunction with the local fire department at least every six months. This deficiency had the potential to affect 42 of 42 residents residing in the facility.</p> <p>Finding includes:</p> <p>A record review of the facility's fire drills for the last year was reviewed on 8/3/16 at 1:15 p.m. The monthly fire drill documentations lacked evidence the facility had attempted a fire and disaster drill in conjunction with the local fire department at least every six months.</p> | R 0092 | R-092: Administration and Management – noncompliance The local fire department has been contacted and requested to participate in a facility fire drill in the month of August. Attachment 1 As a means to ensure ongoing compliance, the tentative fire drill schedule has been revised to ensure the facility requests the participation of the local fire department at least every 6 months. Said contact will be documented, as well as participation documented on the applicable fire drill record. Attachment 2 As a means of quality assurance, the Administrator shall be responsible to review each fire drill record and to confirm compliance with attempting to conduct fire drills in conjunction with the fire department every six months. | 08/31/2016 | | | |

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| R 0117 Bldg. 00 | <p>During an interview on 8/3/16 at 1:15 p.m., the Administrator indicated only one fire and disaster drill had been attempted in conjunction with the fire department in the last year.</p> <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> | | | |

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| R 0214 Bldg. 00 | <p>Based on interview and record review, the facility failed to ensure there was a CPR (cardiopulmonary resuscitation) and first aid certified staff member in the facility available for residents at all times. This had the potential to affect 42 of 42 residents currently residing in the facility.</p> <p>Finding includes:</p> <p>The CPR and First Aid certifications were reviewed on 8/3/16 at 2:25 p.m. There were no staff members available on duty with CPR and First Aid certifications for the following dates and times: 7/28/16 from 5:00 p.m. to 10:00 p.m. 7/29/16 from 2:00 p.m. to 10:00 p.m.</p> <p>During an interview on 8/4/16 at 2:22 p.m., the Administrator indicated she provided all the CPR and First Aid certifications she was able to provide.</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</p> | R 0117 | <p>R-117: Personnel – deficiency An audit has been conducted of all staff with expiration of current certification noted and any staff member documented as not having CPR/first aid certification identified. CPR/First Aid class has been scheduled for 8/17/16. Upon hire, a copy of the new employee's certification shall be requested, placed in the personnel record, and logged per calendar when certification will expire, in an effort to ensure training is again scheduled accordingly. Attachment 3 As a means to ensure ongoing compliance, the Administrator/designee shall be responsible to ensure at least one staff member is scheduled on duty with current CPR/first aid certification at all times. As a means of quality assurance, the Administrator/designee shall sign each schedule to verify review and confirmation of having at least on staff member scheduled on duty with current CPR/first aide certification. Attachment 4</p> | 08/31/2016 | | | |

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| | <p>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 evaluate a resident's needs for a known substantial change in the resident's condition for 1 of 7 residents reviewed for evaluating resident's needs (Resident #44).</p> <p>Finding includes:</p> <p>Resident #44's record was reviewed on 8/4/16 at 11:50 a.m. Diagnoses included, but were not limited to, muscle weakness, Chronic Obstructive Pulmonary Disease (COPD) and insomnia.</p> <p>The resident had a fall on the following dates and times; 6/6/16 at 4:15 p.m. 6/7/16 at 10:30 p.m. 6/7/16 at 1:00 p.m. 6/10/16 at 4:30 p.m. 6/11/16 at 10:35 p.m. 6/11/16 at 1:00 a.m. 7/24/16 at 8:00 a.m. 7/26/16 at 4:10 p.m.</p> <p>The resident's "Evaluation of Needs/Service Plan" dated 4/19/16, indicated the resident's mental status is</p> | R 0214 | R-214: Evaluation: deficiency Resident #44 no longer resides at the facility,thus, no further corrective action can be taken. The service plans of all residents shall be reviewed to ensure the service plan has been updated with any substantial change in resident condition. Attachment 5/6 As a means to ensure ongoing compliance, clinical staff has been addressed as to the need to review and update the service plan when there is a substantial change in resident condition. As a means to ensure ongoing compliance, following a fall, acute condition, infection or other such event, the service plan of the applicable resident shall be reviewed by the Director of Clinical Services to confirm said plan has been reviewed and updated to reflect any substantial change in resident condition. The Director shall initial said review to confirm review. | 08/31/2016 | | | |

