

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155593	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/24/2016
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NAME OF PROVIDER OR SUPPLIER  INDIANA MASONIC HOME HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 15, 16, 17, 18, 19, 22, 23, &amp; 24, 2016.</p> <p>Facility number: 001133 Provider number: 155593 AIM number: 200090430</p> <p>Census bed type: SNF/NF: 118 Total: 118</p> <p>Census payor type: Medicare: 9 Medicaid: 83 Other: 26 Total: 118</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on March 01, 2016.</p>	F 0000	<p>The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the "facility") that the findings and allegation contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 16/17 Programs). To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of stature only.</p>	
F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</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>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a plan of care was in place for a resident with a contracture who refused splint application (Resident #132) and a resident with a decline in activities of daily living (ADL's) (Resident #149).</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #132 was completed on 2/19/16 at 9:22 a.m. Diagnoses included, but were not limited to, cerebrovascular accident (stroke) with left sided hemiplegia (loss of purposeful movement).</p>	F 0279	Resident #149 ADL care plan was initiated to reflect his current level of care and needs. Resident #132 care plan was updated to reflect that he refuses to wear his splint. All residents were reviewed to ensure that they have an ADL care plan reflecting their current level of care and needs. All residents wearing splints were addressed to ensure that their compliance and non-compliance was care planned. New residents, residents with significant changes and other residents will be reviewed upon admission, significant change and quarterly to ensure their care needs are addressed in the ADL care plans. All residents with changes in splints (addition, refusal, and	03/10/2016

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	<p>During a stage 1 interview on 2/18/2016 and 9:30 a.m., Resident #132 indicated he frequently refuses to wear his left hand splint, because it is uncomfortable.</p> <p>A current Physician's order dated 1/8/2016, indicated Resident #132 was to have a splint applied to the left hand at night and removed in the morning.</p> <p>A review of Resident #132's Treatment Administration Record (TAR) for January 2016, indicated the resident refused to wear the splint on January 10, 11, 21, 25, 26, and 28.</p> <p>A review of the TAR for February 2016, indicated the resident refused to wear the splint on February 9, 17, 20, and 22.</p> <p>A review of Resident #132's careplans, lacked a careplan and interventions addressing the left hand splint and Resident #132's refusal to wear the splint at times.</p> <p>On 2/18/2016 at 3:51 p.m., Speech Language Pathologist #4 indicated Resident #132 recently received therapy relating to the left hand contracture (a condition of fixed high resistance to passive stretch of a muscle) and splint. SLP #4 indicated Resident #132's current</p>		<p>discontinuation) will be reviewed to ensure accurate documentation. DON or designee will audit all newadmissions and significant changes to ensure that their ADL care needs toinclude splints, if ordered are addressed in the care plan. DON or designee will audit 10 chartsweekly to ensure that their ADL care plan is present and current for the next30 days. After 30 days, the DON or designee will review 5 charts weekly for 90 days to ensureaccurate reflection of care needs in the care plan. Thereafter, the DON or designee will review3 charts weekly to ensure accurate reflection of the residents care needs inthe care plan. Result of the audits will reviewed at the monthly QAPI meetings.</p>	

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F 0282 SS=D Bldg. 00	<p>splint is the least restrictive, but the left 5th digit is the most contracted and would be the most bothered by the splint. SLP #4 indicated the resident and wife have been educated on the importance of wearing the left hand splint, but the resident continues to refuse to wear the splint at times.</p> <p>On 2/24/2016 at 10:45 a.m., the DON indicated there was no careplan in place prior to 2/22/2016 addressing Resident #132's left hand splint and refusals to wear the splint.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to provide services in accordance with each resident's written plan of care for 2 of 2 residents reviewed for receiving blood glucose testing (Resident #11 and #52).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #52 was completed on 2/19/2016 at 9:19 a.m. Diagnoses included, but were not limited</p>	F 0282	<p>Resident #52 and #11 physicians have been notified of their blood sugars being out of range. Nursing staff (QMA, LPN and RN) were educated regarding notification of physician for blood sugars outside of the resident's parameters. All residents were reviewed to determine if they have blood sugar orders. The MAR (Medication Administration Record) of residents will blood sugar orders will be audited 5 times weekly by the DON or designee to ensure compliance for 30 days</p>	03/10/2016

