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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/28/2014 |
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| NAME OF PROVIDER OR SUPPLIER LAKE CITY PLACE | STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580 |
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| R000000 | <p>This survey was for the Investigation of Complaint IN00154822.</p> <p>Complaint IN00154882 - Substantiated. State residential deficiency related to the allegations are cited at R0006.</p> <p>Survey dates: August 27-28, 2014</p> <p>Facility number: 011389 Provider number: 011389 AIM number: N/A</p> <p>Census bed type: Residential: 20 Total: 20</p> <p>Census payor type: Other: 20 Total: 20</p> <p>Sample: 4</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on September 5, 2014, by Brenda Meredith, R.N.</p> | R000000 | | |
| R000006 | <p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</p> | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| | <p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on observations, record review and interviews, the facility failed to discharge 3 residents who required comprehensive nursing care and oversight related to assistance of 2 staff for toileting and transferring. This deficiency effected 3 of 4 residents in a sample of 4 who were reviewed for comprehensive care needs. (Resident "B", Resident "D" & Resident "E")</p> <p>Findings includes:</p> <p>During the survey, 10 confidential interviews were held with facility staff, outside agency personnel, personal caregivers & family.</p> | R000006 | <p>Corrections made for resident's based on identifiers: Resident B: Attachment A – Resident B Assessment (Negotiated Service Plan) was reviewed and indicates that the Resident is able to Feed self, requires assistance with toileting and assistance with transferring. Negotiated Service Plan has been updated to indicate that the resident requires assistance with showers in addition to the previous note that Hospice was providing this service twice a week for this resident. In reviewing the resident record concerning being laid down following the morning and noon meal, there appears to be no order for this to occur; however, the resident will be given the opportunity to lay down</p> | 10/31/2014 | | | |

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| | <p>1. The record of Resident "B" was reviewed on 08/27/14 at 10:00 a.m. The resident was admitted to the facility on 02/28/13 with diagnoses which included, but were not limited to, depression, GERD (Gastroesophageal Reflux Disease), CAD (Coronary Artery Disease), and hypothyroidism. Review of the Resident's Mini-Mental Scale, dated 08/22/14, as severe cognitive deficit.</p> <p>Review of the record indicated Resident "B" was to be laid down following meals. Resident "B" was observed on 08/27/14 seated in the dining room eating breakfast at 9:00 a.m. Resident "B" continued to be observed throughout the morning, seated in a high back wheelchair. Resident "B" was observed eating lunch at 11:30 a.m. A confidential staff interview indicated the resident had not been laid down between breakfast and lunch. Resident "B" continued to be observed until 2:30 p.m., at which time the resident remained sitting up in his high back wheel chair.</p> <p>Confidential interviews with 6 of 10 staff, during the survey, indicated Resident "B" required extensive assist of 2 or mores for transfers, bathing and toileting needs. Staff interviews indicated the resident's needs extended beyond a residential setting.</p> | | <p>following meals if is so desired. Resident D: Attachment B – Resident D Assessment (Negotiated Service Plan) was reviewed and indicates that the Resident does requires assistance with toileting, transferring and eating (at times). The Resident does receive Hospice Services at this time. The Resident is medically stable and the community continues to meet Resident's needs as Resident ages in place. Resident E: Attachment C – Resident E Assessment (Negotiated Service Plan) was reviewed and indicates that the Resident does require assistance with toileting and transferring. Resident is able to feed self. Attachment D- Physician orders. Per resident choice, resident chooses not to wear her oxygen while dining; Physician order has been received from physician for resident to be allowed to remove oxygen during meal times. Registered Nurse reviewed Negotiated Service Plans of residents with a Care Level of 4 or higher. Appropriate updates were made to the Negotiated Service Plan/Care Plan and task sheets updated for care providers to reflect the care being given. The remaining residents in community will have their Negotiated Service Plan reviewed for appropriateness of Care being provided by Registered Nurse to be completed by end of business</p> | | | | |

