

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155825	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/24/2015
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NAME OF PROVIDER OR SUPPLIER  ST AUGUSTINE HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 2345 W 86TH ST INDIANAPOLIS, IN 46260
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 19, 20, 21, 22, 23, &amp; 24, 2015.</p> <p>Facility number: 000389 Provider number: 155825 AIM number: 100288920</p> <p>Census bed type: SNF/NF: 39 Residential: 20 Total: 59</p> <p>Census payor type: Medicare: 1 Medicaid: 31 Other: 7 Total: 39</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0157	483.10(b)(11)			

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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SS=D Bldg. 00	<p><b>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b> 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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a resident's continued refusal for an intervention for weight loss and possible need to alter treatment for 1 of 3 residents reviewed</p>	F 0157	The MD was immediately notified of resident #32's refusals of supplements when DON was made aware. New orders were put into place, resident was asked her preference of supplements. She stated that she would like	08/12/2015

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	<p>for nutritional status (Resident #32).</p> <p>Findings include:</p> <p>Resident #32's record was reviewed on 7/23/2015 at 3:00 p.m. A Minimum Data Set (MDS) assessment tool, dated 5/19/2015, indicated Resident #32 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, was not on a planned weight loss regimen, did not have a condition or chronic disease which would result in a life expectancy of less than 6 months, and was able to eat with supervision which required oversight, encouragement or cueing from the staff.</p> <p>Weight records indicated Resident #32's weight on 7/23/2015, was 103 pounds and her weight was 109.2 pounds on 7/17/2015.</p> <p>A care plan, dated 12/15/2014, indicated Resident #32 was at nutritional risk and would maintain her weight above 105 pounds. Interventions included to offer 8 ounces of Boost (nutritional drink) three times daily with meals.</p> <p>A nutritional assessment, dated 2/24/2015 at 11:57 a.m., indicated Resident #32 required increased protein and energy needs and the current order for Boost had been increased to offer</p>		<p>Med Pass tid. New orders from MD are to offer Med Pass tid, and to document % consumed. If after 5 days of no consumption of supplement, the DON, MD or RD will be notified so the appropriate supplement changes can be made that are agreeable and beneficial to the resident.</p> <p>Resident #32 also has a DX of Metastatic Breast CA, and that Weight loss is to be expected related to Metastatic Breast CA. Also the week that resident lost weight, the MD had ordered, on July 18, 2015, Lasix 40mg po qd x 3 days. Thus contributing, and or being totally responsible for the weight loss. To identify residents for potential to be affected by the same deficient practice, the RD will do a weekly review of all residents weights, including those on daily weights. She will reassess residents as she deems necessary on supplements and make necessary changes for those with weight gains or losses, and those residents that are not consuming their ordered supplements. The MD will be updated of recent status changes and need for new orders. RD will give the DON weekly updates x 6 months on weights for the residents on qd weights, bi-weekly weights and weekly weights To ensure that the deficient practice does not recur, the Inservice director will conduct an inservice on monitoring residents on supplements.</p>	