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| | <p>best described as follows: severely impaired- never/rarely makes decisions. Transferring: ability to get into and out of bed, get into out of chair, get into and out of shower or roll over in bed. No assistance from staff was checked. Special instructions indicated remind the resident to lock rollator before sitting or standing. Ambulating/Locomotion: Ability to safely walk, once standing, or use a wheelchair, once seated a variety of surfaces: Requires use of a device to walk alone or requires human supervision or assistance to negotiate stairs, steps or uneven surfaces was checked and walker was circled. Special Instructions indicated uses rollator throughout community and cane for outside.</p> <p>During an interview on 8/5/16 at 9:45 a.m., the Administrator indicated the Evaluation of Needs/Service Plan was not updated for falls. She indicated she would look for interventions for falls on the fall incidents.</p> <p>At the end of the exit conference on 8/5/16 at 2:45 p.m., no further information was provided regarding the fall interventions.</p> | | | |

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| R 0216 Bldg. 00 | <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance</p> <p>(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:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview and record review, the facility failed to ensure a self administration assessment and a Physician order were completed for residents who were administering their own medications for 2 of 3 residents reviewed for self med administration assessments (Residents #35 and #30)</p> <p>Findings include:</p> <p>1. On 8/3/16 at 10:50 a.m., during the Environmental tour with the Maintenance Director Resident #35 was observed talking to an unidentified staff member while holding a nebulizer mouthpiece and cup in her hand.</p> <p>On 8/3/16 at 10:58 a.m., Resident #35 was completing a nebulizer treatment</p> | R 0216 | R-216 Evaluation Non-compliance Residents #30 and #35 have been assessed for the ability to self-administer medications and to perform nebulizer treatments onceset up and orders and service plan updated accordingly. An audit has been conducted to ensure accurate identification of all resident who self-administer any type of medication(s) or treatment to ensure assessment has been completed and service plans reviewed and updated to reflect medication/treatment self-administration. As a means to ensure ongoing compliance, clinical staff has been educated as to self-administration, assessment for self-administration and the need to notify the Director of Clinical Services should a resident voice a desire to self-administer who | 08/31/2016 | | | |

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| | <p>with her door open. When asked if a resident interview could be completed when she was finished with her treatment, the resident indicated she was finished with her treatment. The resident interview was completed. There was no nurse or QMA who came into the resident's room to check on her after completing her nebulizer treatment.</p> <p>During an interview on 8/3/16 at 12:15 p.m., QMA #1 indicated Resident #35 administered her own nebulizer treatments.</p> <p>During an interview on 8/3/16 at 1:15 p.m., the Administrator indicated Resident #35 had a MKAB (May Keep at Bedside) order for her nebulizer treatment, so she could administer her own treatments. The Administrator was notified the resident did not have a self medication administration assessment or a Physician order in her record to administer her nebulizer treatments to herself. The Administrator indicated she did not realize an order for residents to administer their own medications with a MKAB order, had to have a self administration order from the Physician and a self medication administration assessment.</p> <p>Resident #35's record was reviewed on</p> | | <p>had not previously self-administered medication(s) to ensure completion of assessment and updating of the service plan. Attachment 7 As a means of quality assurance, the Director of Clinical Services shall maintain a roster of all residents who self-administer medications and shall ensure those residents are again assessed for ability to self-administer at least every six months or upon significant change in condition. Attachment 8</p> | | | | |

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| | <p>8/4/16 at 3:48 p.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), Asthma and Congestive Heart Failure (CHF).</p> <p>During an interview on 8/4/16 at 4:15 p.m., LPN #3 indicated she placed the nebulizer medications in the nebulizer cup for Resident #35, then she came back to her room in a little while to make sure she had completed the nebulizer treatment because the resident did not always complete her nebulizer treatments. She indicated the resident's nebulizer medications had to be kept in the medication cart and the medications had to be given to the resident even though she wanted to keep the medications in her room, because she cannot be trusted to do the nebulizer treatments as ordered.</p> <p>2. On 8/3/16 at 12:55 p.m., QMA #1 was observed preparing Resident #30's Tramadol. As QMA #1 finished preparing the resident's medications, she indicated the nursing staff leave the resident's pills in his room, then go back "later" to make sure he took the pills. She indicated the resident has ALS (Amyotrophic Lateral Sclerosis) and watching him take his pills was a dignity issue for him. She indicated he could not</p> | | | |

