

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/29/2015
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NAME OF PROVIDER OR SUPPLIER BROOKDALE PORTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3444 SWANSON RD PORTAGE, IN 46368
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(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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: December 28 and 29, 2015</p> <p>Facility number: 010889 Provider number: 010889 AIM number: N/A</p> <p>Residential census: 28</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 26143, on January 3, 2015.</p>	R 0000	<p>Plan of correction is not to be construed as an admission of or agreement with finding and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation on our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy the objective.</p>	
R 0217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</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;</p>			

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

TITLE

(X6) DATE

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

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	<p>(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 ensure residents' Service Plans were updated related to coordination of care with Home Health services for 3 of 7 residents whose records were reviewed. (Residents #2, #3, and #4)</p> <p>Findings include:</p> <p>1. Resident #3 ' s record was reviewed on 12/28/15 at 11:45 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, depressive disorder, and basal cell carcinoma.</p>	R 0217	<p>What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>·The residents affected were reviewed. Where necessary, the Personal Service Plans were updated by the Health and Wellness Director (HWD)/ Designee to reflect their Hospice status and Home Health Services.</p> <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <p>·Other Hospice/ Home Health residents have the</p>	01/08/2016			

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	<p>A Physician ' s Order dated 11/13/15 indicated, " Home health, wound care. "</p> <p>The Home Health Certification and Plan of Care dated 11/13/15 indicated wound care treatments were to be performed by a skilled nurse twice weekly.</p> <p>A Service Plan dated 9/12/15 lacked documentation of Home Health services for wound care in the Service Coordination section.</p> <p>A phone interview with the Health and Wellness Director (HWD) on 12/28/15 at 2:55 p.m. indicated Home Health for wound care should have been added to the Service Plan.</p> <p>2. The record for Resident #2 was reviewed on 12/29/15 at 8:40 a.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and anemia.</p> <p>Review of the resident ' s chart, indicated (name of company) home health services began on 12/19/15 with a skilled nurse and a physical therapist.</p> <p>Review of the resident ' s current Service Plan dated 7/26/15, lacked an indication of home health services under " Service</p>		<p>potential to be effected by the alleged deficient practice.</p> <ul style="list-style-type: none"> -The HWD/Licensed Nurse Designee will complete an audit of all current Hospice/ Home Health residents to verify the accuracy of their Personal Service Plan. <p>What measures will be put inplace or what systemic changes will the facility make to ensure the deficient practice does not recur?</p> <ul style="list-style-type: none"> -The HWD and Executive Director (ED) were re-educated by the District Director of Clinical Services on the requirement to complete a"Change of Condition" re-assessment or "Data Correction"Service Plan whenever Hospice, Home Health or other third-party services are initiated and/ or discontinued. -The ED will complete a final review of all Personal Service Plans prior to locking and reviewing with residents and responsible parties. <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> -Collaborative Care Meetings will be held twice monthly to review the status of each resident. -Home Health and Hospice Providers will be consulted at the time to verify the status of the certification. -This information will be communicated to the HWD/ED during these meetings so that the Personal Service Plan may be 				

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	<p>Coordination. "</p> <p>An interview with the HWD (Health and Wellness Director) on 12/29/15 at 11:45 a.m., indicated Service Plans are updated every 6 months and/or with a change of condition. Resident #2 ' s plan was not updated with the home health.</p> <p>3. The record for Resident #4 was reviewed on 12/28/15 at 10:15 a.m. Diagnoses included, but were not limited to, Alzheimer ' s, anxiety, hypertension (high blood pressure) and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>A Physician ' s Order dated 6/17/15 indicated skilled nurse, physical therapy, occupational therapy and a home health aide with the diagnosis of pain and COPD. A Physical order for (name of company) Hospice to evaluate and treat was dated 12/3/15.</p> <p>Review of the resident ' s current service plan dated 7/3/15, lacked an indication of home health services and for hospice services under " Service Coordination. "</p> <p>A policy titled, " Personal Service Plan, " was provided by the HWD on 12/29/15 at 12:15 p.m. This current policy indicated, " ...2. The Service Plan will</p>		<p>updated with such changes.</p> <p>·The HWD/ED will be responsible for checking twice monthly that updates have been completed to accurately reflect resident status.</p> <p>By what date the systemic changes will be completed?</p> <p>· January 08, 2016</p>				