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	<p>three times daily with meals.</p> <p>A physician's order, dated 3/25/2015, indicated to offer Boost three times daily with meals.</p> <p>A review of the treatment record, dated July 2015, indicated Resident #32 had refused her Boost three times daily from 7/10/2015 to 7/21/2015.</p> <p>During an observation on 7/22/2015 from 11:46 a.m., to 12:22 p.m., Resident #32 was observed to eat lunch without a Boost supplement.</p> <p>During an observation on 7/23/2015 from 11:55 a.m., to 12:30 p.m., Resident #32 was observed to eat lunch without a Boost supplement.</p> <p>During an interview on 7/23/2015 at 12:19 p.m., Resident #32 indicated she had refused her Boost for several days.</p> <p>During an interview on 7/23/2015 at 2:40 p.m., the Assistant Director of Nursing (ADON) indicated Resident #32 had refused her Boost for 12 days and the physician or dietitian had not been notified.</p> <p>During an interview on 7/23/2015 at 3:06 p.m., the Director of Nursing (DON)</p>		<p>Educating nursing on monitoring % of consumption of a supplement; making sure the supplement is given when ordered; and if 5 days of non consumption have been documented the nurse will notify the DON &amp; MD, that there might be a need to change supplements due to noneffective, adverse reactions, dislike, continued lack of consumption, also noting the residents preferences. Nursing will also notify DON when there has been no consumption of supplement x 5 days. RD and MD will also be notified at this time, to make necessary changes in supplement orders. The ADON will monitor these supplement flow sheets q week, times 6 months. Residents on daily weights with an order to notify MD, of a weight gain of 3 lbs overnight, or 5 lbs in a week will be monitored by the day nurse, and the order will be carried out. There will be a flow sheet to monitor residents with daily weights and to verify MD was notified of weight loss or gain as MD ordered. ADON will monitor these weight flow sheets q week x 6 months. If 100% compliant the last month of monitoring the supplements and weights, the monitoring can stop. If &lt; 100% compliance with the monitoring the last month, monitoring will continue, until 100% compliant. These systemic changes will be implemented by August 13, 2015.</p>		

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F 0242 SS=D Bldg. 00	<p>indicated the physician should have been notified of Resident #32's continued refusal of a supplement and an alternative nutritional intervention should have been ordered.</p> <p>A policy titled "Change in Resident Condition or Status" dated July 2005, and identified as current by the DON on 7/24/2015 at 11:00 a.m., indicated, "...Changes in Health Status: Immediately inform the resident, physician, family member, or responsible person when there is a need to alter treatment significantly such as a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment...."</p> <p>3.1- 5(a)(3)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents'</p>	F 0242	All residents that were able to make choices on when and how often they have a shower/bath	08/14/2015	

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	<p>choices were honored regarding their preferences for frequency of showers for 2 of 3 residents reviewed for choices (Residents #17 and #20).</p> <p>Findings include:</p> <p>1. During an interview on 7/21/15 at 10:11 a.m., Resident #17 indicated the facility had not asked her shower preference. She indicated she preferred daily showers but was provided showers/baths twice a week.</p> <p>Resident #17's record was reviewed on 7/23/15 a 10:15 a.m. A Minimum Data Set (MDS) assessment tool, dated 1/21/15, indicated Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, required physical assistance from staff for bathing, and indicated it was very important for her to make choices regarding bathing. The record lacked evidence the facility assessed Resident #17's preferences for shower frequency.</p> <p>During an interview on 07/22/2015 at 11:47 a.m., Registered Nurse (RN) #50 indicated residents received two shower/baths a week and bathing schedules were assigned based on residents' rooms.</p>		<p>were interviewed by the coordinators of the units, the Sisters. Their preferences were documented and put into effect. The bath and shower sheets were updated to include their preferences. The aids will ask the residents before each bath/shower if they are meeting their preference. The aids will then sign the bath sheet and turn it into the nurse to sign. The nurses and Sisters will then be able to identify the residents who may need their shower/bath days, frequency and times changed. We will be initiating a flow sheet upon admission of any new residents, and for current residents to identify their preferences for bath/showers. We will update their preferences quarterly. These flow sheets will be kept in their permanent charts. The sisters will be informed quarterly of the residents preferences and they will then be able to make the necessary changes in their bath/shower schedules. These systemic changes will completed during the week of August 10-14, 2015.</p>	

