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
	155294		04/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(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
F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00171807. Complaint IN00171807 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F328 and F425. Survey date: April 22, 2015 Facility Number: 000191 Provider Number: 155294 AIM Number: NA Census Bed Type: SNF: 50 Residential: 27 Total: 77 Census Payor Type: Medicare: 28 Other: 22 Total: 50 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by	F 000		

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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	Tammy Alley RN on April 28, 2015.			
F 157 SS=D Bldg. 00	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 record review and interview the	F 157	F 157 What corrective action will be put in place for the affected	05/15/2015

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	facility failed to ensure notification of a resident's physician, in that when the facility was unable to obtain a specific medication and enteral feeding in a timely manner from the pharmacy, the nursing staff failed to immediately notify the physician for intervention for 1 of 2 residents identified with feeding tubes and as new admissions to the facility in a sample of 3. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 04-22-15 at 10:00 a.m. Diagnoses included, but were not limited to, abnormal weight loss, muscle weakness, congestive heart failure and Parkinsons disease. The resident had a percutaneous endoscopic gastrostomy feeding tube noted upon admission to the facility. At the time of admission, the resident had physician orders, dated 04-01-15, which included "Nova Source Renal formula to be infusing through the feeding tube at 25 mls. [milliliters] per hour for 22 hours continuous via pump/GT [gastrostomy tube]." The physician orders also instructed the nursing staff to "Flush feeding tube with 25 mls of water each hour."		resident? The physician has been notified relative to the delivery ofthe enteral feeding and medications. How will others with the potential to be affected be identified? Residents receiving enteral feedings or medications providedby the Pharmacy have the potential to be affected. Those resident records will be audited toensure that pharmacy provided medications and enteral feeding are available as ordered. What measures will be put in place to prevent recurrence? Nurses will receive re-education regarding Facility policy and procedure for physician notification. Admission documents, 24 hour report sheets and physician orders will be reviewed by the clinical Management team to ensure timely physician notification. Who will monitor The Director of Nursing or her designee will audit 30% of resident records to ensure timely physician notification weekly x 4 weeks, then 30% of resident records every 2 weeks for 12 weeks and then 30% monthly for 3 months. Audit results will be referred to the Quality Assurance Committee for review and recommendations.	

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	A hand written notation to the pharmacy indicated "Send 8 - 237 mls. cans of Nova Source Renal." A review of the Admission Nursing notes, dated 04-01-15 at 5:15 p.m., indicated the "resident is NPO [nothing by mouth]. Has G/T [gastrostomy tube] in RLQ [right lower quadrant] of abdomen." A review of the Nutrition Assessment, dated 04-02-15, indicated the following: "04-02-15 - 2:15 p.m. - This writer was called by night nurse about 5:53 a.m. this date. Nurse stated res. [resident] admitted last night with Rx. [prescription] for Nova Source Renal TF [tube feeding]. Stated no TF sent and res. went all night without it. This writer arrived at facility about 7:00 a.m. and spoke with nurse again who stated that she had called pharmacy re: [regarding] TF and did not get an answer on if they had it in stock. Approx. [approximately] 8:20 a.m. - DON [Director of Nurses] arrived at facility and this writer spoke to her about TF not sent from pharmacy." A review of the nurses notes lacked documentation the physician had been notified of the resident's lack of nutrition via the enteral feeding during the night by			

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	the nursing staff. Further review of the residents record contained a physician order dated 04-02-15, which indicated "Pancrelipase [an enzyme] 6000 mg [milligrams] per JT to declog one time only and Sodium Bicarbonate [a alkalinizer medication] 650 mg 1 tablet per JT to declog one time only Please send STAT." A subsequent physician order, dated 04-03-15, repeated the above order to the Pharmacy. The next order, also dated 04-03-15 indicated "Clarification: D/C [discontinue] Pancrelipase order - Viokase [an enzyme] for declogging J-tube STAT." During an interview on 04-22-15 at 1:00 p.m., the Director of Nurses indicated the pharmacy "only sent the Bicarb.[Sodium Bicarbonate the first time." A review of the Pharmacy delivery receipt, dated 04-02-15 at 8:18 p.m., indicated the receipt of "one - Sodium Bicarb 650 mg tablet." A review of the Pharmacy delivery receipt, indicated the facility did not receive and the medication was not instilled into the resident's feeding tube until 04-03-15.			