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| | <p>use his hands to get the pills to his mouth, so he used his mouth to get the cup and flipped the pills into his mouth and he did not want staff watching him taking his medications this way. QMA #1 entered the resident's room and asked him if she could stay in the room while he took his medications He indicated he did not care if staff watched him take his medications. He indicated the problem was at night he got his sleeping medication anytime between 8:00 p.m. and 12:45 a.m., so the evening nurse left his evening medications in his room around 10:00 p.m. and he took his sleeping pill when he was ready to go to bed. He indicated shortly after he took his sleeping medication he was "knocked out", so he took it when he was ready to go to bed. He indicated if he pulled his call light to ask for his sleeping medication, some nurses were faster at responding with the medication than others. He indicated he could take his own medications.</p> <p>On 8/3/16 at 1:15 p.m., the Administrator was notified the nursing staff was leaving the Resident #30's medications in his room and he did not have a self medication administration assessment or a Physician order to administer medications to himself.</p> | | | |

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| | <p>Resident #30's record was reviewed on 8/4/16 at 3:15 p.m. Diagnoses included, but were not limited to, Amyotrophic Lateral Sclerosis (ALS) and Insomnia.</p> <p>A current policy titled "Medication Administration" dated 10/2014, provided by the Director of Nursing on 8/4/16 at 2:00 p.m., indicated "Purpose: To safely administer medications as per physicians' orders...Guidelines For Medication Administration:...19. Always observe the resident taking their medication (s). Never permit medication to remain in the resident's room. Residents may not self-administer medications unless specifically authorized in writing by the attending physician, and then only in accordance with facility procedures for self-administration...."</p> <p>A current policy titled "Medications, Self-Administration" dated 10/2014, provided by the Administrator on 8/4/16 at 9:30 a.m., indicated "Purpose: To allow those residents who are capable and desire to do so, the opportunity to self-administer medication (s)...1...Should the resident note a desire to self-administer medication (s), the interdisciplinary team will evaluate the resident for the cognitive, physical and visual ability to accomplish this task. If after evaluation and return</p> | | | |

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| | <p>demonstration, the interdisciplinary team determines that the resident is unable to carry out this responsibility, the interdisciplinary team may withdraw the right to self-administer medications. 2. If the evaluation reveals the resident is capable of participation in self-administration, a physician order reflecting the same shall be obtained to specify which medications may be self-administered by the resident. Medication self-administration shall be addressed on the resident's plan of care...8. All residents participating in self-administration shall be reassessed at least quarterly at the time of comprehensive careplan review for continued ability to self-administer medications."</p> <p>A current policy titled "Nebulizer Treatment" dated 10/2014, provided by the Director of Nursing on 8/4/16 at 2:00 p.m., indicated "...Policy: Hand held nebulizer treatments will be administered only by licensed personnel or a respiratory therapist per physician's order... Procedure:...7. NOTE: If a resident is alert and oriented, resident may remain independent with the delivery device in place with responsible personnel checking resident approximately midway through the therapy, if needed. Physician may</p> | | | |

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| R 0241 Bldg. 00 | <p>indicate that resident may self administer the treatment, once set up by qualified personnel. A Self Administration of Medication Assessment should be completed... 8. Assess resident's response and effectiveness of therapy and obtain respiratory rate, heart rate and breath sounds post therapy...."</p> <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, interview and record review, the facility failed to ensure Physician orders were followed during a medication pass for 3 of 5 residents observed during a medication pass (Residents #11, #3 and #31) and failed to ensure Physician orders were followed during record reviews for 1 of 7 residents reviewed for following Physician orders (Resident #13).</p> <p>Findings include:</p> <p>1. On 8/3/16 at 12:18 p.m., Qualified</p> | R 0241 | R-241 Health Service – Offense The medication orders for residents #11, #3 and #31 have been reviewed and clarified by the physician/NP as needed to confirm times to be administered. The QMA was disciplined due to inaccurate medication administration as per order. Resident #13 has been assessed and exhibits no negative side effects as a result of staff failure to accurately and consistently document the obtaining of blood sugar measurement and insulin administration per sliding scale. As all residents could be affected | 08/31/2016 |