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	<p>to, diabetes mellitus type 2.</p> <p>A Physician's order dated 6/9/2015, valid through 1/19/2016, indicated Resident #52 was to receive blood glucose monitoring 2 times per day. The order indicated to notify the physician if blood sugar result was less than 70 or greater than 350.</p> <p>A careplan regarding diabetes mellitus dated 4/2/2015, revised 12/2/2015, indicated an intervention, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness."</p> <p>A review of the MAR (medication administration record) for January 2016, indicated on 1/1 at 5:00 a.m. and 4:00 p.m., the blood sugar was 1067; on 1/13 at 5:00 a.m., the blood sugar was 69; on 1/17 at 5:00 a.m., the blood sugar was 62. No documentation was found in the clinical record indicating the physician was notified of the blood sugar results above 350 or below 70.</p> <p>On 2/23/2016 at 12:05 p.m., the Director of Nursing (DON) indicated no physician notification of the blood sugars on January 2, 13, or 17, 2016, was found in the clinical record for Resident #52. The DON indicated the staff should have</p>		<p>After 30 days, residents with blood sugar orders will be audited 3 days per week for 60 days.</p> <p>After 60 days, residents with blood sugar orders will be audited 1 day per week for 60 days.</p> <p>Thereafter, 10 residents with blood sugar orders will be reviewed weekly.</p> <p>The results of the audits will be discussed at the monthly QAPI meeting.</p>		

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	<p>notified the physician and made a note on the MAR indicating the physician had been notified.</p> <p>2. The clinical record for Resident #11 was reviewed on 2/19/2016 at 1:21 p.m. Diagnoses included, but were not limited to, diabetes mellitus type 2.</p> <p>A current Physician's order dated 1/5/2016, indicated Resident #11 was to have blood glucose tests completed 3 times per day, 2 days per week on Wednesday and Saturday. The order indicated to notify the physician if blood sugar is less than 70 or greater than 350.</p> <p>A careplan regarding diabetes mellitus dated 10/7/2015, revised on 10/2/2015, indicated an intervention of "Accu checks per order [blood glucose test]."</p> <p>A review of the Medication Administration Record (MAR) for February 2016, indicated Resident #11's blood glucose result on 2/3/2016 at 4:00 p.m., was 64. No documentation was found in the clinical record indicating the physician was notified of the blood sugar below 70.</p> <p>On 2/23/2016 at 12:05 p.m., the Director of Nursing (DON) indicated no physician notification of the blood sugar on</p>			

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F 0309 SS=D Bldg. 00	<p>2/3/2016 at 4:00 p.m. was found in the clinical record for Resident #11. The DON indicated the staff should have notified the physician and made a note on the MAR indicating the physician had been notified.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure individualized, person-centered approaches were developed and implemented, in order to attain the highest level of psychosocial well being, for a resident with a diagnosis of dementia who exhibited behaviors, for 1 of 1 residents reviewed for behaviors. (Resident #32)</p> <p>Findings include:</p> <p>The clinical record of Resident #32 was reviewed on 2/23/16 at 9:33 a.m.</p>	F 0309	Resident #32 behavior care plans were reviewed and individualized. Social Services implemented "Behavior Monitoring Policy and Procedure." Residents with behaviors will have an individualized behavior monitoring log noting their behaviors and interventions to divert the behavior. Each resident's behavior monitoring log will be located in a binder at each nurse's station and therapy gym for the staff to refer to. Along with the behavior monitoring log, the residents care plans addressing the behaviors, will be placed with the behavior monitoring logs in the binder. Residents that display behaviors with no	03/10/2016			