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	<p>During an interview on 7/23/2015 at 2:12 p.m., Sister #52 and Sister #53 indicated documentation was not available which indicated the facility assessed Resident #17 for her preference regarding shower/bath frequency.</p> <p>2. During an interview of Resident #20 on 7/20/15 at 10:57 a.m., the resident indicated staff determined the shower schedule and residents were provided two showers a week. She indicated she preferred to shower more often.</p> <p>Resident #20's clinical record was reviewed on 7/22/15 at 9:34 a.m. An admission assessment, dated 10/2/14, indicated the resident was moderately impaired, required assistance and/or monitoring of one person for personal hygiene care, and shower preferences were very important to her.</p> <p>On 7/23/15 at 1:53 a.m., the Director of Nursing (DON) indicated the facility did not have documentation which indicated Residents' preferences regarding shower frequency were assessed.</p> <p>A policy titled "Resident Rights" identified as current by the DON on 7/23/15 at 1:50 p.m., indicated, "...Receive care in a manner which promotes and enhances your quality of life; ...the right to be treated with respect</p>			

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F 0282 SS=D Bldg. 00	<p>and dignity in recognition of your individuality and preferences...."</p> <p>3.1-3(u)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure the resident's care plan and physician's order for pureed diet was followed for 1 of 3 residents reviewed for nutrition (Resident #41).</p> <p>Finding include:</p> <p>On 7/20/15 at 12:10 p.m., during a dining observation, Resident #41 was served a regular diet meal which included a pork chop. Resident #41's daughter was observed to request from Dining Aide #3 a pureed meal. Dining Aide #3 indicated a pureed meal was not available.</p> <p>Resident #41's record was reviewed on 7/22/15 at 11:50 a.m. The record indicated Resident #41 had diagnosis which included, but was not limited to, Alzheimer's disease. A Minimum Data</p>	F 0282	<p>The POC for this deficiency to ensure pureed diets are followed is to plate the pureed diets in the kitchen for residents with pureed diets. The plates will then be in the food truck when its delivered to the appropriate dining room. The plates will be labeled with the residents name on them, The CDM will be notified of any resident with a change in diet to pureed, or a new admission with a pureed diet order. They will then be put on the list to have their food plated in the kitchen before going to the appropriate dining room. The systemic changes to ensure that residents with pureed diets receive only pureed diets is to plate the pureed food in the kitchen and to label each plate with the residents name on them. The Dining Aids will also have a check off flow sheet to check each meal that the pureed diet was delivered from the kitchen. To monitor effectiveness the</p>	08/12/2015

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	<p>Set Assessment (MDS) tool dated 5/27/15, indicated Resident #41 had severe cognitive impairment, required a pureed diet, and required assistance with meals.</p> <p>A care plan dated 5/27/15, indicated Resident #41 had problems comprehending chewing and swallowing and required pureed food and assistance with meals.</p> <p>Resident #41's July 2015, recapitulation of physician's orders indicated an order for a pureed diet.</p> <p>A copy of a current menu provided by the Certified Dietary Manager (CDM) on 7/24/15 at 3:02 p.m., titled, "Week 3" indicated the items on the dinner meal on 7/20/15, included, but were not limited to, roasted pork chops and roasted chicken.</p> <p>On 7/24/15 at 11:12 a.m., the Certified Dietary Manager (CDM) indicated pureed meals were prepared daily and he was not aware a pureed meal was not available on 7/20/15.</p> <p>On 7/24/15 at 11:23 a.m., the CDM indicated the same foods on the regular diet menu were prepared for the pureed diets and the only substitutions used were</p>		<p>CDM or cook for each meal will 3 times a day for 3 weeks check off on a flow sheet that the correct pureed diets were labeled in the kitchen before being transported to the appropriate dining room. Then 3 times a day x 2 days a week for 2 months, then 3 times a day x 1 day a week for 4 months. If 100% compliance is met in the last month, then the monitoring may be stopped. If not 100% compliant in the last month, the cooks will be inserviced again and continue monitoring for one more month. The monitoring will go into effect starting August 12, 2015.</p>	