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| | <p>Medication Aide (QMA) #1 was observed preparing and administering Resident #11's medications to her, which included Dicyclomine (a medication to help bowel spasms), Acetaminophen (a non narcotic pain medication), Calcium (a dietary supplement), Simethicone (a medication used to relieve gas), Lorazepam (an antianxiety medication) and Tramadol (a narcotic pain medication). The resident was observed laying in bed without any food in front of her. Lunch was being served, at that time in the dining room. When QMA #1 administered the resident's medications she did not ask her if she had eaten lunch prior to administering her medications. After QMA #1 had administered the resident's medications she was asked about the Calcium needing to be administered with food, she indicated she did not know if she had lunch or not, but if she had not eaten she had food in her refrigerator.</p> <p>Resident #11's medications were reconciled on 8/4/16 at 2:30 p.m. The resident's Physician Order Recapitulation (Recap) dated August 2016, included, but were not limited to, the following orders: 2/1/16--Calcium 500 mg (milligrams) give one tablet by mouth with meals at 8:00 a.m., 12:00 p.m. and 5:00 p.m.</p> | | <p>the following corrective actions shall be taken. All licensed and qualified personnel shall receive training regarding medication administration as per physician order, including but not limited to, time of administration, correct procedure for Advair Diskus, adherence with special administration instructions (i.e., with food, ac, pc, etc.), and documentation of the blood sugar as well as sliding scale insulin administered by the licensed nurse. Attachment 9 As a means to ensure ongoing compliance, a specific glucose reading/sliding scale insulin administration record shall be utilized which will prompt the licensed/qualified staff to follow facility procedure in documenting blood sugar and actions taken, including insulin administration. Attachment 10 The aforementioned medication administration and blood sugar monitoring training shall also be incorporated into the orientation of any newly hired nurse/QMA. Attachment 11/12 As a means of quality assurance, the Director of Clinical Services/designee shall monitor for compliance by conducting random med pass observations at least three times weekly for four weeks at varied times with varied staff members. The observations will then be conducted twice weekly for four weeks and monthly thereafter ongoing. Should non-compliance be observed, corrective action</p> | | | | |

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| | <p>2. On 8/3/16 at 12:30 p.m., QMA #1 was observed preparing and administering Resident #3's medications, which included Cal Carb (a dietary supplement), Paroxetine (an antidepressant medication), Florastar (a probiotic medication), Carvedilol (a medication used to treat high blood pressure and heart failure), Triamterene-HCTZ (Hydrochlorothiazide) (a medication to treat edema and high pressure), Vitamin D 3 (a vitamin supplement), Vitamin B12 (a vitamin supplement), Pandora (a medication used to treat acid reflux) and Simethicone (a medication to treat gas).</p> <p>Resident #3's medications were reconciled on 8/4/16 at 2:47 p.m. The resident's Physician Order Recap dated August 2016, included, but were not limited to, the following orders: 9/13/15--Carvedilol 6.25 mg give one tablet by mouth every 12 hours. The medication was scheduled to be administered at 12:00 p.m. and 8:00 p.m. 9/13/15--Triamterene-HCTZ 37.5-25 mg give one tablet every morning. The medication was scheduled to be administered at 12:00 p.m.</p> <p>During an interview on 8/4/16 at 3:30 p.m., the Director of Nursing (DON) indicated she spoke to a nurse regarding</p> | | <p>shall be taken. Attachment 13 Those residents with sliding scale insulin shall be monitored daily on scheduled days of work by the Director of Clinical Services for four weeks to confirm compliance with policy and with accurate documentation. Thereafter monitoring shall be conducted on a weekly basis ongoing. Should non-compliance be observed, corrective action shall be taken. Attachment 14</p> | | | | |