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	<p>Diagnoses for the resident included, but were not limited to, obsessive compulsive disorder, depressive episodes, anxiety disorder, and dementia.</p> <p>An annual Minimum Data Set (MDS) assessment, dated 12/7/15, indicated Resident #32 was cognitively independent in his ability to make decisions and did not exhibit any behaviors.</p> <p>On 2/22/16 at 9:00 a.m. the Chief Executive Officer (CEO) and Director of Nursing (DON) indicated an incident had occurred on 2/19/16 at approximately 5:30 p.m. Prior to the incident, the Administrator and the resident made an agreement, due to inappropriate comments made by the resident to Certified Nursing Assistants (CNA), there would always be 2 CNAs in the shower room with the resident. On 2/19/16 at approximately 5:30 p.m. (dinner time), Resident #32 had told Licensed Practical Nurse (LPN) #3 that he did not want 2 CNAs in the shower room, that he only wanted 1, and if he didn't get his shower with 1 female CNA; at 9:00 p.m., that evening he was going to, "take off." LPN #3 did not indicate she offered any other interventions, as indicated in the resident's behavior careplan, for the resident threatening to</p>		<p>medicationintervention, residents on antidepressants, antipsychotics, hypnotics andanxiolytics will be included in the behavior monitoring logs (included in thebinders at the nurse's station). Staff have been educated on how to utilize the behaviormonitoring log when residents are experiencing behaviors. This will allow staff to document thebehavior and what interventions they can utilize to diffuse the behavior. The DON or designee will audit the behavior monitoring logsof 20 residents weekly to observe documentation and utilization by staff for 30days. After 30 days, 10 residents' behavior monitoring logs willbe reviewed weekly for 60 days to observe documentation and utilization bystaff for 60days. After 60 days, 5 residents' behavior monitoring logs will bereviewed weekly to observe documentation and utilization by staff, thereafterto ensure compliance. Results of the audits will be reviewed at the monthly QAPImeetings.</p>				

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	<p>leave the facility.</p> <p>On 2/22/16 at 1:20 p.m., LPN #3 indicated she knew the resident and the Administrator had an agreement and so, on 2/19/16 at 5:30 p.m., LPN #3 brought the resident to the Administrator's office to discuss the resident's refusal of 2 CNA's in the shower and the threat to leave the facility. During the discussion, the Administrator said to the resident, "We had an agreement, were you lying to me?" The resident became very agitated, stood up and raised his arms as if he might hit the Administrator.</p> <p>At this time, LPN #3 and Scheduler #5 stepped in to redirect Resident #32 to prevent aggressive behavior towards the Administrator. Once removed and taken to dinner, the resident was observed to be much calmer, ate without incident, and no further problems were documented that evening.</p> <p>On 2/22/16 at 3:15 p.m., the Director of Social Service (DSS) indicated the resident had a history of physical aggression towards staff, and inappropriate behavior with Certified Nursing Assistants (CNA) while receiving assistance with his shower. An agreement had been reached between the Administrator and the resident that 2</p>			

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	<p>CNAs would be in the shower room with the resident at all times.</p> <p>On 2/22/16 at 12:50 p.m., Scheduler #5 indicated, "If [the resident] gets mad or if there's something he doesn't like, he takes off out of the building."</p> <p>On 2/22/16 at 1:40 p.m., the MDS Coordinator indicated, the resident, "becomes angry if things don't go his way and takes off in his wheelchair out of the building."</p> <p>On 2/22/16 at 2:16 p.m., Resident #32 indicated he did not want 2 CNA's in the shower with him, and when he told the Administrator that (on 2/19/16 at 5:30 p.m.), the Administrator accused him of, "lying" regarding the agreement they had reached. Resident #32 indicated, "I probably would have hit him if he kept calling me a liar."</p> <p>On 2/22/16 at 3:15 p.m., DSS indicated Resident #32 had, "behaviors centering around him not getting what he wants when he wants it, and he likes making inappropriate comments...and deals with behaviors by leaving the building..."</p> <p>During the interviews the staff did not seem to know what to do with the resident to help redirect his behaviors.</p>			

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	<p>A care plan, originating 7/28/15, and updated 12/14/15, indicated the resident, "becomes easily irritated with staff when he doesn't get what he wants immediately (medications, showers, vital signs, Gatorade) and will attempt to leave the building, if his needs are not met immediately. He is difficult to re-direct during these episodes."</p> <p>The goal was, residents, "concerns will be addressed and his needs will be met."</p> <p>Interventions were, "Check blood pressure routinely as requested...Give additional shower per request...Keep Gatorade available in his room...Notify physician as needed."</p> <p>A care plan, originating 2/5/14, and updated 2/22/16, indicated Resident #32, "is at risk for injury related to attempts to elope secondary to irritation with staff. [Resident] gets upset with staff, he will attempt to leave the building. [Resident] makes poor decisions regarding his safety needs."</p> <p>Interventions included, "A new system was installed, key pad. [Resident] is unaware of the code to turn off system," (implemented 2/21/16) "Apply Wander Guard bracelet and</p>			