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R 0241 Bldg. 00	<p>be reviewed and revised as necessary: Following a change in the condition of the resident that results in altered care needs over a period of greater than two weeks "</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure a Physician 's Order was acted upon for a UA (Urinalysis) lab for 1 of 7 resident's records who were reviewed for Physician Orders. (Resident #2)</p> <p>Finding includes:</p> <p>The record for Resident #2 was reviewed on 12/29/15 at 8:40 a.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and anemia.</p> <p>Review of a Physician 's Order dated</p>	R 0241	<p>What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <p>·For affected resident, the physician was notified and did not want UA repeated.</p> <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <p>·A lab record audit will be completed by the Health and Wellness Director.</p> <p>What measures will be put in place or what systemic changes will the facility make</p>	01/22/2016

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R 0273 Bldg. 00	<p>11/30/15 indicated a new order: UA with C & S (Culture and Sensitivity).</p> <p>Review of the resident 's labs from August to present lacked an indication that the UA was completed as ordered. A urine culture dated 12/2/15, indicated as the final report of no growth.</p> <p>Interview with the HWD (Health and Wellness Director) on 12/29/15 at 9:45 a.m., indicated the facility should have caught that error that the UA was not completed.</p> <p>The policy titled, " Physician/Healthcare Provider ' s Orders, " was provided by the HWD on 12/29/15 at 12:15 p.m. This current policy indicated, " ...Policy Detail: ...3. Unless noted otherwise, orders should be implemented within 24 hours ... "</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p>	R 0273	<p>to ensure the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Nursing staff was re-educated on the need to verify all ordered labs are completed and results are communicated with physician. This re-education was provided on 01/22/2016. <p>How will the correctiveactions be monitored?</p> <ul style="list-style-type: none"> ·Health and Wellness Director will perform weekly audits on all labs performed. ·A log will be kept of audits performed. ·The ED will review the log on a periodic basis to verify completion. <p>By what date the systemic changes will be completed?</p> <ul style="list-style-type: none"> · January 22, 2016 <p>What corrective actions(s)will</p>	01/25/2016			

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	<p>Based on observation, interview and record review, the facility failed to ensure a sanitary environment for the kitchen and dining services related to open spices and sugar containers, food was unlabeled and undated in the freezer and uncovered beverages on 1 of 2 room trays. The facility also failed to properly sanitize the puree blender and the temperature probe, this had the potential to affect 2 of 2 residents that receive purees. (Main Kitchen)</p> <p>Findings include:</p> <p>1. During the initial kitchen tour on 12/28/15 at 9:20 a.m. with the DSC (Dining Service Coordinator), the following was observed:</p> <p>a. In the freezer, 2 bags of frozen peas were unlabeled and lacked an open date.</p> <p>b. In the dry storage area, a clear, plastic container of sugar was open and exposed to air.</p> <p>c. In a kitchen cabinet, the lids to these spices were open and exposed to the air; Whole Cloves, Fish and Seafood, Thyme, and White Pepper. A container of Rainbow Sprinkles was also opened and exposed to the air.</p>		<p>be accomplished for those residents found to have been affected by the alleged deficient practice</p> <ul style="list-style-type: none"> ·The actions taken to ensure no other residents were affected by these deficient practices are as follows. An in-service was given to all staff regarding 1, a) b) & c) ·R273 1. a) Both freezer and refrigerators were immediately inspected to ensure all open packages were labeled appropriately and dated to ensure all packages were appropriately labeled. ·R273 1. b) An in-service was given on proper coverage of food containers to ensure proper coverage. ·R273 1. c) The same in-service to staff covers any other dry food items or spices being open and exposed to air. ·R273 2. a) An in-service was given to all dietary staff to ensure they know how to properly clean the puree blender and all other items washed in the High Temp Dishwasher at a rinse cycle of 180 degrees. (Please see attached in-service) ·R273 2. b) The staff was in-serviced on the proper cleaning of the temperature probe as per policy. (Please see attached in-service) ·R273 3. The staff was immediately in-serviced on proper procedure of covering room trays. <p>How will the facility identify other residents with the</p>	