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| | <p>Resident #3's Carvedilol and Triamterene-HCTZ and the nurse indicated the resident took both these medications at 12:00 p.m., instead of in the morning because she slept in and that time was when the resident wanted her medications. The DON indicated there was an order for these medications to be given at 12:00 p.m., but it must be in her thinned out chart. She indicated she would go check her thinned out chart.</p> <p>During an interview on 8/4/16 at 4:05 p.m., with the DON and the Administrator in attendance, the DON indicated she could not find an order for the Carvedilol and Triamterene-HCTZ to be administered at any other time, than the ordered time.</p> <p>During an interview on 8/5/16 at 10:25 a.m., Nurse Practitioner (NP) #2 indicated she was unaware Resident #3's Carvedilol and Triamterene-HCTZ was not being given as ordered. She indicated the facility was probably administering the medications at 12:00 p.m., because the resident slept in. She indicated if she had known the facility was giving the medication at that time, she would have changed those orders.</p> <p>3. On 8/4/16 at 8:40 a.m., QMA #1 was observed preparing and administering</p> | | | | | | |

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| | <p>Resident #31's medications, which included Fish Oil (a dietary supplement), Lisinopril (a medication to treat high blood pressure), Omperazole (a medication to treat acid reflux), Vitamin D3 (a vitamin supplement), Bupropion HCL (Hydrochloride) (an antidepressant medication), Metoprolol Succinate ER (extended release) (a medication to treat high blood pressure), Savella (a medication used to treat fibromyalgia), Doc-Q-Lace (a stool softener), Lorazepam (an antianxiety medication), Hydrocodone (a narcotic pain medication), Senna (a laxative medication), Mucinex DM (Dextromethorphan HBr) ER (a medication to help break up mucus), Advair Diskus (a medication used to treat breathing problems), Digestol (a medication that helps with the breakdown of food). QMA #1 was not observed having Resident #31 rinse her mouth and spit the water out after administering the Advair Diskus. QMA #1 was not observed administering Fluticasone Propionate nasal spray (a medication used to treat irritation of the nose) to Resident #31 during the medication pass.</p> <p>During an interview with QMA #1 immediately following Resident #31's medication administration she indicated she did not have Resident #31 rinse her</p> | | | | | | |

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| | <p>mouth and spit the water out after taking her Advair Diskus inhaler today. She indicated she normally had her rinse and spit the water, but she "just" did not have the resident do that today. QMA #1 indicated the resident did not have an order to rinse and spit water after using her Advair Diskus.</p> <p>Resident #31's Advair Diskus inhaler instructions for use on the box indicated, "Instructions for using ADVAIR DISKUS: Read the Medication Guide that comes with ADVAIR DISKUS before you start using it...Step 5. Rinse your mouth with water after breathing in the medication. Spit out the water. Do not swallow it."</p> <p>Resident #31's medications were reconciled on 8/4/16 at 3:30 p.m. The resident's Physician Order Recap dated August 2016, included, but were not limited to the following orders: 3/29/15--Advair 25-50 Diskus give one inhalation every 12 hours for Asthma. 5/12/16--Fluticasone Propionate 50 mcg (micrograms) spray instill two sprays in each nostril daily.</p> <p>4. Resident #13's record was reviewed on 8/5/16 at 10:24 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus type II and Chronic</p> | | | |

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| | <p>Obstructive Pulmonary Disease.</p> <p>Resident #13's Physician Order Recap dated August 2016, included, but were not limited to the following orders: 4/22/16--Accucheck four times daily at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. 4/26/16--Humalog 100 units/ml (milliliter) Kwik Inject Per Sliding Scale See Flow Sheet.</p> <p>A "Blood Glucose Monitoring/Sliding Scale Insulin Verification Record" dated July 2016, indicated: Finger Stick Blood Glucose Order: Accucheck four times a day Call Orders: If Blood Sugar (BS) below 70 or above 400 Call physician and document above. If symptomatic, document assessment in clinical record. Sliding Scale: If BS 200 or below give no sliding scale insulin. If BS 201-250 give 2 units of Humalog If BS 251-300 give 4 units of Humalog If BS 301-350 give 6 units of Humalog If BS 351-400 give 8 units of Humalog</p> <p>A "Blood Glucose Monitoring/Sliding Scale Insulin Verification Record" dated July 2016, indicated the following dates and times lacked blood sugar reading or insulin amount administered</p> | | | |

