| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155817 | A. BUILDING 00 / B. WING | 04/29/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BARRINGTON OF CARMEL, THE | 1335 S GUILFORD ROAD<br>CARMEL, IN 46032 |

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| F 000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: April 20, 21, 22, 23, 24, 27, 28 and 29, 2015.<br><br>Facility number: 013212<br>Provider number: 155817<br>AIM number: N/A<br><br>Census bed type:<br>SNF: 35<br>Residential: 83<br>Total: 118<br><br>Census payor type:<br>Medicare: 19<br>Other: 16<br>Total: 35<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. | F 000 | Please accept this 2567 Plan of Correction as a Provider's Letter of Credible Allegation. This provider respectfully requests consideration for paper compliance in lieu of a revisit survey. The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies of any violations of regulations. This Plan of Correction is offered as our allegation of compliance. | |
| F 157<br>SS=D | 483.10(b)(11)<br>NOTIFY OF CHANGES | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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| Bldg. 00 | (INJURY/DECLINE/ROOM, ETC)<br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. | | | |
| | Based on interview and record review, the facility failed to notify a physician regarding a significant weight loss for 1 of 17 residents reviewed for physicians notification of change. (Resident #39)<br><br>Findings include: | F 157 | **F157 Notify ofchanges (injury/decline/room, etc)—The Community will notify a physicianregarding a significant weight loss. What correctiveaction (s) will be accomplished for those residents found to have been** | 05/27/2015 |

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| | Resident #39's record was reviewed on 4/24/15 at 1:21 p.m. Diagnoses included, but were not limited to, nausea, malignant bladder tumor and depression.<br><br>The resident's weights were as follows during his admission to the facility:<br>12/18/14--185<br>12/21/14--188<br>12/29/14--179<br>1/4/15--174<br>1/19/14--177<br><br>A nutrition progress note dated 1/9/15, indicated "... wt 1/4 174.2 lbs [pounds], indicates a wt [weight] loss of 4.4 (2%) in one week, loss of 10.8 lbs (6%) in 17 days, this is a sig [significant] wt loss for Res [Resident], wt loss due to less than adequate energy intake, RD [Registered Dietician] spoke to Res at lunch this date, stated usual wt 180 lbs, states he is concerned about his wt loss and would like to gain back to his usual wt... RD asked res if he woud [sic] be able to eat more at meals or a supplement between meal stated he would not be able to eat more at meals... RD will monitor as warranted."<br><br>On 4/29/15 at 4:40 p.m., the Assistant Director of Nursing indicated the physician was not notified of the | | **affectedby the deficient practice:**<br>·Resident #39 no longer resides at the Community.<br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:**<br>·All residents have the potential to be affectedby the alleged deficient practice. By May 27, 2015, a comprehensive review ofall residents with weight loss will be completed to identify any residentswhose physician had not been notified. The identified resident will have their physician and responsible partynotified at that time.<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>·Nurses will be re-educated on notification ofsignificant weight loss/gain by the Director of Nursing or her designee.<br>·Nursing management and the Registered Dieticianwill meet to review weights for residents at risk for weight loss on a weeklybasis, and weights for all residents on a monthly basis. As a part of this review, the physician andresponsible party for any residents identified as having significant weight losswill be promptly notified.<br>**How the correctiveaction (s)** | |

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| | resident's significant weight loss.<br><br>3.1-5(a)(2) | | **will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:**<br>· ANutrition At Risk audit form will be used by the Administrator or her designeeto conduct a clinical record audit on at least 50% of residents identified forweight loss to ensure the physician was notified. This Nutrition At Risk audit will becompleted weekly for four weeks, monthly for three months and then quarterlythereafter for twelve months.<br>·Findings of the Nutrition At Risk audits will bemonitored by the Quality Assurance (QA) meeting until such time consistentsubstantial compliance has been met . | |
| F 257<br>SS=D<br>Bldg. 00 | 483.15(h)(6)<br>COMFORTABLE & SAFE TEMPERATURE LEVELS<br>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F<br>Based on observation and interview, the facility failed to maintain comfortable room temperatures for 2 of 4 resident rooms checked for room temperatures. (Resident #2 and #104)<br><br>Findings include: | F 257 | **F257-Comfortable & Safe temperature levels-** It is the practice of this community to maintaincomfortable room temperatures within the parameters set forth in federalguidelines. **What corrective action (s) will be accomplished forthose residents found to have been** | 05/27/2015 |

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| | On 4/27/15 at 9:16 a.m., an Environmental tour of the facility was conducted with the Plant Operations Director and the Associate Executive Director in attendance. The Plant Operations Director indicated at that time, the facility heated and cooled the resident rooms by heating and cooling a block of 4-7 resident rooms on one circuit. He indicated the resident rooms were kept at a certain temperature, which was 73 F (Fahrenheit), then the residents were able to adjust the temperatures with the thermostats in their rooms by one or two degrees.<br><br>1. During an interview on 4/21/15 at 10:50 a.m., Resident #2 indicated his room was cold and he did not think the heating system had worked for the last week due to a construction problem.<br><br>On 4/27/15 at 9:20 a.m., the ambient temperature (the temperature of an area of a room) in Resident #2's room was observed at 69 F on the Plant Operations Director's ambient thermometer. The thermostat in the room was observed set at 71 F. The air temperature blowing out of the resident's vent was 68 F. The resident indicated at that time, he preferred his room temperature be set at 72 F and his hands were cold. | | **affected by the deficient practice**:<br>·Resident #2 & #104 rooms have been fixed tomaintain a comfortable ambient temperature.<br>**How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:**<br>·All residents have the potential to be affectedby the alleged deficient practice.<br>·The community identified the concerns regardingroom temperatures and responded accordingly. Heating/Cooling technicianswere on site prior to and throughout the duration of survey to makemodifications to the system. All residents have the option to adjusttheir room temperatures with the thermostat in their room. Nursing andmaintenance staff are available to assist with room temperatureadjustment. All room thermostats were replaced throughout the skillednursing unit in order to improve ease of use and better temperature control.<br>**What measures will be put into place or what systemicchanges will be made to ensure that the deficient practice does not recur:**<br>·The Director of Plant Operations/designee hasoverseen the Heating/Cooling technicians and has ensured that | |

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| | 2. During an interview on 4/22/15 at 11:08 a.m., Resident #104 indicated her room had been chilly. She indicated the last few days her room had been colder and she had to turn the heating fan on in the bathroom and open the door to allow heat into her bedroom. She indicated she left the blinds open during the day to allow the sunshine to help heat up the room.<br><br>On 4/27/15 at 9:24 p.m., the ambient temperature in Resident #104's room was observed at 69.5 F on the Plant Operations Director's ambient thermometer. Her thermostat in her room was observed set on 71 F. The resident indicated at that time that she was chilly and she had been cold the last couple of days. She indicated staff had adjusted the thermostat to make it warmer in her room, but she didn't think the thermostat was working. She indicated she preferred the temperature in her room to be 72 F.<br><br>During an interview on 4/29/15 at 10:21 a.m., the Administrator indicated the Quality Assessment and Assurance committee was aware of the cool temperatures in the resident rooms. She indicated the facility had contacted the contractor who built the facility to come and fix the cold issue in the rooms because the issue was a construction | | all thermostatswere replaced. While completing room temperature audits, he will bringany discrepancies to the attention of nursing staff and show them how to makethermostat adjustments as needed.<br>·The Director of Plant Operations/designeewill complete Room Temperature Audits to randomly check 8 roomtemperatures weekly for four weeks, then monthly for three months, and thenquarterly thereafter for twelve months.<br>**How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place:**<br>·Findings of the Room Temperature Audits will bemonitored by the Quality Assurance (QA) meeting until such time consistentsubstantial compliance has been met. | |

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| | issue. She indicated the heating company started last week fixing the heating issues with the rooms.<br><br>3.1-19(h) | | | |
| F 279<br>SS=D<br>Bldg. 00 | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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). | | | |
| | Based on interview and record review, the facility failed to implement a Care Plan for nutrition for 2 of 17 residents reviewed for implementation of a Care Plan. (Resident #14 and #39)<br><br>Findings include: | F 279 | **F279 DevelopComprehensive Care plans**<br>·It is the practice of this Community toimplement a Care Plan for nutrition for our residents.<br><br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient** | 05/27/2015 |

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| | 1. The record for Resident #14 was reviewed on 4/27/15 at 10:32 a.m. Diagnoses included, but were not limited to, Congestive Heart Failure, high blood pressure, and chronic anemia.<br><br>The resident's weights were as follows during her admission to the facility:<br>10/23/14--205<br>10/27/14--200<br>10/28/14--196<br>10/31/14--195<br>11/1/14--189 (Reweigh)<br>11/2/14--190<br>11/3/14--191<br>11/5/14--190<br>11/110/14--188<br>11/11/14--189<br><br>A nutrition progress noted dated 11/3/14 at 7:45 a.m., indicated "...RD [Registered Dietician] spoke to Res [Resident] this AM... states her usual wt [weight] 168 lbs [pounds] two years ago before foot surgery caused decreased activity lelvel [sic], and gained to over 200 lbs... wt 11/2 192.2 lbs [pounds], loss 13.8 (7%) in 10 days, wt loss due to drcreased [sic] fluid retention... Res is happy with wt loss and would like to continue to lose wt, education provided on how to restrict sodium... Dietary goals: promote a gradual wt loss... decrease fluid retention. Intervention: reenforce [sic] restricing | | **practice**:<br>·Resident's #14 and # 39 no longer reside in the facility.<br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken**:<br>·All residents have the potential to be affectedby the alleged deficient practice. Residentsthat have specific nutritional care plans will be reviewed by the RegisteredDietitian and updated, as needed .<br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur**:<br>·Nursing management and the Registered Dieticianwill meet to review weights for residents at risk for weight loss on a weeklybasis, and weights for all residents on a monthly basis.<br>·Those residents identified as at-risk for weightloss will have their nutritional care plans reviewed and modified as needed bythe Registered Dietitian (RD).<br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:**<br>·A Nutrition At Risk audit form will be used bythe Administrator or her designee to conduct a clinical record audit on atleast | |

