STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaints IN00132342, IN00133634, and IN00133783. Complaint IN00132342 Substantiated. Federal/ state deficiencies related to the allegations are cited at F157, and F282. Complaint IN00133634 Substantiated. Federal/ state deficiencies related to the allegations are cited at F282. Complaint IN00133783 Substantiated. Federal/ state deficiencies related to the allegations are cited at F157, F246, F282, and F314. Survey dates: August 4, 5, 6, and 7, 2013 Facility number : 000283 Provider number: 155586 AIM number: 100275020	F000000		

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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	Survey team: Christine Fodrea, RN Census bed type: SNF/NF: 96 Residential: 35 Total: 131 Census payor type: Medicare: 25 Medicaid: 82 Other: 24 Total: 131 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on August 9, 2013 by Randy Fry RN.			

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review the facility failed to notify the physician prior to holding sliding scale insulin for 1 of 3	F000157	**Corrective action for residents affected:** 1.Resident F – unable to correct. 2.Resident F – unable to correct. **Other residents having the potential to be affected and corrective**	09/06/2013

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	residents reviewed for insulin administration, (Resident #F). The facility further failed to notify the family of a change in resident condition for 1 of 3 residents reviewed for family notification in a sample of 7 (Resident #F). The facility additionally failed to notify the physician for order clarification for pressure ulcer treatment for 1 of 3 residents reviewed for pressure ulcer treatment in a sample of 7. (Resident #F) Findings include: 1. Resident #F's record was reviewed 8-6-2013 at 9:39 AM. Resident #F's diagnoses included but were not limited to: chronic kidney disease, diabetes, and prostate tumor. A physician's order dated 3-30-2012 indicated to give Novolog insulin as indicated by blood sugars; 180-220, give 2 units; 221-260, give 4 units; 261-300, give 6 units; 301-340, give 8 units; 341-380, give 10 units, and 381-420, give 12 units and call the physician. Nurse's notes dated 5-2-2013 at 5:01 AM, indicated Resident #F had diarrhea. Nurse's notes dated 5-2-2013 at 6		**actions:** All residents have the potential to be affected by this deficient practice. The nursing staff responsible for not providing the required notification has received disciplinary actions in accordance with employee policies. **Measures to ensure practice does not recur:** Facility policy regarding physician and family notification of changes has been reviewed and updated. Licensed nursing staff have been re-educated on physician and family notification of all applicable changes and/or occurrences in a timely manner. **This corrective action will be monitored by:**Nurse Managers or designees will be responsible for completing audits of all new orders and 24-hour reports to ensure all applicable notifications are made per facility policy. The audits will be completed daily Monday through Friday for three months, then three days per week for three months. The results of the audits will be reviewed by the QA Committee and further corrective actions will be taken if compliance thresholds are below established levels.	

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	AM, indicated Resident #F's blood sugar was 180. The Medication Administration Record dated 5-2-2013 at 6 AM, indicated no insulin was given according to the physician order for a blood sugar of 180. Nurse's notes dated 5-2-2013 at 10:16 AM indicated Resident #F had vomiting and diarrhea. The physician was notified of the vomiting and diarrhea, but there was no note to indicate the physician was notified the insulin was held. Nurse's notes dated 5-3-2013 at 6 AM indicated Resident #F's blood sugar was 262. The note further indicated Resident #F's insulin had been held due to nausea and vomiting. There was no note to indicate the physician had been notified. In an interview on 8-6-2013 at 11:45 AM, LPN #2 indicated Resident #F's sliding scale insulin should have been given, and if held, the physician should have been notified. 2. Nurse's notes dated 5-2-2013 at 5:10 AM indicated Resident #F had diarrhea.			

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	Nurse's notes dated 5-2-2013 at 10:16 AM indicated Resident #F had diarrhea and vomiting. The physician was notified and an order received. There was no indication the family had been notified of Resident #F's change in condition. In an interivew on 8-6-2013 at 2:19 PM, RN #1 indicated the family should have been notified with any changes in condition. 3. A physician's order dated 7-26-2013 for Resident #F had an indicator box checked labeled treatment and wound care. The order was further described in handwriting to follow up with wound care. There was no description of the wound location or what the wound care consisted of. In an interview on 8-7-2013 at 9:37 AM, the Director of Nursing indicated the physician should have been called to clarify the treatment orders. A current policy dated 11-1999 and revised 3-2012 titled Physician Notification provided on 8-7-2013 at 10:28 AM by the Director of Nursing indicated " 1. Medical care problems are communicated to the attending			

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	physician in a timely, efficient and effective manner." This Federal tag relates to Complaints IN00132342 and IN00133783. 3.1-5(a)(2)			