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| | <p>documentation:</p> <p>7/5/16 at 11:30 a.m.--BS 225 no insulin was documented as given-2 units Humalog should have been given, 4:30 p.m.--BS 225 no insulin was documented as given-2 units Humalog should have been given, 9:00 p.m.--No BS was documented</p> <p>7/6/16 at 4:30 p.m.--No BS was documented</p> <p>7/7/16 at 4:30 p.m.--BS 275 no insulin was documented as given--4 units Humalog should have been given.</p> <p>7/9/16 at 9 p.m.--BS 310 20 units insulin documented as given--only 6 units Humalog should have been given.</p> <p>7/11/16 at 4:30 p.m.--BS 275 no insulin was documented as given--4 units Humalog should have been given. 9:00 p.m.--BS 265 no insulin documented as given--4 units Humalog should have been given.</p> <p>7/12/16 at 11:30 a.m.--BS 69 no documentation to indicated the Physician was called for BS below 70. 4:30 p.m.- -255 no insulin documented as given--4 units Humalog should have been given. 9:00 p.m.--280 no insulin documented as given-4 units Humalog should have been</p> | | | |

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| | <p>given.</p> <p>7/13/16 at 11:30 a.m.--BS 249 no insulin documented as given--2 units Humalog should have been given. 4:30 p.m. and 9:00 p.m.--No BS documented</p> <p>7/14/16 at 9:00 p.m.--BS 201 no insulin documented as given--2 units Humalog should have been given.</p> <p>7/16/16 at 11:30 a.m.--BS 226 no insulin documented as given--2 units Humalog should have been given. 9:00 p.m.--BS 220 no insulin was given--2 units Humalog should have been given.</p> <p>7/17/16 at 11:30 a.m.--BS 258 no insulin documented as given--4 units Humalog should have been given.</p> <p>7/19/16 at 4:30 p.m.--BS 254 no insulin documented as given--4 units Humalog should have been given. 9:00 p.m.--BS 308 no insulin documented as given--6 units Humalog should have been given.</p> <p>7/21/16 at 11:30 a.m.--BS 292 no insulin documented as given--4 units Humalog should have been given. 9:00 p.m.--BS 334 no insulin documented as given--6 units Humalog should have been given.</p> <p>7/22/16 at 9:00 p.m.--BS 239 no insulin</p> | | | | | | |

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| | <p>documented as given--2 units Humalog should have been given.</p> <p>7/26/16 at 11:30 a.m.--BS 256 no insulin documented as given--4 units Humalog should have been given. 4:30 p.m.--BS 236 no insulin documented as given--2 units Humalog should have been given.</p> <p>7/27/16 at 9:00 p.m. No BS was documented.</p> <p>7/28/16 at 4:30 p.m.--220 No insulin documented as given--2 units Humalog should have been given. 9:00 p.m.--BS 276 No insulin documented as given--4 units Humalog should have been given.</p> <p>7/29/16 at 11:30 a.m.--BS 249 No insulin documented as given--2 units Humalog should have been given. 4:30 p.m.--No BS documented.</p> <p>7/30/16 at 4:30 p.m.--BS 315 No insulin documented as given--6 units Humalog should have been given.</p> <p>7/31/16 at 11:30 a.m.--BS 256 No insulin documented as given--4 units Humalog should have been given. 4:30 p.m.--BS 258 No insulin documented as given--4 units Humalog insulin should have been given.</p> | | | |