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| | [sic] high sodium foods, increase activity level as feasible. Rd [sic] will monitor as warranted."<br><br>There was no nutritional Care Plan, which indicated the resident desired to lose weight found in her record. At the time of the exit conference on 4/29/15 at 7:46 p.m., there was no further information provided regarding the nutrition Care Plan.<br><br>2. Resident #39's record was reviewed on 4/24/15 at 1:21 p.m. Diagnoses included, but were not limited to, nausea, malignant bladder tumor and depression.<br><br>The resident's weights were as follows during his admission to the facility:<br>12/18/14--185<br>12/21/14--188<br>12/29/14--179<br>1/4/15--174<br>1/19/14--177<br><br>A nutrition progress note dated 1/9/15, indicated "... wt 1/4 174.2 lbs, indicates a wt loss of 4.4 (2%) in one week, loss of 10.8 lbs (6%) in 17 days, this is a sig [significant] wt loss for Res, wt loss due to less than adequate energy intake, RD spoke to Res at lunch this date, stated usual wt 180 lbs, states he is concerned about his wt loss and would like to gain | | 50% of residents identified for weight loss to ensure the nutritionalcare plans are in place. This NutritionAt Risk audit will be completed weekly for four weeks, monthly for three monthsand then quarterly thereafter for twelve months.<br>·Findings of the Nutrition At Risk audits will bemonitored by the Quality Assurance (QA) meeting until such time consistentsubstantial compliance has been met. | |

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| | back to his usual wt... RD asked res if he wold [sic] be able to eat more at meals or a supplement between meal stated he would not be able to eat more at meals... RD will monitor as warranted."<br><br>There was no nutritional Care Plan, which indicated the resident had a significant weight loss and desired to gain the weight back to his usual body weight. At the time of the exit conference on 4/29/15 at 7:46 p.m., there was no further information provided regarding the nutritional Care Plan.<br><br>A current policy titled "Nutritionally At Risk Policy for The Plaza:..." was provided by the Assistant Director of Nursing on 4/28/15 at 5:45 p.m. The policy indicated "Purpose: The purpose the Nutritionally At Risk [NAR] program is to follow and evaluate the nutritional status of those residents who have been determined to be nutritionally at risk... Nutritionally At Risk Definition: Nutritionally At Risk means that a resident has exhibited signs and symptoms of poor or inadequate nutrition. These signs and symptoms may include, but are not limited to: weight loss and/or gain, poor intake at meals/snacks... Criteria for NAR Placement:... The main criteria for being placed on NAR will be focused on | | | |

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| | weight. Significant changes in weight, whether it be a loss or gain, will be cause for immediate placement in the NAR program. Significant changes in weight are defined as:<br>+/- 5% change in body weight within 30 days<br>+/- 7.5% change in body weight within 90 days<br>+/- 10% change in body weight within 180 days...<br>Care plan problem, goals and approaches will be updated for each resident...."<br><br>3.1-35(a) | | | |
| F 314<br>SS=D<br>Bldg. 00 | 483.25(c)<br>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br>Based on interview and record review, the facility failed to perform a wound assessment for pressure ulcers and failed to implement pressure ulcer prevention interventions for a pressure ulcer | F 314 | **F314 Treatment/servicesto prevent/heal pressure sores**<br>**It is the practiceof this Community to perform a wound assessment for pressure ulcers andimplement pressure ulcer interventions** | 05/27/2015 |

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| | (Residents #2 and #44)<br><br>Findings included:<br><br>1. On 04/24/2015 at 10:54 a.m., the record review for Resident #2 was completed. Diagnoses included, but were not limited to, high blood pressure, dementia, and peripheral neuropathy.<br><br>The physician's orders dated:<br>1/28/15, indicated the resident had a pressure reducing mattress on bed and Multivitamin daily for supplement.<br><br>1/29/15: "...Perform a weekly skin assessment on the night shift..."<br><br>2/11/15: "...Apply Santyl [an ointment that removes dead tissue] gram to left great toe daily x 5 days and perform daily dressing changes with non adherent pad to left great toe and wrap with kerlix x 10 days...."<br><br>2/12/15: "...Clarification Cleanse left great toe wound with normal saline pat dry apply Santyl nickel thick to wound bed cover with hydrogel fluffed gauze and secure with hydrofix. Telephone order change daily and as needed soilage dislodgement x 10 days...."<br><br>4/16/15: "...Place resident in open-toed | | **What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:**<br>·Resident #2 had a full skin assessment performedalong with the pressure ulcer risk assessment. At this time, the wound was measured, staged and the treatment orderreviewed. Appropriate revisions weremade to the care plan to reflect all current pressure ulcer preventioninterventions. The C.N.A. assignmentsheet was updated with current pressure reducing devices to be used.<br>·Resident #44 no longer resides at the Community.<br>·Nursing staff will be re-educated on thedocumentation standards for wound staging and descriptions by the DNS/designeeby May 27, 2015.<br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken**:<br>·All residents have the potential to be affectedby the alleged deficient practice. Pressure ulcer risk assessments and skin assessments were completed forall residents by the nursing team. Thoseresidents identified to be at risk had care plans reviewed and updated toensure appropriate interventions were in place.<br>·Nursing staff will be educated on thedocumentation standards for wound staging and descriptions by the Director ofNursing or her | |

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| | shoes/boot until the toe wound is healed. Left great toe area to receive Santyl through 4/22/15...."<br><br>4/22/15: "...Cover the left great toe with gauze for 3 days and wear open toed shoe on left foot...."<br><br>In an interview on 4/21/15 3:56 p.m., LPN #4 indicated Resident #2 had a pressure ulcer on his left great toe area.<br><br>The skin assessments indicated:<br><br>2/4/15: "...No open areas, monitor left toe scab...."<br><br>2/11/15: "...Scab to left toe...."<br><br>2/18/15- "...Scabbed area to left toe...."<br><br>3/4/15- "... Left great toe scabbed area. Treatment monitor...."<br><br>3/11/15- "...Left great toe Scabbed area open to air... Treatment monitor...."<br><br>3/18/15- "...Area dry and intact continue to monitor. Treatment monitor...."<br><br>3/25/14- "...Scabbed area to toe, continue to monitor...Treatment-monitor...."<br><br>4/1/15- "...Chronic area on tip of left toe- | | designee by May 27, 2015.<br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>·The Community policy regarding pressure ulcerprevention was updated to include pressure ulcer risk assessment and skinassessments to be completed upon admission, quarterly, annually and withsignificant changes. Physicians' orderswill be obtained for all alterations in skin integrity. All nursing staff was re-educated on therevised Community policy for Pressure Ulcer Prevention, preventioninterventions and timely reporting of any skin concerns. C.N.A.'s are to report directly to the chargenurse any changes they observe in a resident's skin condition as well asdocumenting on the shower sheets.<br>·The Director of Nursing or her designee willmonitor physicians' orders (M-F, excluding holidays) regarding pressure ulcersto ensure physician orders are followed by conducting wound rounds weekly.<br>·Nursing staff will be educated on thedocumentation standards for wound staging and descriptions by the Director ofNursing or her designee by May 27, 2015.<br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:**<br>·The Director of Nursing or her | |

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| | thickened callus--resident to wear open toe shoes. Monitor per physicians order...."<br><br>4/8/15- "...chronic area on tip of left toe--thicken callus--resident to wear open toe shoes and treated per physician order...."<br><br>4/15/15- "...chronic area tip of toe. Area has scab forming spouse took open toes shoes home. 0.5 x 0.7 cm x 0. serous drainage, , Treatment monitor open toed shoes. The resident had a pressure relieving bed, multi vitamin and protein supplement as interventions...."<br><br>The care plan dated 1/30/15, indicated actual impaired skin integrity resident had<br>a scabbed area to left great toe (callus). Approach Wound care/dressing change as ordered. See Physician's orders. Provide pressure ulcer relieving devices (See Resident Care Guide) and provide diet and snacks as recommended by Dietician.<br><br>On 4/27/15 at 5:00 p.m., the Director of Nursing indicated she would expect nurses to describe the type of wound when they do a skin assessment if the resident had a wound. She indicated the wound documentation did not indicate the type of wound. | | designee willconduct a skin audit tool on all residents with pressure ulcer treatments weeklyfor four weeks, monthly for three months and then quarterly thereafter for 12months.<br>·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met. | |

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| | On 4/28/15 at 11:04 a.m., the Nurse Practitioner (NP) indicated he felt the left great toe area was just a scab when initially assessed. He indicated the area after the trauma of hitting the toe, or the rubbing of the shoe on the area of the toe caused an ulcer. The NP indicated the toe wound came from the pressure caused by the toe rubbing on the shoe. He indicated he used the Santyl to get rid of the scab and underneath was an ulcerated reddened wound area, or a pressure ulcer. | | | |
| F 315 SS=D Bldg. 00 | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | | | |
| | Based on interview and record review, the facility failed to provide medical intervention in a timely manner to treat a urinary tract infection (UTI) (Resident #60)<br><br>Findings included:<br><br>The record review for Resident #60 was | F 315 | **F315 No catheter,prevent UTI, restore bladder**<br>**It is the practiceof this Community to ensure that a resident who enters the Community without anindwelling catheter is not catheterized unless the resident's clinicalcondition demonstrates that catheterization is necessary; and a resident who isincontinent of** | 05/27/2015 |

