

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 08/16/2013
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NAME OF PROVIDER OR SUPPLIER SHIELDS HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2288 NICHOLAS CT SEYMOUR, IN 47274
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: August 19, 20, and 21, 2013</p> <p>Facility number: 004376 Provider number: 004376 AIM number: NA</p> <p>Survey team: Diana Sidell RN, TC Jennifer Carr RN Sunny Jungclaus RN</p> <p>Census bed type: Residential: 19 Total: 19</p> <p>Census payor type: Other: 19 Total: 19</p> <p>Sample: 7 Supplemental sample: 1</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p>	R000000	<p>POC 4376 Shields House Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
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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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R000064	<p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on interview and record review, the facility failed to protect a resident's property from theft for 1 of 1 resident reviewed for money missing in a sample of 7. (Resident #5)</p> <p>Findings include:</p> <p>During an interview on 9/19/13 at 1:24 p.m., Resident #5 indicated she had a "little bit of money" missing about 6 or 7 months ago; \$15.00. She said it was in her closet, she thought she knew who took it, and she had reported it.</p> <p>An investigation, with no date, was provided by the Residence Director on 8/20/13 at 10:20 a.m. The investigation indicated: "Concern reported by [Resident #5] regarding \$15.00 missing. [Resident #5] stated that #15.00 was missing from her billfold, but was not certain exactly when she saw it last. She stated that she did not have it in a locked cabinet</p>	R000064	<p>Citation #1 R064 410 IAC 16.2-5-102(hh) Residents' Rights – Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #5 will have the outcome of the investigation reviewed with him/her. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Residence Director and/or Designee conducted a review of current residents residing at Shields House to ensure compliance with the above referenced citation. No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated as to the policy and procedure regarding securing of resident's property from loss and theft. The Residence Director and/or Designee will be responsible for ensuring that our</p>	09/26/2013			

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	<p>in her room. Staff was questioned regarding [Resident #5's] missing money or possibility that she went on an outing or requested something be purchased for her. No one was aware of any event or the location of her money. Staff assisted in looking in her apartment. R.D. (Residence Director) spoke to [Resident #5's daughter] regarding the reported money missing. [Resident #5's daughter] said that she did not want any further investigating. We discussed [Resident #5's] ability to lock her billfold and any other items of value in the cabinet for safe-keeping."</p> <p>During an interview, on 8/21/13 at 10:20 a.m., the Residence Director indicated the facility didn't report it because they had contacted her daughter and her daughter didn't want anything done. She also indicated they didn't contact the police or report it to the state agency.</p>		<p>policy and procedure are followed and continue to be in compliance with Indiana state regulation R064 410 IAC 16.2-5-1.2(hh). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or Designee will perform random weekly audits of resident reports of missing items to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>	

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R000091	<p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.</p> <p>Based on record review and interview, the facility failed to develop policies and procedures related to resident transfer/discharge. This deficient practice affected 1 of 2 closed records reviewed for transfer/discharge requirements in a sample of 7. (Resident #22)</p> <p>Findings include:</p> <p>Resident # 22's closed record was reviewed on 08/20/13 at 11:15 a.m. The record indicated Resident # 22 was admitted with diagnosis that included, but were not limited to, dementia, high blood pressure, history of stroke, osteoporosis, and hyperlipidemia.</p> <p>Resident Service notes dated 07/21/13 at 3:00 p.m. indicated that Resident #22 was discharged at this</p>	R000091	<p>Citation #2 R091 410 IA 16.2-5-1.3(h)(1-4) Administration and Management – Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #22 no longer resides at this facility. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director and/or Designee conducted a review of current residents residing at Shields House to ensure compliance with the above referenced citation. No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director and nursing staff were re-educated as to the policy and procedure for completion of documents for transfer or</p>	09/26/2013			

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	<p>time and was moving to another nursing facility "per notice". This was the only documentation for the transfer to the other nursing facility that was found in the closed record.</p> <p>During an interview with the Wellness Director (WD) on 08/20/13 at 4:11 p.m., the WD indicated that Resident #22's parents had stayed at the other nursing facility and that Resident #22 was only at this facility awaiting an opening there. The facility's policy and procedure was requested, and on 8/20/13 at 3:55 p.m., the WD indicated that she had contacted by phone the facility's Regional Director for Care and Quality Management regarding a transfer/discharge policy and was told that the is no specific policy and they are to follow state regulations.</p> <p>On 8/20/13, at 4:11 p.m., the WD did provide a copy of the facility's transfer packet which consisted of: Resident Transfer Form, Notice of Transfer or Discharge (State Form 49669), Nursing Facility Bed Hold Policy form (2 pages), and Notice of Transfer or Discharge Request for hearing (State Form 49631). The WD also indicated that she called the other facility to find out what documentation was sent to them from this facility</p>		<p>discharge. The Wellness Director and/or Designee will be responsible for ensuring that transfer or discharge documents are completed per our policy and procedure to ensure compliance with R 091 410 IAC 16.2-5-1.3 (1-4). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform random weekly audits of discharge records to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>				