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| | <p>There was no documentation of BS, insulin administered for the BS or the Physician being notified of the BS of 69 on the Medication Administration Record (MAR) or the Progress notes.</p> <p>During an interview on 8/5/16 at 1:45 p.m., the Administrator indicated after going through the report sheets there was no other available information to provide any missing BS or insulin coverages for BS.</p> <p>A current policy titled "Medication Administration" dated 10/2014, provided by the Director of Nursing on 8/4/16 at 2:00 p.m., indicated "Purpose: To safely administer medications as per physicians' orders...Time Element:...3. Medications that are irritating to the gastric mucosa should be given with food. Be mindful of any specific instructions provided by the pharmacy...Guidelines For Medications Administration: 1. Medications are administered to residents only as prescribed and only by person licensed or qualified to do so. 4. Read orders carefully to be sure that they are understood. Clarify any questions with the charge nurse or the physician. Carefully repeat and clarify verbal orders, if received... 10. Always observe the six rights of giving each medication...RIGHT TIME...."</p> | | | |

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| R 0354 Bldg. 00 | <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review, the facility failed to ensure transfer information was documented prior to a hospital transfer for 2 of 2 residents reviewed for transfer information. (Residents #43 and #44)</p> <p>Findings include:</p> | R 0354 | R-354 Clinical Records-noncompliance The facility staff had historically sent transfer documentation with the resident going to the hospital, but had not retained a copy of said documentation on the resident record; rather recorded the transfer in the nurse's notes. No further action can be taken for the transfers of the two applicable | 08/31/2016 |

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| | <p>1. Resident #43's record was reviewed on 8/4/16 at 2:13 p.m. Diagnoses included, but were not limited to, diabetes, neuropathy, chronic knee pain and hypertension.</p> <p>The resident's record indicated she was transferred to the hospital on 5/10/16. The resident's record lacked documentation of transfer information when she was transferred to the hospital.</p> <p>During an interview on 8/4/16 at 3:33 p.m., the Administrator indicated there was no transfer paperwork sent to the hospital when the resident was transferred to the hospital on 5/10/16</p> <p>2. Resident #44's record was reviewed on 8/4/16 at 11:50 a.m. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), hypertension, atrial fibrillation and insomnia.</p> <p>The resident's record indicated she was transferred to the on 7/28/16. The resident's record lacked documentation of transfer information when she was transferred to the hospital.</p> <p>During an interview on 8/4/16 at 12:30 p.m., the Administrator indicated there</p> | | <p>residents. As all residents could be affected, the following corrective actions shall be taken. Staff shall be educated as to completing the necessary transfer paperwork to be sent with the resident upon transfer and making a copy of the paperwork to be placed on the applicable resident's medical record. Attachment 15 As a means to ensure compliance and quality assurance, the Administrator/designee shall audit the chart of any resident being transferred to the hospital to confirm compliance. Should non-compliance be noted, corrective action shall be taken.</p> | | | | |

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| 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 08/05/2016 |
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| NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL | STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 |
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| R 0406 Bldg. 00 | <p>was no transfer paperwork sent to the hospital when the resident was transferred to the hospital on 7/28/16.</p> <p>410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection.</p> <p>Based on observation, interview, and record review, the facility failed to prevent the possibility of cross contamination during blood glucose testing for 2 of 2 residents observed during blood glucose testing (Resident #24 and #23).</p> <p>Findings include:</p> <p>1. Qualified Medication Aide (QMA) #1 was observed checking Resident #24's blood sugar on 8/4/16 at 11:15 a.m. QMA #1 removed a glucometer, two alcohol wipes, a lancet, and a container of glucometer strips, placing the supplies on top of the medication cart without a</p> | R 0406 | <p>R-406 Infection Control – Offense QMA#1 has been disciplined for failing to follow facility policy. It has been confirmed that all applicable residents have individual glucose meters. Attachment 16 Licensed/certified staff have been educated with return demonstration as to utilizing the resident's individual meter and of the mandatory sanitation of a meter utilizing bleach wipes as per facility policy, should at any time a facility meter be utilized for more than one resident. Attachment 17 As a means of quality assurance, the Director of Clinical Services/designee shall monitor for compliance by conducting random blood glucose</p> | 08/31/2016 |