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	<p>2. During the second kitchen visit on 12/28/15 at 12:27 p.m., the following was observed:</p> <p>a. The sanitation of the puree blender.</p> <p>Cook #1 pureed the ribs, removed the meat from the blender, rinsed the blender with the water sprayer in the sink, place the blender and the blade on a pallet, placed pallet in the dishwasher and then removed blender and blade after the dishwasher cycles were complete. The dishwasher rinse cycle was 170 degree Fahrenheit. He then proceeded to puree the baked potatoes. After the completion of the puree of the baked potatoes, Cook #1 again rinsed the blender with the water sprayer at the sink and placed the blender and the blade on a pallet and placed in the dishwasher. The dishwasher rinse cycle was 174 degrees Fahrenheit. He then removed the blender and blade from dishwasher after the dishwasher cycles were complete, and then proceeded to the next puree.</p> <p>An interview with the DSC on 12/28/15 at 2:45 p.m., indicated the dishwasher is a high temp machine and the rinse cycle should have been 180 degrees Fahrenheit.</p> <p>b. After the completion of the purees, Cook #1 took the temperatures of each</p>		<p>potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> ·The facility ensured no other resident would be affected by this deficient practice by ensuring all open freezer and refrigerated foods are labeled and dated appropriately. All dry food, spices, sugars etc. were immediately covered or thrown out. ·Immediate training was given on proper cleaning of food temperature probe and immediate training was given to all dietary staff regarding proper High Temperature Dish Machine procedures to ensure the High Temp Dish Washer reached the appropriate 180 degree temperature. ·All dietary staff was in-serviced on the proper procedures. (Please see attached in-services) <p>What measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The measures put in place to ensure the deficient practice does not recur will consist of the Executive Director and the dietary manager will monitor daily for two weeks to ensure all freezer and refrigerator products, all spices, all dry foods etc. will be properly stored, labeled and covered. ·All temperature probes will be cleaned according to policy and 		

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	<p>pureed food on the individual plates for the 2 residents. The first plate, Cook #1 picked up the thermometer probe that was located on the countertop, placed the probe in the puree baked potatoes, wiped the probe on a clean cloth from the drawer, then placed the probe in the ribs, wiped on the probe on the same cloth as the baked potatoes, and then placed the probe in the spinach. That plate was served to a resident. Cook #1 then wiped the thermometer probe with a cloth that was sitting in the sanitation bucket. He then proceeded to place the probe into the 2nd plate of pureed foods, and wiped the probe with the same cloth that was used for the 1st plate of food between each food. The 2nd puree plate was served to the resident.</p> <p>Interview with Cook #1 on 12/28/15 at 2:40 p.m., indicated he should have used an alcohol wipe to cleanse the thermometer probe at the beginning and between each food when the temperatures were taken.</p> <p>The policy titled, " Sanitation & Food Safety, " was provided by the DSC on 12/29/15 at 11:30 a.m. This current policy indicated, " ...Food Storage and Labeling: All stored foods must be covered and labeled with initials, product name, date, time and discard dated using</p>		<p>the expected 180 degrees will be used with the High Temp Dish machine.</p> <ul style="list-style-type: none"> ·Ongoing monitoring will occur by ED and DSM. <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> ·The monitoring and quality assurance system will consist of the Executive Director, the Dietary Manager and/or the Dietitian to monitor all the above for two weeks of daily monitoring for each meal. Then weekly for two months for each meal. ·Thereafter, monitoring will continue for random checks monthly, for each meal to ensure the deficient practice does not recur. The random monthly monitoring will include breakfast, lunch, and dinner through the quality assurance with the Executive Director, the Dietary Manager, and / or the Dietitian throughout time. <p>The following to be monitored include:</p> <ul style="list-style-type: none"> ·Proper labeling of all open food ·Proper storage of dry food containers ·Proper covering of dry foods, spices, ect. ·High temp dishwasher cycle at 180 degrees ·Proper cleaning of food temp probes per policy ·Proper covering of room trays <p>By what date the systemic changes will be completed?</p> <ul style="list-style-type: none"> · January 25, 2016 	

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	<p>approved Day dot labels "</p> <p>The policy titled, " 7.19 machine Ware Washing Temperatures, " was provided by the DSC on 12/29/15 at 11:30 a.m. This current policy indicated " ...High temp dish machines: wash cycle shall be at or above 165 F (Fahrenheit) and the rinse cycle is at or above 180 F "</p> <p>The policy titled, " 7.17 Thermometers, " was provided by the DSC on 12/29/15 at 11:30 a.m. This current policy indicated, " ...Thermometers shall be sanitized using alcohol swabs prior, in-between and after each. (sic) "</p> <p>3. During lunch service on 12/28/15 at 1:10 p.m., RCA (Resident Care Assistant) #1 was observed carrying a lunch tray down the hall with uncovered lemonade and coffee. She set the tray down on a table at the end of the hall, picked up a covered plate, and delivered it to the resident in Room 512. She exited the room, picked up the tray including the uncovered drinks, and proceeded to walk with the tray towards Room 405.</p> <p>Interview with RCA #1 at the time of the observation, indicated the drinks should have been covered coming out of the kitchen and she would go dump those</p>			