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F 0325 SS=D Bldg. 00	<p>for foods like green beans, peas, and bacon. He indicated all proteins with the exception of bacon were pureed at each meal by the cooks.</p> <p>The CDM provided a current policy titled, "Dysphagia Diets" on 7/24/15 at 4:07 p.m. The policy indicated the facility was to follow the therapeutic recommendations of the physician, ensure pureed foods had no coarse textures or lumps, meats and meat substitutes were to be a very smooth consistency, and mashed potatoes should be served with gravy. The policy indicated whole or ground forms of meat, poultry, or fish were not allowed.</p> <p>3.1-35(g)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (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 (2) Receives a therapeutic diet when there is</p>			

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	<p>a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to assess efficacy of current nutritional supplements, offer alternative supplements to assist in the prevention of weight loss, and maintain goal weight per resident's care plan for 1 of 3 residents reviewed for nutritional status (Resident #32).</p> <p>Findings Include:</p> <p>Resident #32's record was reviewed on 7/23/2015 at 3:00 p.m. A Minimum Data Set (MDS) assessment tool, dated 5/19/2015 indicated Resident #32 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, was not a planned weight loss regimen, did not have a condition or chronic disease which would result in a life expectancy of less than 6 months, and was able to eat with supervision which required oversight, encouragement or cueing from the staff.</p> <p>Weight records indicated Resident #32's weight on 7/23/2015 was 103 pounds and her weight on 7/17/2015 was 109.2 pounds.</p> <p>A care plan, dated 12/15/2014, indicated Resident #32 was at nutritional risk and the goal would be for her to maintain her</p>	F 0325	<p>The resident was interviewed as to what supplement would be agreeable to her. She sampled MedPass and she loved it. We have put in a monitoring program that if there is no consumption of supplements x 5 days, that the RD and or MD will be notified and the appropriate supplement changes be made that are agreeable and beneficial to the resident. Nursing will have flow sheet of all residents on supplements. All supplements are to be offered as ordered. Nursing will sign off the % of consumption by the resident. Nursing will also notify DON and MD of non consumption x 5 days, and document this on the flow sheet. The Inservice Director will conduct an inservice for the nurses on the flow sheets that they will be required to document on residents on daily weights weight loss or gain, monitoring % of consumption of supplement, making sure supplement is offered as ordered; and after 5 days of non consumption have been documented the nurse will notify MD &amp; DON. The supplemental orders can then be changed due to non effectiveness, adverse reaction, dislike or lack of consumption, noting residents preference, or weight loss or gain. To identify residents for potential to be affected by the same deficient practice, the RD will do a weekly</p>	08/12/2015			

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	<p>weight above 105 pounds. Interventions included to offer 8 ounces of Boost (nutritional drink) three times daily with meals.</p> <p>A nutritional assessment, dated 2/24/2015 at 11:57 a.m., indicated Resident #32 required increased protein and energy needs and the current order for Boost had been increased to offer three times daily with meals.</p> <p>A physician's order, dated 3/25/2015, indicated to offer Boost three times daily with meals.</p> <p>A dietary progress note, dated 6/9/2015, indicated Resident #32 weighed 110.6 lbs., had accepted her Boost, and current dietary interventions were appropriate at the time, without further recommendations.</p> <p>A review of the treatment record, dated July 2015, indicated Resident #32 had refused her Boost three times daily from 7/10/2015 to 7/21/2015.</p> <p>During an observation on 7/22/2015 from 11:46 a.m. to 12:22 p.m., Resident #32 was observed to eat lunch without a Boost supplement.</p> <p>During an observation on 7/23/2015 from</p>		<p>review of all residents weights, including those on daily weights. She will reassess residents as she deems necessary on supplements and make necessary changes for those with weight gains or losses, and those residents that are not consuming their ordered supplements. The MD will be updated of recent status changes and need for new orders. RD will give the DON weekly updates x 6 months on weights for the residents on qd weights, bi-weekly weights and weekly weights ADON will monitor the Weight and supplement flow sheets q week x 6 months. If monitoring is 100% compliant the last month, the monitoring may stop. Monitoring will continue for 1 more month or until 100% compliant x 1 month. These systemic changes will be implemented by August 13, 2015.</p>		