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| | <p>barrier as she removed the items. She took the supplies into Resident #24's room and placed them on top of her five drawer chest without a barrier. QMA #1 donned clean gloves and performed the glucometer procedure. She removed the strip from the glucometer and placed it and the lancet inside her gloves as she removed them. She placed the glucometer and strips container on top of the medication cart without a barrier and threw the used gloves in the sharp's box on the medication cart. She wiped the top and sides of the glucometer with an alcohol wipe. QMA #1 sanitized her hands with hand sanitizer. She removed another lancet and two alcohol wipes from the top drawer of the medication cart and placed them on top of the cart next to the glucometer and strips container without a barrier. QMA #1 left the cart with the glucometer and supplies and entered another resident's room.</p> <p>2. QMA #1 was observed checking Resident #23's blood sugar on 8/4/16 at 11:21 a.m. QMA #1 entered Resident #23's room with the glucometer and supplies and placed the strips container, lancet and alcohol wipes on top of the resident's table next to her recliner without a barrier. She placed the glucometer on top of the left armrest of the recliner without a barrier. QMA #1</p> | | <p>finger stick observations at least three times weekly for four weeks at varied times with varied staff members. The observations will then be conducted twice weekly for four weeks and monthly thereafter ongoing. Should non-compliance be observed, corrective action shall be taken. Attachment 18</p> | | |

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| | <p>donned clean gloves and performed the glucometer procedure. She removed the strip from the glucometer and placed it and the lancet inside her gloves as she removed them. She placed the glucometer and strips container on top of the medication cart without a barrier and threw the used gloves in the trash bin on the medication cart. She wiped the top and sides of the glucometer with an alcohol wipe and placed the glucometer and the strips container in the top drawer of the medication cart. She sanitized her hands with hand gel.</p> <p>During an interview on 8/4/16 at 11:30 a.m., QMA #1 indicated she used alcohol wipes to clean the glucometer during the dayshift, while performing glucometer checks, then at the end of her shift she used a bleach wipe to sanitize the glucometer. She indicated the reason she used alcohol wipes to clean the glucometer after each resident was because the medication cart she was using currently was the 100/300 cart and it was too small for the bleach wipes to fit in. QMA #1 indicated each resident had his or her own individual glucometer, but all the residents' glucometers were kept on the 200/400 cart because it was larger and was able to hold all of them. She indicated she had worked at Long Term Care Facilities in the past and had always</p> | | | |

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| | <p>used a facility glucometer, so she just used one glucometer for all her glucometers and cleaned it in between residents. QMA #1 indicated she placed the used gloves with the glucometer strip and lancet she used with Resident #23 in the sharp box on the medication cart when she came out of the resident's room. She was observed at that time, removing the gloves from the trash bin on the medication cart and placed them in the sharps box on the medication cart.</p> <p>During an interview on 8/5/16 at 12:30 p.m., the Director of Nursing (DON) indicated QMA #1 should have used the residents' individual glucometers or sanitized the facility one with bleach wipes between residents. She indicated Microkill Bleach Germicidal Bleach Wipes were the wipes to be used to sanitize the facility glucometers.</p> <p>On 8/5/16 at 12:30 p.m., the Microkill Bleach Germicidal Bleach Wipes directions for sanitizing indicated, "...4. Apply presaturated towelette and wipe desired surface to be disinfected. 5. A 30 second contact time is required to kill all of the bacteria and viruses on the label except a 1 minute contact time is required to kill Candida Albicans and Trichophyton mentagrophytes and a 3 minute contact time is required to kill</p> | | | | | | |

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| | <p>Clostridium difficile spores. Reapply as necessary to ensure that the surface remains wet for the entire contact time.</p> <p>6. Allow to air dry and discard use wipe...."</p> <p>A current policy titled "Blood Glucose Measurement, Evencare G2" dated 10/2014, provided by the DON on 8/4/16 at 2:00 p.m., indicated "...PROCEDURE:</p> <p>1. Select the resident specific meter/case to be utilized. Place a clean paper towel on the bedside table or stand. Place the closed case on the paper towel... 9. Properly discard the used test strip... 10. Dispose of the lancet in a sharps container. 11. Replace the resident specific equipment in the case and zip/close the case to prevent cross contamination...13. Replace resident specific case in designated storage tote/area. 14. If a "facility" meter was used, follow instructions for sanitization listed on the facility designated wipe in an effort to prepare for next use."</p> | | | |