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	The record lacked immediate physician notification the pharmacy was unable to fill the prescription as written. A review of the facility policy on 04-22-15 at 2:25 p.m., titled "Medication and Treatment Order Guidelines," and dated 03-04-04, indicated the following: "Purpose - To ensure that residents receive medications/treatments as ordered by his/her physician." "Procedure - 1. The licensed nurse is responsible for clarification of all orders that may lead to an error. 2. The licensed nurse will contact the resident's health practitioner to verify/confirm any order that is unclear. New orders involving changes in dose, strength and/or time should be compared with the previous order for appropriateness/accuracy. This Federal tag relates to the Investigation of Complaint IN00171807. 3.1-5(a)			
F 328 SS=D Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the			

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	following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on record review and interview the facility failed to ensure a resident received proper treatment and the necessary specialized care in regard to enteral feeding and hydration needs, in that when a resident had specific orders for enteral nutrition, the resident did not receive the nutrition or hydration needs as ordered for 1 of 2 resident's reviewed with gastrostomy feeding tube in a sample of 3. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 04-22-15 at 10:00 a.m. Diagnoses included, but were not limited to, abnormal weight loss, muscle weakness, congestive heart failure and Parkinson's disease. The resident had a percutaneous endoscopic gastrostomy feeding tube noted upon admission to the facility. At the time of admission, the resident had physician orders, dated 04-01-15, which included Nova Source Renal formula to	F 328	F 328 What corrective action put in place for the affected resident Enteral feedings and ordered flushes are being administeredin accordance with Physician orders. How will others with the potential to be affected beidentified Residents receiving enteral feedings have the potential tobe affected. Those residents will bereviewed to ensure that orders are in place, orders are being followed relativeto flushes and that the ordered enteral feeding is available. What measures will beput in place to prevent recurrence Nurses will be reeducated on facility policy entitled"Enteral Nutrition guidelines" Who will monitor The Director of Nursing or her designee will audit residentrecords for those residents receiving enteral feedings to ensure that enteralfeedings and flushes are completed according to Facility Policy and physicianorder weekly x 4 weeks, then every 2weeks for 12 weeks and then monthly for3	05/15/2015

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	be infused through the feeding tube at 25 mls. (milliliters) per hour for 22 hours continuous via pump/GT (gastrostomy tube). The physician orders also instructed the nursing staff to "Flush feeding tube with 25 mls of water each hour." A hand written notation to the pharmacy indicated "Send 8 - 237 mls. cans of Nova Source Renal." A review of the Admission Nursing notes, dated 04-01-15 at 5:15 p.m., indicated the "resident is NPO [nothing by mouth]. Has G/T [gastrostomy tube] in RLQ [right lower quadrant] of abdomen." A review of the resident's plan of care, dated 04-01-15, indicated the resident "Required a GT due to CVA [cerebral vascular accident], dysphagia, GT, JT." Interventions to this plan of care included, "Provide nutrition, flushes and route per MD [Medical Doctor] order. Monitor for residual and tolerance to enteral fdg. [feeding]. Monitor site for s/s [signs and symptoms] of adverse effects of formula, diarrhea, hypo/hyperglycemia, change in stool color, weight gain/loss, nausea/vomiting and s/s of dehydration."		months. Audit results will be referredto the Quality Assurance Committee for review and recommendations.	