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F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interview, the facility failed to ensure call lights were within reach for 1 of 7 residents reviewed for call lights in reach in a sample of 7. (Resident #J) Findings include: Resident #J's record was reviewed on 8-7-2013 at 9:10 AM. resident #J's diagnoses included but were not limited to: acute kidney failure, high blood pressure, and scoliosis. On 8-4-2013 at 7:18 PM, Resident #J was observed in his room facing the television. Resident #J's call light was observed on the overbed table farther than an arm's length away. On 8-5-2013 at 1:38 PM, Resident #J was observed in his room facing the window. Resident #J's call light was on his overbed table more than an arm's length away.	F000246	**Corrective action for residents affected:** Resident J's call light was placed in reach when the surveyor queried CNA #6 about the placement. **Other residents having the potential to be affected and corrective actions:** All residents have the potential to be affected by this deficient practice. Nursing staff responsible for not having the call light in reach during the observation times by the surveyor has received disciplinary actions in accordance with employee policies. **Measures to ensure practice does not recur:** All charge nurses, QMAs, and CNAs were re-educated on the importance of placing call lights in reach at all times when residents are in their rooms. All department heads were instructed to require their employees to look for call lights in reach every time they need to enter a resident's room. **This corrective action will be monitored by:** Dignity rounds including monitoring for call lights in reach will be completed by managers on duty on rotating shifts daily Monday through Friday for three months, then	09/06/2013

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	In an interview on 8-5-2013 at 1:50 PM, CNA #6 indicated Resident #J's call light should have been with in reach. A copy of an inservice conducted by the Administrator on 8-7-2013 at 7 AM provided by the Director of Nursing on 8-7-2013 at 9:48 AM indicated all staff were to answer call lights in a timely manner. In an interview on 8-7-2013 at 9:48 AM, the Director of Nursing indicated there was no specific policy, but it was understood call lights should be within reach. This Federal tag relates to Complaint IN00133783. 3.1-3(v)(1)		three days per week for three months. The results of these rounds will be reviewed by the QA Committee and further corrective actions will be taken if compliance thresholds are below established levels.	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to follow physician orders for thickened liquids for 1 of 3 residents reviewed with thickened liquids in a sample of 7 (Resident #I). The facility further failed to follow physician orders for medication administration for 1 of 3 residents reviewed for medication administration in a sample of 7. (Resident #F) Findings include: 1. Resident #I's record was reviewed 8-7-2013 at 11 AM. Resident #I's diagnoses included, but were not limited to: osteoporosis, dementia with depression, and anemia. A physician's order dated 7-25-2013 indicated to serve a pureed diet with nectar thick liquids. On 8-4-2013 at 7:02 PM, Resident #I was observed in her room, an ivory colored water pitcher was observed on Resident #I's bedside stand. The	F000282	**Corrective action for residents affected:** 1.Resident #1 – The unthickened water was removed from the bedside and replaced with nectar-thickened liquid on 8/5/13. 2.Resident #F – unable to correct. **Other residents having the potential to be affected and corrective actions:** All residents have the potential to be affected by this deficient practice. Nursing staff responsible for not following physician orders as observed by the surveyor has received disciplinary actions in accordance with employee policies. The rooms of all residents with thickened liquids orders were observed for the presence of liquids thickened to the correct consistency. **Measures to ensure practice does not recur:** Applicable facility policies were reviewed to ensure they reflected current standards of practice. Charge nurses, QMAs, and CNAs were re-educated on facility policy regarding thickened liquids. All licensed nursing and QMA staff were re-educated on facility policy regarding physician order implementation in accordance with the plan of care. **This corrective action will be monitored by:**Charge nurses on	09/06/2013

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	pitcher was filled with ice and unthickened water. On 8-5-2013 at 12:25 PM, Resident #I was observed in her room; an ivory colored water pitcher was observed on Resident #I's bedside stand. The pitcher was filled with ice and unthickened water. In an interview on 8-5-2013 at 1:47 PM, RN #1 indicated the water on the bedside stand should have been nectar thick. In an interview on 8-6-2013 at 9:33 AM, the Dietary Manager indicated the dietary department sends out prethickened water that is lemon flavored. If the resident does not like the prethickened water, dietary sends out packets with directions to thicken the water. A current policy dated 3-1-2012 titled Thickened Liquids provided by the Director of Nursing on 8-6-2013 at 10:00 AM indicated "residents requiring thickened liquids will be served liquids as ordered to minimize the risk of choking and aspiration." 2. Resident #F's record was reviewed 8-6-2013 at 9:39 AM. Resident #F's diagnoses included but were not		the night shift will be responsible for completing reviews of all new orders written in the previous 24hours to ensure proper transcription and timely implementation. The reviews will be conducted every night. Charge nurses will act upon any order(s) found that have not been properly executed to the degree possible, and will communicate any remaining concerns to the Director of Nursing for follow-up on the next business day. Charge nurses will be responsible for completing physical observations of the room of all residents receiving thickened liquids daily Monday through Friday for three months,then three days per week for three months. The Director of Nursing or designee will monitor exceptions related to insulin administration per the EMR system once weekly for three months, then every other week for three months. The results of these monitors will be reviewed by the QA Committee and further corrective actions will be taken if compliance thresholds are below established levels.	