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R 0298 Bldg. 00	<p>two drinks and return to the resident ' s room with covered drinks.</p> <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 record review and interview the facility failed to ensure the consulting pharmacist reviewed the drug regimen of each resident receiving those services at least once every 60 days for 4 of 7 residents whose records were reviewed. (Residents #2, #3, #4, and #8)</p> <p>Findings include:</p> <p>1. Resident #3 ' s record was reviewed on</p>			R 0298	<p>What corrective actions(s)will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <ul style="list-style-type: none"> Remedi Pharmacy was informed of the need to replace current pharmacy review form which states "All Residents Reviewed" to providing an individualized list. <p>How will the facility identify other residents with the potential to be affected by the</p>		12/30/2015

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	<p>12/28/15 at 11:45 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, depressive disorder, and basal cell carcinoma.</p> <p>Review of the Pharmacy Log book from February 2015 until present lacked documentation Resident #3 's medications were reviewed and no recommendations were indicated.</p> <p>Review of the Physician 's Order Summaries from June 2015 until present lacked indication the pharmacist had reviewed the medications for the resident.</p> <p>Interview with the Executive Director (ED) on 12/28/15 at 1:20 p.m., indicated she had spoken with the pharmacy and the pharmacist reviewed all residents each month, but there was no documentation of which residents were specifically residing in the building and reviewed on the pharmacist visit day each month.</p> <p>Interview with the Health and Wellness Director (HWD) on 12/29/15 at 11:50 a.m. indicated she was not aware the pharmacy did not provide resident-specific medication review documentation or that it was necessary and would speak with the pharmacy.</p>				<p>same alleged deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> ·Remedi Pharmacy will provide and individualized roster of residents reviewed every sixty days. <p>What measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Health and Wellness Director to ensure an individualized list is sent along with individual pharmacy recommendations. <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> ·Health and Wellness Director and ED to review pharmacy reviews every 60 days. <p>By what date the systemic changes will be completed?</p> <ul style="list-style-type: none"> · December 30, 2016 		

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	<p>2. Resident #8 's closed record was reviewed on 12/29/15 at 9:25 a.m. Diagnoses included, but were not limited to, dementia with behaviors, depression, hypertension, anemia, arthritis, congestive heart failure, pneumonia, and anxiety.</p> <p>Review of the Pharmacy Log book from February 2015 until she was discharged to the hospital on 12/26/15 lacked indication Resident #8 's medications were reviewed and only August 2015 had a pharmacy recommendation given.</p> <p>Review of the Physician 's Order Summaries from June 2015 until she was discharged to the hospital on 12/26/15 lacked indication the pharmacist had reviewed the medications for the resident.</p> <p>Interview with the Executive Director (ED) on 12/28/15 at 1:20 p.m., indicated she had spoken with the pharmacy and the pharmacist reviewed all residents each month, but there was no documentation of which residents were specifically residing in the building and reviewed on the pharmacist visit day each month.</p> <p>Interview with the Health and Wellness Director (HWD) on 12/29/15 at 11:50</p>			

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	<p>a.m. indicated she was not aware the pharmacy did not provide resident-specific medication review documentation or that it was necessary and would speak with the pharmacy.</p> <p>3. The record for Resident #2 was reviewed on 12/29/15 at 8:40 a.m. The resident 's move in date was 6/26/15. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and anemia.</p> <p>Review of the Pharmacy log book from July through present, lacked an indication of Resident #2 's medications were reviewed by a Pharmacist and only August had a Pharmacy Recommendation.</p> <p>Review of the Physician Order Summary ' s (POS) from July until present, lacked an indication of Resident #2 's medications were reviewed by a Pharmacist.</p> <p>Interview with the Executive Director (ED) on 12/28/15 at 1:20 p.m., indicated she had spoken with the pharmacy and the pharmacist reviewed all residents each month, but there was no documentation of which residents were specifically residing in the building and reviewed on the pharmacist visit day each</p>			