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| | completed on 04/27/2015 at 2:20 p.m. Diagnoses included, but were not limited to, acute renal failure, urinary tract infections, and congestive heart failure.<br><br>The nursing notes indicated:<br><br>11/1/14 at 7:49 a.m., "...CNA informed nurse that resident had a greenish mucousy discharge from his penis this am [morning] and that resident had no report of pain, burning, urgency during the discharge. The residents temperature was taken and was 98.9 and there was no distress present. The on call Physician was contacted and had no new order, and no change of treatments. The physician indicated it is possible the resident had an incontinent episode with a mix of urine and mucous in the urethra...."<br><br>11/1/14 at 2:22 p.m., "... the resident had a small amount of green penile discharge noted. The resident had no complaints of urinary discomfort at that time...."<br><br>11/3/14 at 5:09 a.m., "...The resident refused food due to complaints of nausea, Zofran (a medication for nausea) given at 4:30 a.m. for nausea...."<br><br>11/4/14- "... The resident's urine input and output was adequate, but urine was discolored-awaiting urinalysis [UA)]and | | **bladder receives appropriate treatment and services to preventurinary tract infections and to restore as much normal bladder function aspossible.**<br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**:<br>·Resident #60 no longer resides at the Community.<br><br>**How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken:**<br>·All residents residing in the Community have thepotential to be affected by the alleged deficient practice. Any residents exhibiting signs of a urinarytract abnormality will be referred to the physician for evaluation.<br>·Licensed nurses will be re-educated on theprocedure to follow when residents exhibit signs of a urinary tract abnormalityby the Director of Nursing or her designee by May 27, 2015.<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur**:<br>·Licensed nurses will be re-educated on theprocedure to | |

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| | culture and sensitivity [C&S]. The residents urine description dark colored. The resident had no complaints of frequency or dysuria [burning with urination], but the resident was incontinent...."<br><br>11/6/14- "...The results for the UA indicated Pseudomonas Aeruginosa (an identified bacterial organism) the Physician was notified and no orders received at this time. The physician would like to assess the resident and review the chart before prescribing antibiotic...."<br><br>11/20/14- "...The resident was complaining of burning upon urination at this time. The staff was attempting to obtain urine sample test for infection, and was unsuccessful at that time...."<br><br>11/22/14- "...The urine sample was collected for UA. The urine was observed to be yellow and cloudy. The resident had frequency, dysuria, and incontinence...."<br><br>11/26/14- "...The urine description was cloudy and yellow. No frequency was present, there was some dysuria and incontinence present...."<br><br>12/3/14-"...The resident's urine was | | follow when resident's exhibit signs of a urinary tractabnormality by the Director of Nursing or her designee by May 27, 2015.<br>·The Director of Nursing or her designee willmonitor the acute change status daily (M-F, excluding holidays) for physicianfollow up to unaddressed nursing concerns.<br>·Nurses have been re-educated to call thephysician with the resident's symptoms, duration of symptoms, and any otherpertinent information concerning the resident. They will then document this information in the clinical record alongwith any new orders. If no orders areobtained, the clinical record will also reflect that. If resident's condition orsymptoms persist, the licensed nurse will contact the physician with updates onthe resident status and document such in clinical record. If the physician still does not respond tothe nurses concerns, the nurse will notify the Director of Nursing or herdesignee of this situation for additional follow up. The Director of Nursing or her designee willcontact the Community medical director for assistance in the situation.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: | |

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| | described as yellow and slightly cloudy. He had symptoms of frequency and incontinence, resident denies dysuria...."<br><br>12/10/14- "...The residents urine was described as yellow and cloudy. The resident had symptoms of frequency, dysuria, incontinence, and dribbling. A urine sample was collected and the Physician was made aware, awaiting results...."<br><br>12/13/14- "...The residents urine was described as yellow. The resident had symptoms of frequency, dysuria, and incontinence present. The UA results were in and physician was made aware, the results had been faxed to urologist...."<br><br>12/23/14-"...The resident was indicating that he didn't feel well. The resident had a fever of 101.3. The Nurse Practitioner was notified and ordered Rochephin (an antibiotic)1 gram intramuscularly daily for 3 days for fever and weakness...."<br><br>The Physician progress notes indicated:<br><br>11/10/14- indicated "...Chief Complaint : None recorded.<br>Assessment/plan: no further issues with penile discharge. The resident's cultures revealed the same organism that he grew in his uring [sic] at the hospital and | | ·Licensed nurses will be re-educated on theprocedure to follow when resident's exhibit signs of a urinary tractabnormality by the Director of Nursing or her designee by May 27, 2015.<br>·The Director of Nursing or her designee willconduct a change of condition audit on four residents weekly for four weeks,monthly for three months and then quarterly thereafter for twelve months.<br>·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met. | |

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| | received course of cefipime post hemodialysis. The resident had no dysuria,. Says he does still void reasonable quantities of urine...."<br><br>12/8/14- indicated "...follow up for dysuria. Patient went to the urologist last week for his follow up. He had been complaining of dysuria and it was felt that some of his problem was coming from the stent. He did have a positive UA and Culture grew pseudomonas, however patient was not ill. Urology did not make any changes or order antibiotics at that time. He was scheduled to have his urethral stent replaced in February...Assessment/Plan Penile drainage and mild dysuria : did follow up with urology and had dysuria at that time, but no new orders received. The last couple of days, the resident started to have yellow penile discharge again. The resident's temperature was 99.7 This week repeated UA culture to ensure that bacteria is the same. The resident would likely need to have intravenous cepfipime [an antibitoic] after dialysis as done during hospitalization...."<br><br>12/10/14-"... chief complaint: Resident having dysuria and discharge from his penis. The resident went to the urologist 2 weeks ago for a follow up visit. The resident had been complaining of dysuria | | | |

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| | at the nursing home and had a positive UA and culture with pseudomonas (11/22/14). It was felt that some of his problem was coming from the urethral stent so it was hoped that urology would help to address this, however patient did not mention the dysuria to the Urologist and the Urologist was not aware of the positive UA. The resident began to complain of dysuria again and pus coming from his penis on 12/8/14. The resident's urine analysis was positive and culture pending. The resident was treated with intravenous antibiotics for pseudomonas in the hospital prior to his admission to the facility...Penile drainage and mild dysuria : did follow up with urology, but had not mentioned dysuria and pus. Would really appreciate having urologists input. The facility will fax over all lab results and this note. The resident's body temperature at a maximum, was at 99.7 over last 2 weeks...."<br><br>12/23/14-"...The resident indicated he had a positive UA and culture which had been sent to the urology as infection thought to be involving his urethral stent, however after several phone calls and faxing all pertinent information, no response had been given. The resident had developed malaise, fatigue and fever of 100.3 over the last few days. The | | | |

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| | resident stated that he had a cough but otherwise no specific symptoms...."<br><br>The physicians orders indicated:<br><br>12/23/14 -"...Rochephin 1 gram IM [into the muscle] for 3 days...."<br><br>1/19/15 -"...Gentamyacin [an antibiotic] inject 80 milligrams IM x 1 prior to surgical procedure to prevent infection...."<br><br>A request was made for all of the correspondence with the Urologist and the Assistant Director of Nursing provided a document on 4/28/15 at 5:45 p.m., dated 1/16/15. The Urology Department had a document provided from the Surgery Coordinator and there was a line crossed through information that indicated to advise the urologist regarding results of urine C & S done on 1/12/15. The Urologist notes indicated the resident was to go to the hospital and have another urethral stent placed on 1/19/15. There was also a fax dated 1/16/15 indicating having sent the resident's lab results (no date indicated).<br><br>There was no documentation provided from the facility to the urologist during the 12/10/14 time frame. There was no documentation provided from the facility | | | |

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| | of notification of the Urologist regarding the resident's Urinalysis results on 11/22/14.<br><br>In an interview on 4/27/15 at 4:45 p.m., the Director of Nursing indicated the facility had done what they needed to do for the resident in regards to the resident having pus in his urine.<br><br>3.1-41(a)(2) | | | |
| F 325<br>SS=G<br>Bldg. 00 | 483.25(i)<br>MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br>Based on interview and record review, the facility failed to perform a dietary assessment in a timely manner on a resident who had a significant weight loss and failed to implement dietary interventions for a resident who had a significant weight loss for 2 of 3 residents reviewed for nutrition. Resident #39 lost 10.8 pounds or 6% of his body weight in 17 days. (Residents #39 and #14) | F 325 | **F325 Maintainnutrition status unless unavoidable**<br>**It is the practiceof this Community to perform a dietary assessment in a timely manner on aresident who has significant weight loss and to implement dietary interventions**<br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:**<br>·Resident's #14 and #39 no longer reside in thefacility. | 05/27/2015 |

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| | Findings include:<br><br>1. Resident #39's record was reviewed on 4/24/15 at 1:21 p.m. Diagnoses included, but were not limited to, nausea, malignant bladder tumor and depression.<br><br>The resident's weights were as follows during his admission to the facility:<br>12/18/14--185 (Admission weight)<br>12/21/14--188<br>12/29/14--179<br>1/4/15--174<br>1/19/14--177<br><br>A nutrition progress note dated 12/19/14, indicated "Initial Nutritional assessment completed this date:... Res [resident] unable to answer nutrition questions. Diet RX [prescription] Regular, intake poor, Res refused Bfk [breakfast] this date, wt [weight] 185 lbs [pounds]... estimated needs: 84 gm [grams] prot/day [protein per day]... 2102 cal/day [calories per day]... present intake is not adequate to meet needs. RD [Registered Dietician] will monitor as warranted."<br><br>A nutrition progress note dated 12/22/14, indicated "...12/21 wt 188 lbs, includes a wt gain of 3 lbs, Res oral intake remains poor with some meal refusals, staff feeding or assisting with meals, unable to | | **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:**<br>·All other residents have the potential to beaffected by the alleged deficient practice.<br>·All other facility resident weights will bereviewed for significant weight changes with Registered Dietitian assessmentand IDT NAR meeting assessment completion as needed. Residents who have significant weight losswill have dietary interventions implemented.<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:**<br>·Nurses will be re-educated by May 27, 2015, onthe referral to the Registered Dietician of significant weight change.<br>·The Registered Dietitian will continue to reviewsignificant weight losses/gains on a weekly basis and complete residentnutrition assessments with recommendations.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality** | |

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| BARRINGTON OF CARMEL, THE | 1335 S GUILFORD ROAD<br>CARMEL, IN 46032 |