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| | <p>Review of the most recent "ASSESSMENT and NEGOTIATED SERVICE PLAN SUMMARY," dated 08/22/14, did not indicate the totally dependent resident required staff assist for showering or bathing.</p> <p>2. The record of Resident "D" was reviewed on 08/27/14 at 1:00 p.m. Resident "D" was admitted to the facility on 11/04/11 with diagnoses including dementia, hypertension, constipation, left extremity weakness, and affective mood disorder.</p> <p>Confidential interviews with 6 of 10 staff, during the survey, indicated Resident "D" required assist of 2 for toileting, transfers, and assist of 1 for eating. Staff interviews indicated the resident's needs extended beyond a residential setting.</p> <p>Review of the most recent "ASSESSMENT and NEGOTIATED SERVICE PLAN SUMMARY," dated 03/21/14, indicated, "Res [Resident] requires the use of a mechanical lift for safety of transfers and toileting r/t [related/to] physical jerks and involuntary movements PRN [as needed]."</p> <p>3. The record of Resident "E" was</p> | | <p>10/14/14. Staffing Patterns have been reviewed for appropriate level of staffing based on care needs. Staffing will be based on acuity of current residents assuring that Residents scheduled and unscheduled needs are met. Monitoring will occur as follows: Registered Nurse and Executive Director or Regional Team member will collaborate weekly to determine based on current Task Sheets, Schedule, move-ins and changes in condition that staffing levels are appropriate. Weekly discussion of At Risk Residents and new move-ins will identify needs for review of Negotiated Service Plans on an ongoing basis.</p> | | | | |

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| | <p>reviewed on 08/28/14 at 8:00 a.m.</p> <p>Resident "E" was admitted to the facility on 11/17/12 with diagnoses including, but limited to, hypertension, GERD (Gastroesophageal Reflux Disease), anemia, diabetes, and CAD (Coronary Artery Disease).</p> <p>Confidential interviews with 6 of 10, during the survey, indicated Resident "E" required assist of 2 for toileting and transfers.</p> <p>Review of the most recent "ASSESSMENT AND NEGOTIATED SERVICE PLAN SUMMARY," dated 12/02/13, indicated the resident did not receive Oxygen. The service plan indicated for bathing: "Res [Resident] is taken into bathroom. Res is undressed and place on shower chair in shower. Water is brought to temperature that res. specifies. Res does not get hair washed; hair is washed in beauty salon. Res body is washed with soap and wash cloth. Res is then rinsed and dried. Lotion is applied to body. Res. is the [sic] dressed." Under "BATHROOM ASSISTANCE" a note indicated, "Res. needs full assistance in restroom." The area, "DRESSING AND GROOMING," indicated, "Resident needs full assist with dressing & grooming."</p> | | | |

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| | <p>Review of the most recent MARS (Medication Administration Record), dated 08/2014, indicated an order for continuous oxygen was not being followed by staff.</p> <p>"07/03/14 OXYGEN AT 2 L/MIN [liters/minute] PER NC [Nasal Cannula] CONTINUOUSLY."</p> <p>Resident "E" was observed sitting in the dining room, without Oxygen, for breakfast on 08/27/14, lunch on 08/27/14 and breakfast on 08/28/14.</p> <p>A review of the facility's staffing schedule indicated: Days: 6:00 a.m.-2:00 p.m. 1 Resident Care Provider (RCP [CNA]) & 1 Nurse Evenings: 2:00 p.m.-10:00 p.m. 1 RCP & 1 Nurse Nights: 10:00 p.m.-6:00 a.m. 2 RCPs with a nurse on call for any medication needs</p> <p>Confidential staff interviews indicated a minimum of 4 residents required total assistance of 2 or more to meet their needs. In addition, 3 staff indicated, at times, only 1 nurse or CNA is in the building to provide resident care needs.</p> <p>The Administrator was interviewed on 08/27/14 at 2:00 p.m. in regards to a Policy & Procedure to address at point a resident is reevaluated for discharge. The</p> | | | |

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| | <p>Administrator indicated and provided, at the time, the facility would utilize the "STATE OF INDIANA RESIDENCY AGREEMENT - 11/2012."</p> <p>Review of the agreement indicated, "The residence may terminate this Agreement upon thirty (30) days written notice to You for one of more of the following reasons:...</p> <p>b. Your safety or the safety of others in the Residence is endangered;...</p> <p>d. Transfer or discharge is necessary for Your welfare and Your needs cannot be met by the Residence;..."</p> <p>This State tag relates to Complaint IN00154822.</p> | | | | | | |