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	A review of a subsequent plan of care, dated 04-01-15 also indicated the resident was at "Risk for dehydration related to feeding tube." Interventions included medications as MD order, monitor skin turgor, mucous membranes and urine. Provide dietary intervention as needed to maintain adequate hydration." A review of the Nutrition Assessment, dated 04-02-15, indicated the following: "04-02-15 - 2:15 p.m. - This writer was called by night nurse about 5:53 a.m. this date. Nurse stated res. [resident] admitted last night with Rx. [prescription] for Nova Source Renal TF [tube feeding]. Stated no TF sent and res. went all night without it. This writer arrived at facility about 7:00 a.m. and spoke with nurse again who stated that she had called pharmacy re: [regarding] TF and did not get an answer on if they had it in stock. Approx. [approximately] 8:20 a.m. - DON [Director of Nurses] arrived at facility and this writer spoke to her about TF not sent from pharmacy." A review of the "Enteral Fluids Flow Sheet" dated April 2015, indicated the resident did not receive enteral nutrition from the time of admission on 04-01-15 at 5:15 p.m. until the following day - April 3, 2015, during the day shift (7:00 a.m. - 3:30 p.m.), and received 287 mls.			

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	of the enteral feeding and the prescribed water flush. In addition, although the resident did not received the enteral nutrition as ordered by the physician, the nursing failed to provide any hydration to the resident until the pharmacy provided the enteral feeding the following day. A review of the facility policy on 04-22-15 at 2:25 p.m., titled "Enteral Nutrition Guidelines," and dated 03-15-12, indicated the following: "Purpose" A feeding tube is used to deliver a liquid feeding formula directly to the stomach, duodenum or jejunum. This applies to both nasogastric and gastrostomy tube feedings. A feeding tube is used to attempt to maintain or improve nutritional and hydration parameters." "Fundamental Information - Enteral feedings are typically indicated for the resident who cannot eat normally because of dysphagia, oral or esophageal obstruction or injury. They are also given to the resident who is unconscious, intubated, or who cannot ingest food orally or no other viable alternative to maintain nutrition and/or hydration is possible. Medical conditions that results			

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	in impairment of the resident's ability to maintain appropriate for: nutritional status, comfort level desire for prolongation of resident's life, hydration parameters." "Procedure: 21. The nurse contacts the physician to discuss and receive orders when complications from or intolerance to enteral feedings and/or inadequate progress toward goals is identified." This Federal tag relates to the Investigation of Complaint IN00171807. 3.1-47(a)(2)			
F 425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview the facility failed to ensure a resident received timely pharmaceutical medication and enteral feeding via a percutaneous endoscopic gastrostomy feeding tube, in that when a resident had specific orders for enteral nutrition and subsequent medication intervention related to the malfunction of the feeding tube the resident did not receive the nutrition/hydration or medication needs as ordered for 1 of 2 resident's reviewed with a gastrostomy feeding tube in a sample of 3. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 04-22-15 at 10:00 a.m. Diagnoses included, but were not limited to, abnormal weight loss, muscle weakness, congestive heart failure and Parkinson's disease. The resident had a percutaneous endoscopic gastrostomy feeding tube noted upon admission to the facility. At the time of admission, the resident had physician orders, dated 04-01-15, which included Nova Source Renal formula to	F 425	F 425 What corrective action will be put in place for the affectedresident. Enteral feedings and medications have been provided inaccordance with physician orders. How will others with the potential to be affected beidentified? Residents receiving tube feedings or medications provided bythe Pharmacy have the potential to be affected. Those resident records will be audited to ensure that pharmacy providedmedications and tube feeding are available as ordered. What measures will be put in place to prevent recurrence? Nurses will receive re-education regarding Facility policyand procedure for physician notification and facility policy when there is adelay in the delivery of medications or enteral feedings. Admission documentsand physician orders will be reviewed by the clinical Management team toensure that ordered medications orenteral feedings are available. Who will monitor The Director of Nursing or her designee will audit 30% ofresident records to ensure medications and/or enteral feedings are delivered ina timely manner weekly	05/15/2015