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	when Resident #22 transferred there and was told that these forms were sent to them: [local hospital] Discharge Summary from 03/18/13, copies of Resident's Identification, cards, current Medication Record, and Medication Inventory form. The WD indicated that she could not find that she had sent any of the facility's transfer packet forms with Resident #22 when she transferred to the other nursing facility on 07/21/13.			

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to provide an environment in a state of good repair for all residents for 2 of 2 observations and 1 of 1 environmental tour.</p> <p>Findings include:</p> <p>During an observation and resident interview with Resident #1, in room #101, on 8/19/13 at 1:35 p.m., multiple dark brown stains were observed on the carpet; the largest two of which were on the left side of the entry and in front of the bathroom.</p> <p>During an environmental tour, with the Maintenance Director, on 8/20/13 at 10:15 a.m., the same multiple carpet stains were again observed in room #101. The Maintenance Director indicated he believed the stains were a result of the resident repeatedly spilling his coffee. He further indicated that he had witnessed the resident spill his coffee in the stained area near the residence entry.</p> <p>During an environmental tour, with the</p>	R000144	<p>Citation #3 R144 410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #1's carpet has been professionally cleaned on 9/3/13. All of the PVC chairs were discarded on 8/20/13. All of the cushions mentioned were discarded 8/20/13. The swing chains were replaced on 8/20/13. The metal furniture "feet" were re-painted. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The furnishings have been inspected by the Maintenance Tech and/or Housekeeper to ensure there are no furnishings in disrepair. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? All staff has been re-educated to report furnishings that are in disrepair. The Residence Director and/or Designee are responsible to ensure the furnishings are in good repair per our policy and procedure to ensure compliance</p>	09/26/2013

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	<p>Maintenance Director, on 8/20/13 at 9:30 a.m., multiple brown stains were noted on Resident #10's carpet in room #118. The resident and his [pet], were present in the room at the time of the tour. The Maintenance Director indicated that the stains on the carpet observed were "...stains from [pet]". He further indicated that facility staff "...come in with an extractor and cleanse two times a week."</p> <p>During an interview with Resident #7 on 8/21/13 at 3:10 p.m., the Director of Nursing was present in room #113. Multiple large brown stains were observed on the resident's carpet.</p> <p>During an environmental tour with the Maintenance Director on 8/20/13 at 9:45 a.m., 4 of 4 white plastic chairs on the east porch courtyard were observed to be dirty, cracked, and unsteady; 3 of 4 chair cushions were observed to have circular burns, which the Maintenance Director indicated were cigarette burns; 1 of 4 chair cushions was observed to be ripped across the width of the seat cushion. 2 of 2 white metal chains suspending a swing were observed to be 50% brown - orange in color. The Maintenance Director indicated that the facility planned to replace the</p>		<p>with R144 410 IAC 16.2-5-1.5(a). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Housekeeper and/or Designee will perform random weekly audits of furnishings to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>				

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	<p>cushions, but could not provide a time frame or specific plan of correction. He further indicated that the substance on the swing chains was rust and that he planned to re-paint them.</p> <p>During the same environmental tour with the Maintenance Director, all of the metal furniture on the west courtyard was observed to be a brown - orange color at the bottom. The Maintenance Director indicated the discoloration was rust as a result of Resident #10's pet urinating on the furniture. He further indicated that he paints the furniture annually.</p>			

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R000178	<p>410 IAC 16.2-5-1.6(b) Physical Plant Standards - Deficiency (b) The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission (675 IAC). Plumbing, heating, and ventilating systems shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all areas.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that resident rooms (101, 118, 136) were free of objectionable odors for 8 of 8 observations on 3 of 3 survey days.</p> <p>Findings include:</p> <p>During an initial tour, on 8/19/13 at 1:00 p.m., a strong urine odor was detected from the hallway outside room numbers 101, 118, and 136.</p> <p>During an observation and interview with Resident #1, on 8/19/13 at 1:35 p.m., a strong urine odor was still present in the hallway outside room #101; a stronger urine odor, as well as a cat feces/litter box odor, was observed inside room #101. Resident #1 indicated he had a cat, which was observed to be sitting on a recliner in the room. Multiple large stains were observed on the carpet. A cat litter box with multiple dried cat feces was</p>	R000178	<p>Citation #4 R178 410 IAC 16.2-5-1.6(b) Physical Plant Standards - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? For residents in room #101, #118 and #136, a commercial carpet cleaning was completed on 9/3/13. The resident in room #101 has been reminded to clean the litter pan daily. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All new pet owners will be educated on the proper care needed for pet ownership. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? All staff has been re-educated to report pet odors/carpet stains to the Maintenance Tech. The Residence Director and/or Designee are responsible to ensure the pet odors are minimized per our policy and</p>	09/26/2013			