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NAME OF PROVIDER OR SUPPLIER  ST AUGUSTINE HOME FOR THE AGED	STREET ADDRESS, CITY, STATE, ZIP CODE 2345 W 86TH ST INDIANAPOLIS, IN 46260
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	<p>11:55 a.m. to 12:30 p.m., Resident #32 was observed to eat lunch without a Boost supplement.</p> <p>During an interview on 7/23/2015 at 12:19 p.m., Resident #32 indicated she had refused her Boost for several days.</p> <p>During an interview on 7/23/2015 at 2:40 p.m., the Assistant Director of Nursing (ADON) indicated Resident #32 had refused her Boost for 12 days and the dietitian or physician had not been notified.</p> <p>During an interview on 7/23/2015 at 3:06 p.m., the Director of Nursing (DON) indicated the physician should have been notified of Resident #32's continued refusal of a supplement and an alternative nutritional intervention should have been ordered.</p> <p>During an interview on 7/24/2015 at 10:36 a.m. the DON indicated staff had recently began to only offer Boost to Resident #32 if she didn't eat her meal. She indicated other nutritional supplement interventions had not been offered.</p> <p>During an interview on 7/24/2015 at 10:39 a.m., Resident #32 indicated she no longer wished to receive Boost. She</p>			

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F 0371 SS=D Bldg. 00	<p>indicated she would prefer ice cream with her meals as a supplement.</p> <p>A policy titled "Weight, Loss or Gain" dated July 2005, and identified as current by the DON on 7/24/2015 at 11:00 a.m., indicated, "...The physician, dietitian MDS Assessment Coordinator will be notified of the results of the daily weights...any diet changes and/or supplements will be added as ordered..."</p> <p>3.1-46(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure staff distributed and served food under sanitary conditions for 1 of 3 dining observations. (Resident #28) (CNA # 1 and Volunteer # 1)</p> <p>Findings include:</p> <p>1. On 7/20/15 at 12:12 p.m., Certified</p>	F 0371	All CNA's, dining aides, and who handle food will attend an inservice by CDM and go over Food handling, sanitation and hand washing. All present will acknowledge understanding of the policy and procedures for food handling, sanitation and hand washing by passing a post test. Any resident in the dining room has the potential to be affected by the same deficiency, therefore any CNA, volunteer, or	08/19/2015

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	<p>Nursing Assistant #1 (CNA #1) with her bare hand, fed bites of a dinner roll to Resident #28 two times.</p> <p>On 7/23/15 at 2:59 p.m., Director of Nursing (DON) indicated CNA's are not to touch the resident's food with their bare hands, but should have used gloves or an utensil.</p> <p>On 7/24/15 at 10:24 a.m., CNA #1 indicated she should not have used her bare hand to feed Resident #28 the dinner roll but should have used gloves or an utensil to assist a resident with eating.</p> <p>2. On 7/20/15 at 12:09 p.m., Volunteer #1, walked into the dining room, placed a hairnet on her head, sat down at the dining table, and began spoon feeding Resident #31 yogurt. Volunteer #1 was not observed to wash her hands nor put on gloves prior to feeding Resident #31 the yogurt.</p> <p>On 7/23/15 2:59 p.m., Director of Nursing (DON) indicated Volunteers are instructed to wash their hands prior to assisting a resident with their meals.</p> <p>A facility policy titled "Hand Washing Technique" identified as current by the DON on 7/23/15 at 1:50 p.m., indicated, "...All food service employees will wash</p>		<p>dining aid who handles food will be inserviced. The volunteers will receive a newsletter with our policy and procedures on food handling and sanitation. We will make it clear what must be done to volunteer in the dining rooms. They will sign and return a notice that they received read and understand what is expected of them to volunteer in the dining room. The Inservice Director will monitor meals on the nursing units for 3 meals a week x 4 weeks to ensure all persons feeding residents and handling food are following P&amp;P. Then 1 meal every week for 3 months, then 3 meals a month for 2 months. If anyone if found to be deficient in the P&amp;P, they will be removed from the dining room and reeducated on proper procedures. We will also post signs in the pantry: "STOP, before you serve, wash your hands and put on gloves&gt;" And "Never handle food with bare hands, wash hands and apply glove." If the monitoring for food handling and sanitation is 100% compliant the last month, the monitoring can stop. If not the monitoring will continue until 100% compliance is met x 1 month. These systemic changes will be implemented by 8-19-15</p>	