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| | determine how Res gained wt, no edema. RD will monitor as warranted."<br><br>A nursing progress note dated 12/22/14 at 7:52 p.m., indicated "...Refused dinner tonight resident offered boost breeze 100% consumes... 3+ pitting edema ankle and feet...."<br><br>A nursing progress note dated 12/27/14 at 9:22 p.m., indicated "...Resident in bed this evening stating his doesn't want to get up in recliner to eat stated he is weak...Lungs congested bilateral cough productive thick clear sputum...appetite remains poor... offered supplement and ice cream 100% consumed...."<br><br>A nutrition progress note dated 12/29/14, indicated "14 day assessment completed this date: wt 185 lbs... intake poor, will eat ice cream or house supplement instead of solids... RD will monitor as warranted."<br><br>A nutrition progress note dated 1/9/15, indicated "... wt 1/4 174.2 lbs, indicates a wt loss of 4.4 (2%) in one week, loss of 10.8 lbs (6%) in 17 days, this is a sig [significant] wt loss for Res, wt loss due to less than adequate energy intake, RD spoke to Res at lunch this date, stated usual wt 180 lbs, states he is concerned about his wt loss and would like to gain | | **assurance program will be put into place:**<br>·The Registered Dietitian will review the weeklyand monthly significant weight losses and refer findings to the interdisciplinaryNutrition at Risk Meeting for further review.<br>·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155817 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 04/29/2015 |
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| | back to his usual wt... RD asked res if he wold [sic] be able to eat more at meals or a supplement between meal stated he would not be able to eat more at meals... RD will monitor as warranted."<br><br>A nutrition progress note dated 1/16/15, indicated "30 day assessment was completed... weight was 174.2... RD will monitor as warranted..."<br><br>There was no documentation in the progress notes or no documentation on the Electronic Medication Administration or Treatment Administration Record, which indicated the resident was receiving ice cream or house supplements consistently as an intervention to prevent weight loss.<br><br>The resident's laboratory results were as follows:<br>12/19/15--CMP (Comprehensive Metabolic Panel)<br>Sodium--130 (dietary nutrient) (low)<br>Normal--135-145 meq/L<br><br>(millieqivalents per liter)<br>Cloride--91 (dietary nutrient) (low)<br>Normal--98-113 meq/L<br>Total Protein--5.9 (low)<br>Normal--6.0-8.2 gm/dL (grams<br><br>per decaliter) | | | |

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| | There were no physician orders for weight loss interventions or dietary interventions found in the resident's record, which prevented further weight loss or assisted the resident gain the weight back the weight he lost and reach his usual body weight.<br><br>During an interview on 4/27/15 at 12:33 p.m., Registered Dietician (RD) #7 indicated she was not the RD when the resident was admitted to the facility. She indicated she started in orientation on 1/5/15. She indicated a contracted RD was the RD in the facility at that time. She indicated dietary interventions should have been put into place to allow the resident to gain the weight back to his usual body weight if that was his desire. She indicated she would have added 500 calories a day depending on the resident's meal intakes to increase his weight to meet his desired goal. She indicated she would have added a dietary supplement three times a day because each shake supplement contained 250 calories. She indicated the RD should always try to promote food before a supplement, but the facility did not have a fortified food program yet, so she would have had to offer the resident a supplement to increase his weight to reach his desired goal. | | | |

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| | 2. The record for Resident #14 was reviewed on 4/27/15 at 10:32 a.m. Diagnoses included, but were not limited to, Congestive Heart Failure, high blood pressure, and chronic anemia.<br><br>The resident's weights were as follows during her admission to the facility:<br>10/23/14--205 (Admission weight)<br>10/27/14--200<br>10/28/14--196<br>10/31/14--195<br>11/1/14--189 (Reweigh)<br>11/2/14--190<br>11/3/14--191<br>11/5/14--190<br>11/110/14--188<br>11/11/14--189<br><br>A nutrition progress noted dated 11/3/14 at 7:45 a.m., indicated "...RD spoke to Res this AM... states her usual wt 168 lbs two years ago before foot surgery caused decreased activity lelvel [sic], and gained to over 200 lbs... wt 11/2 192.2 lbs, loss 13.8 (7%) in 10 days, wt loss due to drcreased [sic] fluid retention... Res is happy with wt loss and would like to continue to lose wt, education provided on how to restrict sodium... Dietary goals: promote a gradual wt loss... decrease fluid retention. Intervention: reenforce [sic] restricing [sic] high | | | |

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| | sodium foods, increase activity level as feasible. Rd [sic] will monitor as warranted."<br><br>During an interview on 4/27/15 at 12:48 p.m., Registered Dietician (RD) #7 indicated she was not the RD at this facility when this resident was admitted. She indicated RD #6 was here during that time, who was a contracted RD. She indicated she had not seen an initial dietary assessment, which RD #6 would have completed for this resident before 11/3/14. She indicated she assessed residents within 3-5 days of their admission.<br><br>During an interview on 4/27/15 at 3:04 p.m., the Administrator indicated RD #6 was at the facility two days a week on Mondays and Fridays until RD #7 became the full time RD.<br><br>During an interview on 4/29/15 at 10:21 p.m., the Administrator indicated she had assumed RD #6 was assessing the residents, which was admitted over the weekend on Mondays and assessing the residents on Mondays and Fridays because she was getting reports from her.<br><br>A current policy titled "Nutritionally At Risk Policy for The Plaza:..." was provided by the Assistant Director of | | | |

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| | Nursing on 4/28/15 at 5:45 p.m. The policy indicated "Purpose: The purpose the Nutritionally At Risk [NAR] program is to follow and evaluate the nutritional status of those residents who have been determined to be nutritionally at risk... Nutritonally At Risk Definition: Nutritionally At Risk means that a resident has exhibited signs and symptoms of poor or inadequate nutrition. These signs and symptoms may include, but are not limited to: weight loss and/or gain, poor intake at meals/snacks... Criteria for NAR Placement:... The main criteria for being placed on NAR will be focused on weight. Significant changes in weight, whether it be a loss or gain, will be cause for immediate placement in the NAR program. Significant changes in weight are defined as:<br>+/- 5% change in body weight within 30 days<br>+/- 7.5% change in body weight within 90 days<br>+/- 10% change in body weight within 180 days...<br>NAR Process: Once a resident has been identified to be nutritionally at risk, that resident will be placed in the NAR program... The Registered Dietician will be responsible for providing nursing with an updated list of residents who are being followed in NAR weekly. The RD will | | | |

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| | also provide Social Services, Therapy, and MDS [Minimum Data Set] with a list. These residents will be monitored closely by all disciplines during the week in order to have a complete assessment and find the underlying issues for the weight loss/gain... Interventions to treat weight loss include, but are not limited to: fortified foods, increases in portion sizes, frequent snacks, oral nutrition supplements, nutrition education/counseling, appetite stimulants, or enteral feedings... Care plan problem, goals and approaches will be updated for each resident...."<br><br>3.1-46(a)(1) | | | |
| F 329<br>SS=E<br>Bldg. 00 | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a | | | |

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| | resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | | | |
| | Based on interview and record review, the facility failed to monitor for specific targeted behaviors for psychotropic drugs for 5 of 5 residents (Residents # 43, #88, #58,# 93 & #77) and failed to monitor for side effects and have the appropriate diagnosis for the use of an antidepressant medication for 2 of 5 residents reviewed for unnecessary medications. (Residents #58 and #88)<br><br>Findings included:<br><br>1. The record review for Resident #77 was completed on 4/27/15 at 10:47 a.m. Diagnoses included, but were not limited to, dementia, gout, reactive arthritis, diabetes, atrial fibrillation and high blood pressure.<br><br>The resident's nursing progress note dated 3/4/15, indicated the resident had dementia and had a prior history of a hallucination of being in an airport. | F 329 | **F329 Unnecessarydrugs**<br>**It is the practiceof this Community to monitor for specific targeted behaviors for psychotropicdrugs and to monitor for side effects and have the appropriate diagnosis forthe use of an antidepressant medication.**<br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice**:<br>·The medication regime for residents #43, #88,#58, #93, #77 has been reviewed by the physician. The indication for the prescribedantipsychotic drug was clearly documented by the physician in the medicalrecord.<br><br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken**:<br>·All residents receiving antipsychotic drugs havethe potential to be affected by the alleged deficient practice. A review of all the medication | 05/27/2015 |

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| | The nurses notes indicated:<br>3/4/15 at 12:22 a.m., "...note indicated no anxiety tonight or hallucinations voiced...."<br><br>3/5/15 at 7:35 a.m., "...staff found the resident on the floor next to his bed and he stated he had to find wife as they were coming to lay carpet in the house...."<br><br>3/5/15 at 10:14 a.m., "...resident noted with increased anxiety, confusion and restlessness, as needed Ativan [an antianxiety medication] administered. The medication was effective with noted decreased anxiety and less anxiousness, the residents wife was notified. The wife stated the resident had been very rude and blaming her for being at facility, states the resident was noted to have frequent episodes of sundowning prior to admission. will continue to monitor for behavior...."<br><br>3/6/15 at 4:29 a.m., "...The resident became very restless and agitated at 3:15 a.m. He was trying to climb out of his bed and yelling for help. He stated he was in a car wash and needed the car keys to get out. He stated that this was the craziest, hospital room he had ever seen and he needed his keys. The resident was very anxious and agitated with the staff...." | | orders forantipsychotic drugs and indications for use has been completed.<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur**:<br>·All licensed nursing staff have been re-educatedregarding the Community policy for Indications for use of AntipsychoticDrugs. A copy of this information is ateach nurses' station for reference. Inaddition, a copy of the regulations and the Community policy regarding theiruse have been provided to the physicians as a resource.<br>·The licensed nursing staff have also been re-educatedon the documentation needed for each resident to ensure the medications arespecific for them. The nurses have beeninstructed to provide exact descriptions of the behavior of concern. Documentation must show quantitativeevaluation of specific behaviors in order to determine the effectiveness of themeds and to track their progress toward the specific goal.<br>·All residents who are on the behavior monitoringprogram will have a monthly summary that includes a review of the behaviors andinterventions as well as a psychotropic med review. Any identified interventions or changes willbe care planned and | |