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	<p>observed in the resident's bathroom under the sink, along with a cat litter scoop lying next to the litter box.</p> <p>During an observation 8/20/13 at 8:50 a.m., a strong urine odor was detected from the hallway outside room numbers 101, 118, 136.</p> <p>During an environmental tour with the Maintenance Director, on 8/20/13 at 9:22 a.m., he indicated the odor outside the hallway was that of Resident #1's cat urine and cat litter box.</p> <p>During the same environmental tour on 8/20/13 at 10:15 a.m., Resident #1's residence was observed with the Maintenance Director. A strong odor of urine was again noted in the hallway outside room #101; a stronger odor of urine was observed inside the residence. The Maintenance Director again indicated that the odor was Resident #1's cat urine and litter box. The litter box under the sink was again observed to contain multiple dried cat feces.</p> <p>During an environmental tour with the Maintenance Director on 8/20/13 at 9:30 a.m., a strong urine odor was again observed outside room #118; a stronger urine odor was observed</p>		<p>procedure to ensure compliance with R178 410 IAC 16.2-5-1.6(b). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Housekeeper and/or Designee will perform random weekly audits of apartments with pets to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>				

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	<p>inside the residence. In an interview with Resident #10 inside his residence, he indicated that he cared for his dog, independently. The dog was also observed in the residence. The Maintenance Director indicated that the multiple brown stains on the carpet observed were "...stains from [dog]". He further indicated, "It's a constant fight with the smell outside." The Maintenance Director indicated that facility staff spray the carpet with vinegar and water every morning and "...come in with an extractor and cleanse two times a week."</p> <p>During an environmental tour with the Maintenance Director, on 8/20/13 at 9:55 a.m., a strong urine odor was observed in the hallway outside room #136. The Maintenance Director indicated the odor was urine from Resident #18's dog, Lucy. He indicated, "The corporate DON (Director of Nursing) has been down more than once" to address strong urine odors related to resident pets.</p> <p>During an observation, on 8/21/13 at 9:30 a.m., a strong urine odor was again observed in the hallway outside room numbers 101, 118, and 136.</p> <p>A copy of the facility policy regarding pets was provided by the Director of</p>			

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	<p>Nursing (DN) on 8/20/13 at 9:20 a.m. and reviewed on 8/20/13 at 10 a.m. The policy entitled "Pets" indicated, "The resident must sign a separate Pet Agreement....The Director may require removal of the pet, if in the Director's opinion, the pet becomes a nuisance, or due to illness or incontinence causes damages or an offensive odor, or poses a threat to the resident or others."</p> <p>"Pet Agreements" were requested for Residents #1, #7, and #18 and provided by the DN on 8/20/13 at 3:00 p.m. "Pet Agreements" for each resident were reviewed on 8/20/13 at 3:20 p.m., and each indicated, "At all times, You shall be responsible for the care and control of your pet."</p>				

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident had an accurate assessment in regards to smoking. This affected 1 of 1 supplemental sample and 3 residents reviewed for smoking in a sample of 6. (Resident #7)</p> <p>Findings include:</p> <p>A review of Resident #7's clinical record was reviewed on 8/21/13 at 9:00 a.m. Diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, quadriplegia, and seizures. The resident's record indicated he was admitted to the facility 4/1/11.</p>	R000216	<p>Citation #5 R216 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #7 spoke with multiple surveyors and denied sleeping. This resident's posture is less than erect due to his diagnosis and the sun was in his eyes, therefore, his eyes were closed. A new smoking evaluation was completed by the Wellness Director and signed by the resident. Resident was reeducated on proper smoking protocol. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who smoke were re-assessed for smoking. The Wellness Director signed each</p>	09/26/2013			