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	limited to: chronic kidney disease, diabetes, and prostate tumor. A physician's order dated 3-30-2012 indicated to give Novolog insulin as indicated by blood sugars; 180-220, give 2 units; 221-260, give 4 units; 261-300, give 6 units; 301-340, give 8 units; 341-380, give 10 units, and 381-420, give 12 units and call the physician. Nurse's notes dated 5-2-2013 at 6 AM, indicated Resident #F's blood sugar was 180. The Medication Administration Record dated 5-2-2013 at 6 AM, indicated no insulin was given according to the physician order for a blood sugar of 180. Nurse's notes dated 5-3-2013 at 6 AM indicated Resident #F's blood sugar was 262. The note further indicated Resident #F's insulin had been held due to nausea and vomiting. There was no physician's order to hold the insulin. In an interview on 8-6-2013 at 11:45 AM, LPN #2 indicated Resident #F's sliding scale insulin should have been given as ordered.			

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	A current policy dated 2-2012 titled Physician Medication Order provided by the Director of Nursing on 8-6-2013 at 10:00 AM, indicated "Medications will be administered....upon the clear, complete, and signed order of a person lawfully authorized to prescribe medication. " This Federal tag relates to Complaints IN00132342, IN00133634, and IN00133783. 3.1-35(g)(2)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview and record review, the facility failed to assess pressure areas for 1 of 3 residents reviewed with pressure areas in a sample of 7. (Resident #F) Findings include: Resident #F's record was reviewed 8-6-2013 at 9:39 AM. Resident #F's diagnoses included but were not limited to: chronic kidney disease, diabetes, and prostate tumor. In a confidential interview on 8-5-2013 at 12:04 PM, a visitor of Resident #F indicated he had open areas on his feet on 7-27-2013, and produced a photo of the wounds.	F000314	**Corrective action for residents affected:** Resident #F – A comprehensive skin assessment was completed on Resident #F on 8/6/13. The skin impairment areas on bilateral feet were assessed, measurements of discoloration documented, and tracking initiated. **Other residents having the potential to be affected and corrective actions:** All residents at risk for developing pressure ulcers have the potential to be affected by this deficient practice. A complete skin assessment was completed on every in-house resident by 9/6/2013. Any new area of skin impairment was assessed, measurements documented, and tracking initiated. Physician and family notification was completed with appropriate treatment orders obtained and implemented. Applicable resident care plans were updated. **Measures to ensure practice does not recur:** Applicable facility policies were	09/06/2013

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	A physician's order dated 7-26-2013 indicated the facility was to follow up with wound care including an air mattress and bunny boots to protect both feet. During on observation on 8-6-2013 at 2:19 PM, areas were observed on Resident #F's feet as follows: on Resident #F's left foot metatarsophalangeal joint had an area that was about the size of a nickel with a crescent shaped black area covering about 20% of the area; the left heel on the lower, inner aspect was blackened area approximately the size of a quarter; and the right instep had a black area the size of a dime. These wounds appeared improved from the 7-27-13 photo. The skin over the areas was hard but not crusty like a scab and there was no break in skin integrity between the in tact skin and the blackened areas. Observations during the survey indicated this resident was being turned and repositioned, and the air mattress and bunny boots were in place.		reviewed to ensure they reflected current standards of practice. Licensed nursing staff were re-educated on facility policy regarding the admission process including completing a comprehensive skin assessment, and on facility policy regarding on-going identification and assessment of new skin impairment. They were instructed on the proper procedure for entering assessment data related to skin impairment into the applicable domain of the electronic chart. **This corrective action will be monitored by:** Charge nurses are responsible for completing daily audits of all shower sheets to ensure any new skin areas have been identified and for submitting documentation of this review to the Director of Nursing. The Director of Nursing or designee will complete review of these audits of all shower sheets/skin assessments completed Monday through Friday to ensure licensed nurses are documenting completion of a skin assessment during the shower, and to ensure that any new areas of skin impairment are appropriately documented and treatment initiated timely.These monitors will continue daily Monday through Friday for three months, then be reduced to three days per week for three months. The results of the audits will be reviewed by the QA Committee and further corrective actions will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/07/2013
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	In an interview on 8-6-2013 at 2:19 PM, RN #1 indicated the areas were dry skin and not pressure. Resident #F had been hospitalized 7-22 through 7-26-2013. On return for the hospital on 7-26-2013, the facility initiated a low air loss mattress and bunny boots to both feet. A review of Resident #F's skin tracking did not indicate the facility had tracked the areas. A review of Resident #F's skin assessments did not indicate the facility had assessed the areas. In an interview on 8-7-2013 at 9:37 AM, the Director of Nursing indicated the facility had not assessed or tracked the areas. A current undated policy titled Management of Skin and Prevention of Pressure Ulcers provided on 8-6-2013 at 2:14 PM by the Director of Nursing indicated " all residents will have a complete head to toe visual inspection of skin by the licensed		betaken if compliance thresholds are below established levels.	

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	nurse: on admission, upon readmission, during showers and baths, quarterly, and with any change in condition." This Federal tag relates to Complaint IN00133783. 3.1-40(a)(1)			