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| | 3/7/15 at 2:12 a.m., "...The resident was alert and oriented to self. He had readily recognized the staffs faces, but did not know from where. The resident was very confused and anxious. He stated he was sleeping in the crawlspace under the house. The resident became agitated and irritable. The resident stated this isn't a room what's wrong with you? can't you see this is a basement?'...."<br><br>3/7/15 at 4:54 a.m., "...The resident continued to claim he was sleeping in the crawl space below the basement. He denies any pain or discomfort. He was found up looking for his car and his wife...."<br><br>The Physician progress notes from a psychiatrist who evaluated the resident on 3/11/15, indicated, " ...Senile dementia (by history) likely Vascular vs. Diffused Lewy Body with delusions/hallucinations and behavioral difficulties. The Physician indicated the resident knew he was in a rehabilitation place and was there because he was sick and had surgery. He indicated when he first came here he was confused, but denies feeling confused at the present time...."<br><br>There was a physician's order dated 3/11/15, for Seroquel (an antipsychotic | | added to the C.N.A. assignment sheet. The Interdisciplinary Team (IDT) will reviewthe summaries monthly.<br>·The Director of Nursing or her designee willcomplete weekly audits of any newly ordered psychotropic medication to ensurethat appropriate indications for use of any these medications are clearlydocumented in the clinical record.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**:<br>·The Director of Nursing or her designee willcomplete weekly audits of 2 charts of new med orders to ensure that appropriateindications for use of any anti-psychotic drugs are clearly documented in theclinical record.<br>·Findings of these audits will be monitored bythe Quality Assurance (QA) meeting until such time consistent substantialcompliance has been met. | |

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| | medication) 25 milligrams daily for psychosis.<br><br>The Treatment Administration Record (TAR) for the month of April 2015, indicated the resident was on an antipsychotic medication and to monitor for the following behaviors.<br>0- none<br>1- Hallucinations<br>2- Physical aggression<br>3- verbal aggression<br>4- paranoia<br>5- agitation<br>6- delusions<br><br>The documentation for monitoring of behaviors did not have a specific description of what type of hallucination or delusion the resident displayed as the progress notes indicated. | | | |
| F 364<br>SS=E<br>Bldg. 00 | 483.35(d)(1)-(2)<br>NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br>Based on observation, record review and interview, the temperature of food when served to the residents was warm instead of hot for 1 of 2 sampled food items for food quality. (Residents #2, #72, and #77) | F 364 | **F364 Nutritivevalue/appear, palatable/prefer temp**<br>**It is the practiceof this Community to ensure each resident receives food prepared by methodsthat conserve nutritive value, flavor, and appearance; and food that** | 05/27/2015 |

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| | Findings included:<br><br>On 04/21/2015 at 9:50 a.m., Resident # 77 indicated the food was sometimes hot enough, and sometimes it was not.<br><br>On 4/21/15 at 10:54 a.m., Resident #2 indicated the food could be hotter.<br><br>On 4/21/2015 at 2:21 p.m., Resident #75 indicated the food was more recently warm and satisfactory. Indicated the issue of food had come up before and more recently it was getting a bit better.<br><br>The Registered Dietician brought the sample test tray with a crab patty and hash brown casserole which were the main hot dishes for lunch on 4/24/15.<br><br>The temperatures for the lunch tray on 4/24/2015 at 2:02 p.m., were as follows: 173 degrees F (Fahrenheit) for the crab patty and hash brown casserole 141 degrees F.<br><br>The hash browns were moist and had flavor, but were warm when sampled. The crab patty was hot and had steam coming off of it when cut.<br><br>3.1-21(a)(1) | | **ispalatable, attractive, and at the proper temperature**<br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:**<br>·Any food identified as warm was discarded andreplaced promptly with hot food per the residents' preference.<br><br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:**<br>·All residents have the potential to be affectedby the alleged deficient practice. Hinged lids for hot holding for the tray line were ordered. All hot food items will be placed in hotholding wells with temperatures monitored.<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:**<br>·Hinged lids for hot holding food tray line wereordered and education with dietary staff will be conducted by May 27, 2015,regarding how to use the hinged lids on tray line and to keep food hot in trayline holding.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality** | |

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| | | | **assurance program will be put into place:**<br>·Director of Dining Services or designee willconduct audits of hot holding food implementation practices, review hinged lidusage on tray line, and obtain last test tray temperatures. These audits will be completed five times weeklyfor four weeks, weekly for three months and then monthly thereafter for twelvemonths.<br>·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met. | |
| F 371<br>SS=F<br>Bldg. 00 | 483.35(i)<br>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br>Based on observation, interview and record review, the facility failed to maintain sanitary kitchen conditions and to prevent kitchen staff from utilizing unsanitary practices while serving food to 35 of 35 residents who were served food from the kitchen.<br><br>Findings included:<br><br>The tour of the main kitchen was | F 371 | **F371 Food procure,store/prepare/serve-sanitary**<br>**It is the practiceof this Community to maintain sanitary kitchen conditions and to preventkitchen staff from utilizing unsanitary practices while serving.**<br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:**<br>·All areas identified as allegedly | 05/27/2015 |

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| | completed on 4/20/2015 at 10:25 a.m., with the Registered Dietician (RD) in attendance. The main mixer was observed to have an off white colored sticky debris on it. The RD indicated they do not have a cover for the mixer. The plastic cover of the soup kettle had red colored debris and other dark colored matter stuck to it. The RD indicated the cleaning was done weekly by dietary aids.<br><br>The double broiler oven had dark debris on the bottom.<br><br>The vents above the stove and ovens, behind the grill area, and the wall up above the grill area had dark rust colored debris on it. The broiler also had dark rust colored debris on top of it. The RD indicated she thought they were cleaned weekly.<br><br>The drawers with cold holding plates and bowls for salads had debris in the drawer and on 1 out of 8 plates observed. Another cold holding drawer for plates had standing water at the bottom of the drawers. The RD indicated at that time, the water and debris should not be in the cold holding drawers<br><br>The lighting and vents in the prep service area with a steam table had 3 dirty panels, | | deficient wereaddressed promptly.<br><br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:**<br>·All residents have the potential to be affectedby the alleged deficient practice. Allareas identified as allegedly deficient were addressed promptly.<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>·Sanitary kitchen conditions will be maintainedwith an updated cleaning schedule and improved staff clean-as-you-gopractices. Dietary staff will bere-educated regarding proper hand washing, glove usage, food storage, andtasting of service food practices by May 27, 2015.<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:**<br>·Director of Dining Services or designee willconduct sanitation audits of cleaning schedule implementation and staff handwashing, glove usage, food storage, and tasting of service | |

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| | 3 dirty lights, and 2 dirty vents with visible dark debris on each light, panel and vent directly over the prep area. At that time, the RD indicated the staff should have had a weekly cleaning list and the head chef indicated he did not know where the list was. The RD indicated she had discussed the dirty vents and lighting above the prep area with the kitchen staff and those areas should have been clean.<br><br>There was a small freezer for potato items. The freezer had one uncovered pan with tator tots, one uncovered pan with waffle fries, one uncovered pan with sweet potato fries, and one uncovered pan with french fries. The RD indicated at that time, the items should be covered. There was one bag of frozen item that was not sealed.<br><br>A lunch preparation observation was done with Cook #2 on 4/24/15 at 12:17 p.m. Cook #2 was touching drawer handles and refrigerator handles, then took off his gloves and replaced them with clean gloves without washing or sanitizing his hands. Cook #2, then touched lettuce salad and sliced oranges to place on plates for garnish.<br><br>Cook #2 touched the phone handle and was talking to someone on 4/24/15 at | | food practices.These audits will be completed twice weekly for four weeks, monthly for threemonths and then quarterly thereafter for twelve months. Trends will be reportedto Quality Assurance (QA) Meeting until such time consistent substantialcompliance has been met. | |

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| | 12:23 p.m. He changed gloves again without washing hands, then touched hamburger buns and placed the buns on the plates to serve to residents.<br><br>Cook #2 was observed getting into refrigerator/freezer unit on 4/24/15 12:25 p.m., and was touching resident meal tickets and placing them on the top of the steamtable. Cook #2 took off his gloves and put on a new set of gloves without washing or sanitizing his hands. Cook #2 opened a new bag of potato chips and placed his gloved hand into the potato chip bag and grabbed some chips out of the bag and placed them on the plate. Cook #2 changed his gloves again without washing or sanitizing his hands and opened a bag of Tostitos and placed some chips on 2 plates.<br><br>Cook #2 also scooped up taco ground beef and was using his gloved forefinger to spread out over taco, then went and grabbed some silverware, rinsed them off by a spray of water and placed the silverware on top of the condiment holders.<br><br>Cook #2 took off his old gloves, put on a new set of gloves and then repeated the process of changing gloves not washing or sanitizing hands while doing other tasks. | | | |

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| | On 4/24/2015 at 12:45 p.m., Cook #2 was observed taking his gloved hand and placing it into the Tostitos bag and placing the gloved hand with the chips into his mouth. Cook #2 indicated at that time he was tasting them to make sure they were fresh.<br><br>The cleaning schedule provided by the Executive Chef on 4/20/15 at 12:44 p.m., indicated under the task "Hood filters and clean canopy" initials for the week of 3/24-4/4/15, 4/5/15-4/11/15, and 4/12/15-4/18/15. These initials indicated these tasks had been done. The cleaning list also indicated for the same dates that the ovens had been cleaned. There was no documentation found regarding cleaning of the ceiling tiles, lighting units or vents above the food prep area.<br><br>3.1-21(i)(3) | | | |
| F 441<br>SS=D<br>Bldg. 00 | 483.65<br>INFECTION CONTROL, PREVENT SPREAD, LINENS<br>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. | | | |

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| | (a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | | | |
| | Based on observation, interview and record review, the facility failed to ensure proper hand sanitation and handwashing during medication pass for 1 of 1 observations for infection control. (Resident #105)<br><br>Findings included: | F 441 | **F441 Infectioncontrol, prevent spread, linens**<br>**It is the practiceof this Community to ensure proper hand sanitation and hand washing duringmedication pass**<br>**What correctiveaction (s) will be accomplished for those residents found to have been affectedby the deficient practice:**<br>·LPN #3 was immediately | 05/27/2015 |