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	<p>A "Smoking Assessment" signed by the DN and dated 8/6/13 was provided on 8/21/13 at 9:25 a.m. The lines indicating "Resident/Legal Representative" and "Date" were blank. There was no resident name on the form. In an interview conducted with the DN on 8/21/13 at 2:00 p.m., she indicated, "Oh...I guess I should have put his name on it." She then wrote Resident #7's name on the form. She further indicated that she did not have the resident sign the form because there were not any "No" (negative) answers. The DN was unable to produce any "Smoking Assessment" forms for Resident #7 prior to 8/6/13, confirmed that his admission date was 4/1/13, and indicated the "Smoking Assessment" form was a "relatively new" requirement.</p> <p>The Smoking Assessment indicated the resident was "1. Able to communicate understanding of smoking standard and procedure. 2. Demonstrates ability to make his/her own decisions in relation to daily activities. 3. Demonstrates ability to hold cigarette securely. 4. Demonstrates ability to maintain hold of cigarette if physically distracted or bumped. 5. Demonstrates ability to light his/her cigarette? 6.</p>		<p>assessment and each resident signed their assessment. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director and Residence Director were re-educated regarding signatures needed on assessments. The Wellness Director and/or Designee are responsible to ensure the assessments are signed per our policy and procedure to ensure compliance with R216 410 IAC 16.2-5-2(c) (1-4)(d). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform random weekly audits of assessments to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>				

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	<p>Demonstrates appropriate use of an ashtray or receptacle (i.e. does not drop ashes on self, furniture, etc). 7. Demonstrates ability to let go of cigarette and then retrieve it appropriately. 8. Demonstrates ability to appropriately extinguish cigarette and dispose of in appropriate receptacle. If the answer to any of the above question is no, the resident needs assistance with smoking. The Residence Director or Wellness Director should make the necessary adjustments on the Service Assessment/Negotiated Service Plan (OC124) to reflect the resident's smoking status."</p> <p>During an observation on 8/21/13 at 9:35 a.m., Resident #7 sat in the courtyard in a wheel chair with a lit cigarette. The resident's head was down, and his eyes were closed. The Wellness Director was notified at that time, and indicated he appeared to be sleeping. She then approached the resident who was startled. The Wellness Director indicated the resident doesn't have very good control of his hands, and his left hand was observed to be contracted. The resident was observed with a cigarette butt in his lap as he wheeled in the door towards his room, and three cigarette ashes had been</p>			

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	<p>observed on the ground, one of them still burning, and the Wellness Director was observed to stomp them out with her foot.</p> <p>During an interview on 8/21/13 at 2:15 p.m., Resident #7 was observed sitting in his room in his wheelchair. The resident was queried as to what he did with with his cigarette butts, and he indicated he puts them in the trash, he doesn't wet them and makes sure they are out. He said he puts them here on his lap and would know if they weren't out. A round hole was observed on his shirt and the resident denied it was a burn hole.</p>				

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R000298	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication administered to residents was documented after the medication was given for 3 of 5 residents observed for medication administration. (Residents # 13, 10, and 18)</p> <p>Findings include:</p> <p>During a medication pass observation, on 8/20/13, between 10:58 a.m. and 12:31 p.m., LPN #1 was observed to initial the medications on the Medication Administration Records (MARs), as she removed them from the bottles or blister pack cards. Residents #13, 10, and 18's medications were then</p>	R000298	<p>Citation #6 R298 410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? The nurse #1 was given a written counseling for signing the MAR prior to administration instead of after administration. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Nurses and licensed staff were re-educated to the policy for medication administration. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director was re-educated the nurses regarding</p>	09/26/2013

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	<p>administered to them after they were signed as being given.</p> <p>During an interview on 8/20/12 at 11:25 a.m., LPN #1 indicated she usually signs the medications off as she gives them, then will go back and circle her initials, and write the explanation on the back of the MARs if the resident refuses.</p> <p>A policy for "Medication Documentation" was provided by the Director of Wellness Services (DNS) on 8/20/13 at 11:38 a.m. The policy indicated, but was not limited to, "The Medication Administration Record (MAR/TAR) is the record of medications prepared and administered to the resident or medications with which the resident is assisted...Staff will observe the resident taking the medication, then initial in the corresponding square of that medication's time and date...."</p>		<p>the medication administration policy and procedure. The Wellness Director and/or Designee is responsible to ensure documentation of medication administration is per our policy and procedure to ensure compliance with R298 410 IAC 16.2-5-6(c)(2). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform random weekly audits of medication administration to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>				