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R 0000  Bldg. 00	<p>hands frequently, such as: 1. Before: ...Handling food, Handling clean dishes, equipment or utensils...2. After: ...Touching hair, face, mouth, etc....</p> <p>A facility policy, identified as current, titled "Handling Foods" provided by the DON on 7/23/15 at 1:50 p.m., indicated, "...Food products are handled under sanitary conditions and in acceptable temperatures. Hand contact with ready-to-eat foods is prohibited regardless of hand washing. (i.e. use clean utensils and/or disposable gloves must be used for those food products...."</p> <p>3.1-21(i)(3)</p>			
	This visit was for a State Residential Licensure Survey.	R 0000		
	Residential Census: 20			
	Residential sample: 7			
	This state finding was cited in accordance with 410 IAC 16.2-5.			
R 0217	410 IAC 16.2-5-2(e)(1-5)			

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Bldg. 00	<p><b>Evaluation - Deficiency</b></p> <p>(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:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to identify and document the nursing services needed for 1 of 7 residents reviewed for service plans (#4).</p> <p>Finding include:</p> <p>Resident #4's record was reviewed on</p>	R 0217	An admission evaluation will be done upon admission along with the institution of a new service plan sheet to document the services needed for the resident, their functional status, risks and potential interventions. The service plan will be updated on a quarterly basis and will reflect any changes occurring with the last quarter. It will address changes	08/19/2015
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	<p>7/24/15 at 3:00 p.m. The service plan, dated April 2015, lacked documentation of nursing services to be provided to Resident #4 by the facility.</p> <p>The physician order summary, dated 6/25/15, ordered medications including, but not limited to: warfarin sodium (anticoagulant) 3 milligrams (mg) tablet orally twice weekly on Sunday and Saturday, warfarin sodium (anticoagulant) 4 mg tablet orally 5 times a week Monday through Friday, Toresmide (diuretic) 20 mg tablet orally twice daily, Lorazepam (anxiolytic) 1 mg tablet at night, Celexa (antidepressant) 20 mg tablet orally daily, and DuoNeb (bronchodilator) 0.5 mg-3 mg/3 milliliter (ml) solution per nebulizer twice daily. The order summary indicated the resident's nebulizer was allowed at bedside. The order summary indicated the staff was to check bedside medications every Sunday, obtain monthly labs, and obtain accu-checks (blood sugar testing) if the resident showed symptoms of hyperglycemia or hypoglycemia. The order summary indicated Resident #4 had diagnoses including, but not limited to: kidney transplant, acute kidney failure, hypertension, anxiety, atrial fibrillation, wheezing, depression, and dyspnea.</p>		<p>needed to maintain residents highest quality of life. All residents in residential have the potential to be affected by this deficient practice. The service plan will be instituted for all resident living in the residential unit. DON will monitor every month for 6 months to insure that service plans are completed. A Policy and Procedure will be implemented by August 19, for admission and quarterly Service Plans to be completed on all residents in residential unit.</p>	

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	<p>During an interview on 7/24/15 at 3:20 p.m., the Assistant Director of Nursing (ADON) indicated there was not documentation regarding medications, diagnoses, nursing tasks, or potential risks included on the service plan. She indicated the service plans were to address a resident's preferences and did not include nursing services or potential risks for the resident.</p> <p>During an interview on 7/24/15 at 3:57 p.m., the Director of Nursing indicated there was no policy related to service plans.</p>				