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| | On 4/27/15 at 8:41 a.m., during the medication pass observation, Resident #105 was lying on her right side. Resident #105 was repositioned by LPN #3 by placing a pillow underneath the resident's legs and between the residents legs. After this, LPN #3 went into the restroom, rinsed her hands with water and wiped her hands with a paper towel.<br><br>LPN #3 then prepared the medications for Resident #105. The resident took the medication. LPN #3, then rinsed her hands with water for 3 seconds and used a paper towel to dry her hands. LPN #3 grabbed the plastic bag inside of the medication cart garbage can, and emptied the garbage into another garbage can at the nurses desk. LPN #3 went into the medication room to obtain Tylenol from the Emergency Drug Kit (EDK). She opened the EDK and obtained the pain medication of Tylenol 325 milligrams 2 tablets from the EDK. She took the Tylenol and gave it to Resident #105.<br><br>On 4/27/15 at 8:56 a.m., after the medication pass, LPN #3 was not observed sanitizing or washing her hands.<br><br>The undated Hand Hygiene procedure for the facility was provided by the Director of Nursing indicated," Hand hygiene continues to be the primary means of | | re-educated on properhand washing procedures.<br><br>**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:**<br>·All residents in the Community have thepotential to be affected by the alleged deficient practice<br><br>**What measures willbe put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>·Nursing personnel in the Community were re-educatedon the hand washing policy. Thetraining included random observations of personnel doing hand washing accordingto the Community policy. Findings arereviewed with personnel and the procedureis reviewed annually at orientation and with all new hires. Corrective actions is implemented for failureto follow the policy correctly<br><br>**How the correctiveaction (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:**<br>·The Director of Nursing or her designee willcomplete random validation checklists of personnel on all shifts. Three randomly | |

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| | preventing the transmission of infections. The following is a list of situations that require hand hygiene: ...Upon & after coming in contact with a resident's intact skin...must wash hands with soap and water for 20 seconds...."<br><br>3.1-18(l) | | selected employees will havetheir hand washing timed and techniques evaluated per Community protocol weeklyfor four weeks, monthly for three months and then quarterly thereafter for 12months.<br>·Findings of the audit will be monitored by theQuality Assurance (QA) meeting until such time consistent substantialcompliance has been met. | |
| R 000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Residential Census: 83<br>Sample: 7<br><br>These state findings were cited in accordance with 410 IAC 16.2-5. | R 000 | Please accept this 2567 Plan of Correction as a Provider's Letter of Credible Allegation. This provider respectfully requests consideration for paper compliance in lieu of a revisit survey. The creation and submission of this plan of correction does not constitute an admission of any conclusion set forth in the statement of deficiencies of any violations of regulations. This Plan of Correction is offered as our allegation of compliance. | |
| R 006<br><br>Bldg. 00 | 410 IAC 16.2-5-0.5(f)(1-5)<br>Scope of Residential Care - Deficiency<br>(f) The resident must be discharged if the resident:<br>(1) is a danger to the resident or others;<br>(2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight;<br>(3) requires less than twenty-four (24) hour | | | |

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| | 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;<br>(4) is not medically stable; or<br>(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:<br>(A) Requires total assistance with eating.<br>(B) Requires total assistance with toileting.<br>(C) Requires total assistance with transferring. | | | |
| | Based on observation, interview and record review, the facility failed to ensure a resident who required a daily dressing change for a chronic ulcer obtained an appropriate licensed provider to provide those services for 1 of 5 residents reviewed for providing comprehensive nursing. (Resident #2705)<br><br>Findings include:<br><br>Resident #2705's record was reviewed on 4/29/15 at 3:17 p.m. Diagnoses included, but were not limited to, chronic ulcer, malignant melanoma of the skin of the scalp and neck and edema.<br><br>On 4/29/15 at 4:03 p.m., the resident was observed with a 4 x 4 allevyn foam dressing to the top of her posterior part of her head. At that time, the resident indicated she had received to much | R 006 | **R006- Scope of residential care- deficiency It is the practice of this Community to ensure residents requiring a daily dressing change for a chronic ulcer obtain an appropriate licensed provider for those services. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice**: · Resident #2705 head wound has been measured,staged and the physician order reviewed.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents living in the Community's Assisted Living have the potential to be affected by the alleged deficient practice. Service plans will reviewed to | 05/27/2015 |

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| | radiation years ago and she developed sores on her head, which the nurses at the facility were treating for her every other day. She indicated at that time the nurses had treated these wounds on her head since she was admitted to the facility in May 2014.<br><br>The Electronic Treatment Record (ETAR) dated April 2015, included, but was not limited to, the following orders: 4/24/15--"Remove old dressing, cleanse with water, cleanse peri-ulcer area with soap and water, use silver alginate 4.25x4.25, use foam adhesive border 4x4 daily...."<br><br>The resident's Admission assessment dated 5/24/14, indicated she had open pressure wounds to her scalp and the treatments needed to be applied daily.<br><br>The resident's Service Plan dated 12/14/14, indicated she required complete supervision and administration of all meds and the facility staff were responsible for administering her medications. The Service Plan indicated the facility staff assisted with skin care, including treatments and dressings. The Physical Health area indicated the resident's health was "Stable, chronic condition, minimal staff monitoring." The Service Plan indicated the resident | | evaluate conditions requiring care from an appropriately licensed provider for those services. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · Assisted Living residents will be informed through direct letters that any health care issues requiring 24 hour/day comprehensive nursing care, comprehensive nursing oversight or rehab therapies will required them to enter into a contract with an appropriately licensed provide of their choice to provide these services. All wounds will need to be treated by nurses from a licensed home health agency.<br>· The Service Plan will reflect the level of care required and type of treatment needed. The expected duration of the treatment will be listed in the service plan with updates and changes. The clinical record will fully document the treatment including the site, stage,wound base and response to treatment. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: · Service plans for each resident are reviewed approximately each three to four months with nursing staff, the resident and (if applicable)the resident's family member. If issues are identified that require | |

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| | had a dressing change to her head daily.<br><br>The wound documentation found in the resident's record were as follows:<br>A progress note dated 9/14/14, indicated the resident's wound bed was yellow and the wound had yellow drainage. The treatment was completed as ordered. No documentation was found indicating the physician was notified.<br><br>A progress note dated 9/23/14, indicated the resident's wound bed had yellow slough with slight yellow drainage. The treatment was completed as ordered. No documentation was found indicating the physician was notified.<br><br>A progress note dated 10/16/14, indicated the resident was started on an antibiotic for an infection in her head wound.<br><br>A progress note dated 1/2/15, indicated her dressing was changed to her head as ordered.<br><br>A progress note dated 1/3/15, indicated her dressing was changed to her head as ordered.<br><br>A wound care physician progress note dated 1/14/15, indicated the resident had a scalp ulcer that measured 4.8 x 3.7 x 0.3 cm (centimeters). No further wound | | skilled nursing services, this will be reflected in the service plan and a licensed home health provider will provide these services. · The Assisted Living Coordinator or his/her designee will audit three service plans weekly for four weeks, monthly for three months and then quarterly thereafter for 12 months. · Findings of the audit will be monitored by the Quality Assurance (QA) meeting until such time consistent substantial compliance has been met.The results of these audits will be brought to QA for evaluation and follow up until substantial compliance is achieved. | |

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| | reports were found in the residents record at that time for this wound.<br><br>During an interview on 4/29/15 at 4:03 p.m., the resident indicated the nurses complete the dressing to her head every other day instead of every day because she did not shower daily and she had to take a shower before the dressing was changed, because she had to wash the area. She indicated the doctor did not change the order to every other day, she changed the directions herself.<br><br>During an interview on 4/29/15 at 5:20 p.m., LPN #1 indicated the facility nurses completed the resident's dressing changes to her head every other day because the resident would not allow the dressings to be done daily. She indicated the facility nurses had been completing these dressing changes to the resident's head since she was admitted in May 2014. She indicated the wound care physician visits were set up to take care of the wound to the resident's head. She indicated since she was going to the wound clinic monthly and the wound was assessed there, the facility staff thought the wound visits took care of the assessments, so they had not been documenting on the resident's wound. She indicated the most current wound measurements the facility had in the | | | |

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| | resident's record was 1/14/15. She indicated the resident brought the wound reports back with her from her wound care clinic appointments, but she kept them for herself. She indicated no facility nurses had called the wound clinic and asked them to fax those reports to the facility. She indicated she did not know the status of the resident's head ulcer presently because she had not gotten the updated measurements and assessment of the wound. | | | |
| R 092<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(i)(1-2)<br>Administration and Management - Noncompliance<br>(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:<br>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and 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.<br>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster | | | |

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| BARRINGTON OF CARMEL, THE | 1335 S GUILFORD ROAD<br>CARMEL, IN 46032 |

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| | 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.<br>Based on interview and record review, the facility failed to show documentation that they had attempted to hold a fire and disaster drill in conjunction with the local fire department at least every six months. This deficiency had the potential to affect 83 of 83 residents residing in the facility.<br><br>Findings include:<br><br>A record review of the facility's fire drills for the last year was reviewed on 4/28/15 at 4:30 p.m. The monthly fire drill documentation lacked evidence the facility had attempted a fire and disaster drill in conjunction with the local fire department at least every six months.<br><br>During an interview on 4/29/15 at 12:47 p.m., the Plant Operations Director indicated he had only been at the facility since March 2015. He indicated he had not found any documentation of attempts of fire and disaster drills in conjunction with the local fire department within the last year. | R 092 | **R092 Administration and Management-noncompliance** It is the practice of this Community to attempt a fire and disaster drill in conjunction with the local fire department at least every six months. **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** · The Community has had fire drills and situations in which the local fire department was on site over the period of the past year; however, the Community was unable to locate documentation showing their participation. On 5/11/2015 at 8:25PM, the Community had a fire drill in which the fire department was on site participating. Their on-site participation has been logged on the fire drill log. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. The community will attempt a fire and disaster drill in conjunction with the local fire department at least every six months. **What measures will be put into place or what systemic changes will be made** | 05/27/2015 |