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to maintain complete and accurately documented clinical records for 3 of 4 residents reviewed for complete and accurate clinical records, (Residents # 22, 1, and 10) and 1 of 1 supplemental sample. (Resident #7)</p> <p>Findings include:</p> <p>1. Resident #22's closed record was reviewed on 8/20/13 at 11:15 a.m. Diagnoses included, but were not limited to, dementia, hypertension, stroke, osteoporosis, and hyperlipidemia. Resident #22 was admitted to the facility on 5/25/2013 and discharged to another facility on 7/21/13.</p> <p>"Resident Services Notes" dated 7/21/13 at 3:00 p.m. indicated, "Res D/C'd (discharged) at this X (time)...."</p>	R000349	R349 410 IAC 16.2-5-8.1(a) (104) Clinical Records – Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #22 no longer resides at this facility. Resident #1's pet agreement was put in place. Resident #10's document was signed by the current Residence Director and dated as such. Resident #7's smoking assessment was completed again and was signed/dated by the resident. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? An audit of the current residents' records was conducted to ensure all documents were in place and complete. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated regarding the	09/26/2013			

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	<p>No further documentation related to the resident's transfer or discharge was located in the chart.</p> <p>In an interview with the Director of Nursing (DN) on 8/20/13 at 2:55 p.m., she indicated she was unable to locate any additional transfer information for Resident #22. At 3:55 p.m., she indicated that the facility has no policy related to transfers and/or discharges other than "follow the regs (regulations)". At 4:10 p.m., she provided a copy of a form entitled "Resident Transfer Form" and indicated, "This is what I call our transfer packet." When asked if she could locate a completed "Resident Transfer From" for Resident #22, she indicated there was "None that I could find."</p> <p>2. Following a request for "Pet Agreement" forms and pet immunization records for Residents #1, #7, and #22, the DN provided all documents requested except for a "Pet Agreement" form for Resident #1 on 8/20/13 at 2:50 p.m. The DN was immediately notified that there was no "Pet Agreement" provided for Resident #1. At 3:00 p.m., the DN provided a "Pet Agreement" form dated April 19th, 2013 for Resident #1 with the Administrator's signature</p>		<p>clinical records policy and procedure. The Residence Director, Wellness Director and/or Designee are responsible to ensure clinical records are maintained per our policy and procedure to ensure compliance with R349 410 IAC 16.2-5-8.1(a) (1-4). How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will perform random weekly audits of clinical records to ensure continued compliance for a period of 6 months. Finding will be reviewed through the Shields House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional Director of Quality and Care Management and/or Designee will complete quarterly site visits of community to ensure continued compliance. By what date will the systemic changes be completed? 9/26/13</p>				

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	<p>noted in the line indicating "Residence Representative". No date was indicated. The line "You or Your Representative" (resident or resident representative signature line) was blank. The administrator was interviewed 8/20/13 at 3:05 p.m. and indicated that she completed the form after it was requested "because we didn't have it on file".</p> <p>On 8/20/13 at 4:15 p.m., the Administrator and DN provided a copy of a "Pet Agreement" for Resident #1 indicating, "On this 19th day of April, 2013, Resident #1 and Shields House enter into this Pet Agreement...." Resident #1's signature was indicated in the line designated "You or Your Representative." The Administrator's signature was again indicated in the line designated as "Residence Representative", followed by, "8/20/13". The Administrator indicated that the resident signed the form on 8/20/13. The Administrator indicated on the bottom right corner of Resident #1's "Pet Agreement" form, "This document prepared on 8/20/13 and signed by (Resident #1) on 8/20/13", followed by her signature.</p> <p>3. During a record review of Resident #10's "Pet Agreement" provided by the DN on 8/20/13 at 2:50 p.m. and</p>						

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	<p>reviewed on 8/20/13 at 2:55 p.m., the "Residence Representative" line was blank.</p> <p>4. A review of Resident #7's clinical record was reviewed on 8/21/13 at 9:00 a.m. Diagnoses included, but were not limited to.....The resident's record indicated he was admitted to the facility 4/1/11.</p> <p>A "Smoking Assessment" signed by the DN and dated 8/6/13 was provided on 8/21/13 at 9:25 a.m. The lines indicating "Resident/Legal Representative" and "Date" were blank. There was no resident name on the form. In an interview conducted with the DN on 8/21/13 at 2:00 p.m., she indicated, "Oh...I guess I should have put his name on it." She then wrote Resident #7's name on the form. She further indicated that she did not have the resident sign the form because there were not any "No" (negative) answers. The DN was unable to produce any "Smoking Assessment" forms for Resident #7 prior to 8/6/13, confirmed that his admission date was 4/1/13, and indicated the "Smoking Assessment" form was a "relatively new" requirement.</p> <p>In an interview with the Administrator</p>			

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	on 8/21/13 at 2:15 p.m., she indicated the "Smoking Assessment" form and requirement were "not new....There should be one in there before then (8/6/13)".			