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	<p>check for placement every shift." (implemented 2/5/14)</p> <p>"Check functioning of wander guard daily," (implemented 2/24/15)</p> <p>"Follow up with psychologist," (implemented 7/28/15)</p> <p>"Place picture in elopement risk books," (implemented 7/28/15)</p> <p>"Reassure about blood pressure." (implemented 2/21/14)</p> <p>No other individualized, person-centered interventions were found in these care plans which addressed the resident's threats to leave of the building, and verbal and physical aggression towards staff, prior to the incident which occurred 2/19/16 at 5:50 p.m.</p> <p>During the interview with the DSS on 2/22/16 at 3:22 p.m., she indicated, when the resident was upset, she would have staff handle the situation by not arguing with him, give him some time, then reapproach the resident. The DSS indicated she did not think bringing the resident to the Administrators office was appropriate. She did not indicate any staff education had been provided for appropriately addressing the resident's behaviors.</p> <p>A Behavior Monthly Flowsheet for Resident #32, dated 1/2016, listed</p>			

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F 0441 SS=D Bldg. 00	<p>behaviors of anxiety, continuous screaming/yelling, striking out/hitting, wandering/exit seeking, making threats, comments of sexual nature and physical abuse. Interventions included food and drink. No other interventions were found on the flow sheet.</p> <p>3.1-37(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program</p>						

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NAME OF PROVIDER OR SUPPLIER  INDIANA MASONIC HOME HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to clean a glucometer for a resident as indicated by facility policy (Resident #86, Resident #144).</p> <p>Findings include:</p> <p>During an observation on 2/23/2016 at 4:40 p.m., Licensed Practical Nurse (LPN) #1 used a glucometer machine on Resident #86. LPN #1 indicated, "I cleaned the glucometer between residents with alcohol swabs. At least that is what I do, I don't know what the other nurses do."</p> <p>During an observation on 2/24/16 at 11:09 a.m., Registered Nurse (RN) #2 completed a blood glucose test on</p>	F 0441	<p>LPN #1 and RN #2 were educated on the policy and procedure for disinfecting glucometers and were given a skill competency test to physically demonstrate their competency to disinfect glucometers according to policy and procedure.</p> <p>Nursing staff (LPN, RN and QMA) were educated on the policy and procedure for disinfection of glucometers. Skill competency testing was completed on nursing staff (LPN, RN, and QMA) to physically demonstrate their competency to disinfect glucometers according to policy and procedure.</p> <p>The DON or designee will conduct 2 random glucometer disinfecting competency tests with nursing 5 times weekly for 30 days to ensure compliance.</p> <p>After 30 days, the DON or designee will conduct 2 random glucometer</p>	03/10/2016

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	<p>Resident #144. After completing the glucose test, RN #2 removed gloves, proceeded to the medication cart and obtained a germicidal disposable wipe. RN #2 wiped the glucometer, gloveless, for 5 seconds with the germicidal wipe, then placed the glucometer in the top drawer of the medication cart to dry.</p> <p>On 2/24/26 at 11:27 a.m., RN #2 indicated to cleanse glucometer machines, she wipes the machine off with a germicidal wipe for no specific length of time and then lets it dry for 30 seconds.</p> <p>During an interview on 2/24/16 at 1:15 p.m., the Director of Nursing (DON) indicated germicidal wipes are supposed to be used to sanitize the glucometer machines and that the staff have been inserviced on this topic.</p> <p>During a review of the label of the disinfecting wipes on 6/17/15 at 9:44 a.m., the label indicated, "...To Disinfect and Deodorize: To disinfect nonfood contact surfaces only: Use a wipe to remove heavy soil as needed. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time. Let air</p>		<p>disinfecting competency tests with nursing 3 times weekly for 30days. After 30 days and thereafter, 3 random glucometerdisinfecting competency tests with nursing will be completed weekly. The results of the audits will be reviewed at the monthlyQAPI meeting.</p>				

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	<p>dry...PRECAUTIONARY STATEMENTS Hazards to Humans and Domestic Animals Danger: Causes irreversible eye damage. Do not get in eyes or on clothing. Avoid contact with skin. Wash thoroughly with soap and water after handling...."</p> <p>On 2/24/16 at 12:30 p.m., the DON provided the policy Glucometers dated 5/20/11, and indicated the policy was the one currently used by the facility. The policy indicated, "After use/Between Residents: Wipe entire surface of glucometer with the 2 minute disinfectant wipe. After wiping, wrap the glucometer in the disinfectant wipe for 2 minutes to ensure proper disinfecting...."</p> <p>3.1-18(a)</p>				