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| | | | **to ensure that the deficient practice does not recur:** · The Carmel Division Chief of the Fire Department has assured the community that they would assist the community in completing required semi-annual fire drills. The Community will perform required fire drills monthly, and attempt to involve the local fire department at least every six months. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Findings of the fire drills will be monitored by the Quality Assurance (QA) committee throughout the year to ensure that substantial compliance has been met. | |
| R 151<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(h)<br>Sanitation & Safety Standards<br>-Noncompliance<br>(h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.<br>Based on interview and record review, the facility failed to have a resident's cat examined and receive the required vaccinations for the pet. This deficient practice affected 1 of 3 pets regularly residing in the facility.(Resident #3805's cat)<br><br>Findings include: | R 151 | **R151—Sanitation & Safety Standards It is the practice of this Community to have resident pets examined and receive the required vaccinations for the pet. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice**: · The cat belonging to Resident #3805 has all required | 05/27/2015 |

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| | A pet vaccination record for Resident #3805's cat was reviewed on 4/28/15 at 5:00 p.m. The vaccination record indicated the cat's vaccinations had been given on 3/10/14. Another vaccination record indicated the cat's next vaccination was due by 3/10/15. An invoice from an animal hospital dated 4/20/15 indicated Resident #3805's cat had an examination with vaccinations on 4/20/15.<br><br>During an interview on 4/29/15 at 12:30 p.m., the Administrator indicated the vaccinations for Resident #3805's cat was expired as of 3/10/15. She indicated she had called his family member on 4/20/15, to ask for updated vaccination records and she was told by the family member that she was taking the cat to the vet that day to get his vaccinations.<br><br>A current policy titled "Standards & Guidelines Pets" dated 12/1/13, provided by the Administrator on 4/21/15 at 9:00 a.m., indicated "...Guidelines:... 5..Current proof of vaccinations is required...." | | immunizations up to date. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**: · Any resident owning small animals in the community have the potential to be affected by the alleged deficient practice. All other records are current at this time. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · As service plans are reviewed the current status of the pet vaccinations will also be reviewed at that time. If vaccinations have expired or nearing expiration, the owner will be required to obtain the shots within 72 hours and furnish proof of immunizations to the Assisted Living Coordinator or his/her designee. Failure to comply with this guideline may result in loss of pet privileges. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**:On a monthly basis, a review of each resident's pet records will be reviewed in order to ensure the vaccinations are current. Findings of the review will be monitored by the Quality Assurance (QA) meeting until such time consistent substantial | |

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| | | | compliance has been met. | |
| R 187<br><br>Bldg. 00 | 410 IAC 16.2-5-1.6(k)<br>Physical Plant Standards - Deficiency<br>(k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.<br>Based on observation, interview and record review, the facility failed to maintain water temperatures between 100 degrees F (Fahrenheit) and 120 degrees F on the Memory Care unit for 4 of 4 facility apartments, which had the water temperatures monitored. This deficit practice had the potential to affect 24 of 24 residents residing on the Memory Care unit. (Apt #1702, Apt #1806 Apt #1813 and Apt #1816)<br><br>Findings include:<br><br>An Environmental tour began on 4/29/15 at 12:47 p.m., with the Plant Operations Director in attendance.<br><br>The following bathroom sink apartment water temperatures were checked and the temperatures were:<br>1:00 P.M.--Room 1817-120.6 degrees F. This apartment was an empty apartment.<br>1:06 P.M.--Room 1813-122.5 degrees F. This apartment was an empty apartment. | R 187 | **R187 Physical plant standards**<br>It is the practice of the Community to maintain water temperatures between 100 degrees F and 120 degrees F, as per the state regulations. **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** · Residents in Apartments #1702, 1806, 1813, □ have had their water temperatures adjusted within normal limits. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. Water temperatures throughout the Assisted Living community have been adjusted within normal limits. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not** | 05/27/2015 |

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| | 1:13 P.M.--Room 1806-121.6 degrees F. This apartment was a resident's apartment.<br>1:18 p.m.--Room 1702-125.8 degrees F. This apartment was a resident's apartment.<br><br>Review of a document titled "Monthly Hot Water Temperature Log" for January 2015, indicated the only day the water temperatures was checked that month was 1/16/15.<br><br>Review of a document titled "Monthly Hot Water Temperature Log" for February 2015, indicated the only day the water temperatures was checked that month was 2/9/15.<br><br>Review of a document titled "Monthly Hot Water Temperature Log" for March 2015, indicated the only day the water temperatures was checked that month was 3/10/15.<br><br>Review of a document titled "Monthly Hot Water Temperature Log" for April 2015, indicated the only day the water temperatures was checked that month was 4/10/15.<br><br>During an interview on 4/29/15 at 1:55 p.m., the Plant Operations Director indicated the water temperatures resident | | **recur:** · The Director of Plan Operations or his designee will randomly check three rooms for proper water temperatures twice weekly for four weeks, then weekly for three months, and then monthly thereafter for twelve months. Any issues identified will be promptly addressed to maintain proper water temperatures throughout the Assisted Living community. **How the corrective action (s) will be monitored toensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · Findings of the audit will be monitored by the Quality Assurance (QA) meeting until such time consistent substantial compliance has been met. | |

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| | rooms on the dementia unit usually ranged from between 105 degrees F and 114 degrees F. He indicated he had started this position in March 2015, and he assumed the water temperatures were completed daily on one to two rooms in each area of the facility a day including the nurses stations and spas, so that by the end of the month all the room water temperatures had been checked at least once. He indicated that was the procedure he had been taught when completing water temperatures and that was how he thought the maintenance staff was completing the water temperature logs in the facility. He indicated he did not know if there was a policy on how to perform the water temperatures, but if he could find one he would provide it as requested. | | | |
| R 214<br><br>Bldg. 00 | 410 IAC 16.2-5-2(a)<br>Evaluation - Deficiency<br>(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.<br>Based interview and record review, the facility failed to ensure the resident had a current self medication administration evaluation for 1 of 5 residents reviewed | R 214 | **R214 Evaluation-deficiency It is the practice of this Community to ensure the residents have a current self-medication administration evaluation.** | 05/27/2015 |

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| | for current self medication administration evaluations. (Resident #2807)<br><br>Findings include:<br><br>Resident #2807's record was reviewed on 4/29/15 at 3:45 p.m. Diagnoses included, but were not limited to, high blood pressure, diabetes, and quadriplegia.<br><br>The resident had a "Self-Medication Evaluation" dated 4/29/14 / 5/29/14, and signed by the nurse who completed the evaluation. The evaluation was signed and dated 5/29/14, by a Physician.<br><br>During an interview on 4/29/15 at 6:30 p.m., LPN #1 indicated the "Self-Medication Evaluation" dated 4/29/14 / 5/29/14, was the current self medication administration evaluation for this resident. She indicated she should have had one completed with her last semi-evaluation on 12/14/14. | | **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice**: · Resident #2807 has been evaluated for self-administration of medication, by the Nurse and Physician, and it has been determined that this practice is safe. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**: · All residents who self-administer their medications have the potential to be affected by the alleged deficient practice. Residents who self-administer their medications will be evaluated for safe practices at least twice yearly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · At the quarterly, annual or change in condition review of the resident's service plan, a self-administration evaluation of medication will be done. The results will be reviewed by the physician for final approval. If approval is given the service team will decide who is responsible for storing of medications. If it is found resident is not safe to do this, the resident will be notified by the nurse or AL Coordinator/designee | |

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| | | | of the concerns. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: · The Assisted Living Coordinator or his/her designee will audit three service plans for weekly for four weeks, monthly for three months and then quarterly thereafter for twelve months.<br>·Findings of the audit will be monitored by the Quality Assurance (QA) meeting until such time consistent substantial compliance has been met.<br>· The results of these audits will be brought to QA for evaluation and follow up until substantial compliance is achieved. | |
| R 217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(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:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(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. | | | |

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| | (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.<br>(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.<br>(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. | | | |
| | Based on observation, interview and record review, the facility failed to ensure service plans were updated as resident's individual needs changed for 3 of 5 resident's reviewed for service plans. (Residents #2705, #3804 and #1811)<br><br>Findings include:<br><br>1. Resident #2705's record was reviewed on 4/29/15 at 3:17 p.m. Diagnoses included, but were not limited to, chronic ulcer, malignant melanoma of skin of scalp and neck and edema.<br><br>On 4/29/15 at 4:03 p.m., the resident was observed with a 4 x 4 allevyn foam (soft foam for extra padding) dressing to the top of her posterior part of her head. At that time, the resident indicated she had received to much radiation years ago and she developed sores on her head, which the nurses at the facility were treating for | R 217 | **R217 Evaluation-deficiency It is the practice of this Community to ensure service plans are updated as resident's needs changed. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** · Service plans for residents #2705, #3804 and#1811 have been reviewed and updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**: · All residents have the potential to be affected by the alleged deficient practice. Service plans will be updated at least twice annually and with significant changes in condition. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · On | 05/27/2015 |

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| | her every other day. She indicated at that time, the nurses had treated these wounds on her head since she was admitted to the facility in May 2014.<br><br>The Electronic Treatment Record (ETAR) dated April 2015, included, but was not limited to, the following orders: 4/24/15--"Remove old dressing, cleanse with water, cleanse peri-ulcer area with soap and water, use silver alginate [a dressing applied to the wound to prevent bacteria from growing to cause an infection] 4.25x4.25, use foam adhesive border 4x4 daily...."<br><br>The resident's Service Plan dated 12/14/14, indicated she required complete supervision and administration of all meds and the facility staff was responsible for administering her medications. The Service Plan indicated the facility staff assisted with skin care, including treatments and dressings. The Physical Health area indicated the resident's health was "Stable, chronic condition, minimal staff monitoring." The Service Plan indicated the resident had a dressing change to her head daily.<br><br>A wound care physician progress note dated 1/14/15, indicated the resident had a scalp ulcer that measured 4.8 x 3.7 x 0.3 cm (centimeters). | | admission, quarterly, annually and with a significant change in condition, the resident's service plan will be reviewed and updated with POA, family and resident.<br>· All changes needing to be made will be explained to all concerned as well as the risks and consequences of failure to follow them. The resident's safety is non-negotiable in the Community.<br>**How the corrective action (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place**: · The Assisted Living Coordinator or his/her designee will audit three service plans for weekly for four weeks, monthly for three months and then quarterly thereafter for twelve months.<br>·Findings of the audit will be monitored by the Quality Assurance (QA) meeting until such time consistent substantial compliance has been met.<br>· The results of these audits will be brought to QA for evaluation and follow up until substantial compliance is achieved. | |