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	be infused through the feeding tube at 25 mls. (milliliters) per hour for 22 hours continuous via pump/GT (gastrostomy tube). The physician orders also instructed the nursing staff to "Flush feeding tube with 25 mls of water each hour." A hand written notation to the pharmacy indicated "Send 8 - 237 mls. cans of Nova Source Renal." A review of the Admission Nursing notes, dated 04-01-15 at 5:15 p.m., indicated the "resident is NPO [nothing by mouth]. Has G/T [gastrostomy tube] in RLQ [right lower quadrant] of abdomen." Further review of the residents record contained a physician order dated 04-02-15, which indicated "Pancrelipase [an enzyme] 6000 mg [milligrams] per JT to declog one time only and Sodium Bicarbonate [an alkalinizer] 650 mg 1 tablet per JT to declog one time only Please send STAT." A subsequent physician order, dated 04-03-15, repeated the above order to the Pharmacy. The next order, also dated 04-03-15 indicated "Clarification: D/C [discontinue] Pancrelipase order - Viokase [an enzyme] for declogging J-tube STAT."		x 4 weeks, then 30% of resident records every 2 weeksfor 12 weeks and then 30% monthly for 3 months. Audit results will be referred to the Quality Assurance Committee forreview and recommendations.	

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	A review of the Pharmacy delivery receipt, dated 04-02-15 at 20:18 (8:18 p.m.), indicated the receipt of "one - Sodium Bicarb 650 mg tablet." A review of the Pharmacy delivery receipt, indicated the facility did not receive and the medication was not administered to the resident until 04-03-15. During an interview with the Director of Nurses on 04-02-15 at 1:00 p.m., indicated, the order for the "Pancrelipase was written and sent to the pharmacy. The one thing they sent was the Bicarb. Then we found out they did not have the Pancrelipase and they used something else - which was the Viokase. The delivery of the Sodium Bicarb. and Viokase were delivered the following day around 11:30 a.m. and instilled into the resident's feeding tube around 12:30 p.m. A review of the Nutrition Assessment, dated 04-02-15, indicated the following: "04-02-15 - 2:15 p.m. - This writer was called by night nurse about 5:53 a.m. this date. Nurse stated res. [resident] admitted last night with Rx. [prescription] for Nova Source Renal TF [tube feeding]. Stated no TF sent and res. went all night without it. This writer arrived at facility about 7:00 a.m. and			

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NAME OF PROVIDER OR SUPPLIER FORUM AT THE CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240	

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	spoke with nurse again who stated that she had called pharmacy re: [regarding] TF and did not get an answer on if they had it in stock. Approx. [approximately] 8:20 a.m. - DON [Director of Nurses] arrived at facility and this writer spoke to her about TF not sent from pharmacy. DON stated it was faxed last night. This writer called PRN pharmacy and they stated TF had just been sent out to facility - Nova Source Renal TF. This writer then wrote order for Nova Source Renal once it arrived. Writer contacted RD [Regional Dietician]. I explained all events that took place." During an interview with the facility Dietician on 04-22-15 at 2:00 p.m., indicated "The resident didn't receive the tube feeding as ordered. I consulted with the Regional dietician and recommended Osmolyte and calculated fluids. When we completed the calculations the pharmacy called and said the Nova Source Renal was on the way. I think it got here around 9:00 a.m., but I can't be sure." Subsequent interview with the Director of Nurses at 2:15 p.m., the Director of Nurses provided documentation/communication she had with the Pharmacy related to the issue of the resident's enteral feeding. The			

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
	155294		04/22/2015

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	documentation indicated the following: "04-02-15 at 10:21 a.m. - Resident arrived at approximately 1800 [6:00 p.m.]. My staff transcribed and verified and even called the pharmacy to ask about the interchange for a specific feeding. They sent over the STAT order at approximately 1816 [6:16 p.m.] as stamped on the fax [facsimile] confirmation. Around 0230 [2:30 a.m.] my staff phoned the pharmacy inquiring about the status of the pts. [patients] medication. She was then left on 'hold' with the Customer Service representative - not returning to the line. At 0430 [4:30 a.m.] my staff phoned the pharmacy again inquiring about the medication just to be told they are in route. At 0615 [6:15 a.m.] the STAT medication arrived. Again we have a delivery problem along with a communication problem. This patient went the entire night without feeding because of this." This Federal tag relates to the Investigation of Complaint IN00171807. 3.1-25(a)			