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| | During an interview on 4/29/15 at 5:20 p.m., LPN #1 indicated the facility nurses completed the resident's dressing changes to her head every other day because the resident would not allow the dressings to be changed daily. She indicated the wound care physician visits were set up to take care of the wound to the resident's head. She indicated the resident did not have an updated Service plan. She indicated the wound clinic visits for the chronic ulcer were not placed on her Service Plan. | | | |
| R 273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(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.<br>Based on observation, interview and record review, the facility failed to maintain sanitary kitchen conditions and to prevent kitchen staff from utilizing unsanitary practices while serving food to 83 of 83 residents who were served food from the kitchen.<br><br>Findings included:<br><br>The tour of the main kitchen was completed on 4/20/2015 at 10:25 a.m., with the Registered Dietician (RD) in | R 273 | **R273 It is the practice of this Community to maintain sanitary kitchen conditions and to prevent kitchen staff from utilizing unsanitary practices while serving. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** · All areas identified as allegedly deficient were addressed promptly. **How other residents having the potential to be affected by the same deficient practice will be** | 05/27/2015 |

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| | attendance. The main mixer was observed to have an off white colored sticky debris on it. The RD indicated they do not have a cover for the mixer. The plastic cover of the soup kettle had red colored debris and other dark colored matter stuck to it. The RD indicated the cleaning was done weekly by dietary aids.<br><br>The double broiler oven had dark debris on the bottom.<br><br>The vents above the stove and ovens, behind the grill area, and the wall up above the grill area had dark rust colored debris on it. The broiler also had dark rust colored debris on top of it. The RD indicated she thought they were cleaned weekly.<br><br>The drawers with cold holding plates and bowls for salads had debris in the drawer and on 1 out of 8 plates observed. Another cold holding drawer for plates had standing water at the bottom of the drawers. The RD indicated at that time, the water and debris should not be in the cold holding drawers<br><br>The lighting and vents in the prep service area with a steam table had 3 dirty panels, 3 dirty lights, and 2 dirty vents with visible dark debris on each light, panel | | **identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. All areas identified as allegedly deficient were addressed promptly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Sanitary kitchen conditions will be maintained with an updated cleaning schedule and improved staff clean-as-you-go practices. Dietary staff will be re-educated regarding proper hand washing, glove usage, food storage and tasting of service food practices by May 27, 2015. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** · Director of Dining Services or designee will conduct sanitation audits of cleaning schedule implementation and staff handwashing, glove usage, food storage and tasting of service food practices. These audits will be completed twice weekly for four weeks, monthly for three months and then quarterly thereafter for twelve months. · Trends will be reported to Quality Assurance (QA)Meeting. · Findings of the audit will be monitored by the Quality Assurance (QA) meeting | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155817 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 04/29/2015 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BARRINGTON OF CARMEL, THE | 1335 S GUILFORD ROAD<br>CARMEL, IN 46032 |

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| | and vent directly over the prep area. At that time, the RD indicated the staff should have had a weekly cleaning list and the head chef indicated he did not know where the list was. The RD indicated she had discussed the dirty vents and lighting above the prep area with the kitchen staff and those areas should have been clean.<br><br>There was a small freezer for potato items. The freezer had one uncovered pan with tator tots, one uncovered pan with waffle fries, one uncovered pan with sweet potato fries, and one uncovered pan with french fries. The RD indicated at that time, the items should be covered. There was one bag of frozen item that was not sealed.<br><br>A lunch preparation observation was done with Cook #2 on 4/24/15 at 12:17 p.m. Cook #2 was touching drawer handles and refrigerator handles, then took off his gloves and replaced them with clean gloves without washing or sanitizing his hands. Cook #2, then touched lettuce salad and sliced oranges to place on plates for garnish.<br><br>Cook #2 touched the phone handle and was talking to someone on 4/24/15 at 12:23 p.m. He changed gloves again without washing hands, then touched | | until such time consistent substantial compliance has been met. | |

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| | hamburger buns and placed the buns on the plates to serve to residents.<br><br>Cook #2 was observed getting into refrigerator/freezer unit on 4/24/15 12:25 p.m., and was touching resident meal tickets and placing them on the top of the steamtable. Cook #2 took off his gloves and put on a new set of gloves without washing or sanitizing his hands. Cook #2 opened a new bag of potato chips and placed his gloved hand into the potato chip bag and grabbed some chips out of the bag and placed them on the plate. Cook #2 changed his gloves again without washing or sanitizing his hands and opened a bag of Tostitos and placed some chips on 2 plates.<br><br>Cook #2 also scooped up taco ground beef and used his gloved forefinger to spread out over taco, then went and grabbed some silverware, rinsed them off by a spray of water and placed the silverware on top of the condiment holders.<br><br>Cook #2 took off his old gloves, put on a new set of gloves and then repeated the process of changing gloves not washing or sanitizing hands while doing other tasks.<br><br>On 4/24/2015 at 12:45 p.m., Cook #2 | | | |

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| | was observed taking his gloved hand and placing it into the Tostitos bag and placing the gloved hand with the chips into his mouth. Cook #2 indicated at that time he was tasting them to make sure they were fresh.<br><br>The cleaning schedule provided by the Executive Chef on 4/20/15 at 12:44 p.m., indicated under the task "Hood filters and clean canopy" initials for the week of 3/24-4/4/15, 4/5/15-4/11/15, and 4/12/15-4/18/15. These initials indicated these tasks had been done. The cleaning list also indicated for the same dates that the ovens had been cleaned. There was no documentation found regarding cleaning of the ceiling tiles, lighting units or vents above the food prep area. | | | |
| R 354<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(g)(1-7)<br>Clinical Records - Noncompliance<br>(g) A transfer form shall include the following:<br>(1) Identification data.<br>(2) Name of the transferring institution.<br>(3) Name of the receiving institution and date of transfer.<br>(4) Resident ' s personal property when transferred to an acute care facility.<br>(5) Nurses ' notes relating to the resident ' s:<br>(A) functional abilities and physical limitations;<br>(B) nursing care;<br>(C) medications; | | | |

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| | (D) treatment; and<br>(E) current diet and condition on transfer.<br>(6) Diagnosis.<br>(7) Date of chest x-ray and skin test for tuberculosis.<br>Based on interview and record review, the facility failed to ensure intrafacility information was documented prior to a hospital transfer for 1 of 1 residents reviewed for transfer information. (Residents #290)<br><br>Findings include:<br><br>Resident #290's record was reviewed on 4/29/15 at 9:57 a.m. Diagnoses included, but were not limited to, pulmonary embolism (blood clot in the lung), dyspnea (difficulty breathing) and pain.<br><br>The resident's record indicated he had been transferred to the hospital on 11/14/14 and 12/28/14. The resident's record lacked documentation of transfer information when the resident was transferred to the hospital on 11/14/14 and 12/28/14.<br><br>During an interview on 4/29/15 at 6:30 p.m., the Assistant Director of Nursing indicated no transfer forms or transfer information was located in the resident's record for his transfers to the hospital. | R 354 | **R354-Clinical Records-noncompliance It is the practice of this Community to ensure intra-Community information is documented prior to a hospital transfer. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice**: · Resident #290 no longer resides at the Community **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**: · All Assisted Living (AL) residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · The Interact "Resident Transfer Form" is now being used to convey information when a resident is transferred to an acute care Community. A copy of this form will be maintained in the clinical record. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put** | 05/27/2015 |

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| | | | **into place**: · The AL Coordinator/designee will review transfers from the Community on a monthly basis for 3 months to ensure the criteria has been followed. The results will be taken to the monthly Quality Assurance (QA) meeting for discussion and evaluation until such time consistent substantial compliance has been met. | |
| R 357<br>Bldg. 00 | 410 IAC 16.2-5-8.1(j)(1-3)<br>Clinical Records - Noncompliance<br>(j) If a death occurs, information concerning the resident ' s death shall include the following:<br>(1) Notification of the physician, family, responsible person, and legal representative.<br>(2) The disposition of the body, personal possessions, and medications.<br>(3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death.<br>Based interview and record review, the facility failed to ensure documentation was completed when a resident passed away for 1 of 1 residents reviewed for death of a resident. (Resident #226)<br><br>Findings include:<br><br>Resident #226's record was reviewed 4/29/15 at 12:16 p.m. Diagnoses included, but were not limited to, Congestive Heart Failure, high blood pressure, and chronic kidney disease. | R 357 | **R357 - Clinical records-noncompliance It is the practice of this Community to ensure documentation is completed when a resident passes away. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident #226 no longer resides at the Community **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All | 05/27/2015 |

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| | The resident's record lacked documentation of the disposition of her medications and the disposition of her personal belongings after she passed away.<br><br>During an interview on 4/29/15 at 6:30 p.m., the Assistant Director of Nursing indicated she was not able to locate a disposition of medication form for the resident's medications or documentation of the disposition of her personal belongings after her death. | | residents at the Community have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: · The clinical record contains the medication reconciliation log and the inventory of personal belongings sheet. All staff has been in-serviced on the appropriate use of both of these forms. Nurses must document completely all the belongings sent with the POA/family. All medication must be accounted for with signature page completed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**: · The AL Coordinator/designee will review transfers/discharges from the Community on a monthly basis for 3 months to ensure the criteria has been followed. The results will be taken to the monthly Quality Assurance (QA) meeting for discussion and evaluation until such time consistent substantial compliance has been met. | |