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	<p>month.</p> <p>Interview with the Health and Wellness Director (HWD) on 12/29/15 at 11:50 a.m. indicated she was not aware the pharmacy did not provide resident-specific medication review documentation or that it was necessary and would speak with the pharmacy.</p> <p>4. The record for Resident #4 was reviewed on 12/28/15 at 10:15 a.m. The resident moved into the facility on 6/3/15. Diagnoses included, but were not limited to, Alzheimer ' s, hypertension (high blood pressure), anxiety, COPD (Chronic Obstructive Pulmonary Disease).</p> <p>Review of the Pharmacy log book from July through present, lacked an indication of Resident #4 's medications were reviewed by a Pharmacist.</p> <p>Review of the Physician Order Summary ' s (POS) from July until present, lacked an indication of Resident #4 's medications were reviewed by a Pharmacist.</p> <p>Interview with the Executive Director (ED) on 12/28/15 at 1:20 p.m., indicated she had spoken with the pharmacy and</p>			

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R 0349 Bldg. 00	<p>the pharmacist reviewed all residents each month, but there was no documentation of which residents were specifically residing in the building and reviewed on the pharmacist visit day each month.</p> <p>Interview with the Health and Wellness Director (HWD) on 12/29/15 at 11:50 a.m. indicated she was not aware the pharmacy did not provide resident-specific medication review documentation or that it was necessary and would speak with the pharmacy.</p> <p>The policy titled, " Coordination of Services with Outside Agencies, " was provided by the HWD on 12/29/15 at 12:15 p.m. This current policy indicated, " ...Outside providers who provide services to residents will supply documentation of services delivered for the resident ' s record "</p> <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</p>						

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	<p>follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain complete and accurately documented records related to missing and conflicting Physician 's Orders pertaining to the collaboration of services for wound care and catheter treatment with Home Health for 2 of 7 residents whose records were reviewed. (Residents #3 and #6)</p> <p>Findings include:</p> <p>1. Resident #3 's record was reviewed on 12/28/15 at 11:45 a.m. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, depressive disorder, and basal cell carcinoma.</p> <p>A facility written verbal Physician ' s Order dated 11/13/15 at 8:00 p.m. and signed off by the Physician indicated, " Cleanse abrasion to L (left) mid back [with] NS (Normal Saline), pat dry. Apply Polymem and secure [with] Tegaderm q (every) 5 days et (and) PRN (as needed) if soiled or detached. " This order was also noted on the Physician ' s Order Summary (POS) for December</p>	R 0349	<p>What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <ul style="list-style-type: none"> ·An immediate audit of all third parties services to ensure accuracy and are communicated upon every visit and are accurately noted in the clinical record. <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> ·HWD to audit charts to ensure accuracy noted in clinical record. <p>What measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Third parties providers will be informed of the need to provide documentation of all services delivered for resident's records. <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> ·Health and Wellness Director will review third party log weekly to ensure documentation of services delivered are being completed. <p>By what date the systemic</p>	01/22/2016			

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	<p>2015.</p> <p>The Home Health Certification and Plan of Care dated 11/13/15 indicated a Physician 's Order for, "Skilled nurse to perform/ teach wound care to basal cell CA (cancer) to left flank, cleanse with NS, apply triple antibiotic ointment, cover with Band-Aid, using clean/ aseptic technique. 2 x week (twice weekly) and prn "</p> <p>A Physician 's Order dated 12/11/15 indicated, "Discontinue wound care."</p> <p>Review of the upcoming POS for January 2015, signed off as checked by LPN #2 on 12/27/15, lacked any wound treatment orders.</p> <p>A Physician 's Verbal Order printout brought to the facility and provided by the Director of Home Health on 12/29/15 at 10:00 a.m. was dated 11/18/15 and indicated, "Cleanse wound to back with NS, apply Bacitracin and cover with Allewyn. Change two times week and PRN if becomes soiled or dislodged."</p> <p>Interview with LPN #1 on 12/28/15 at 2:20 p.m. indicated she was unsure why the facility written orders did not match services being provided by Home Health, but knew they were treating Resident #3</p>		<p>changes will be completed?</p> <p>· January 22, 2016</p>	

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	<p>twice weekly for his wound care. She further indicated communication with Home Health staff was usually verbal, but they would occasionally write a note for any order changes to be called and clarified with the physician.</p> <p>Interview with the Director of Home Health on 12/28/15 at 3:45 p.m., indicated there was a communication issue between Home Health and the facility which needed to be addressed. The Home Health staff should have given a copy of any orders received to the facility for the residents' charts and should also have been checking the residents' charts for any new orders received by the facility. She further indicated she was unsure how the discrepancy between the different Physician Orders occurred, but Home Health followed the treatment orders they personally received.</p> <p>2. Resident #6 's record was reviewed on 12/28/15 at 3:30 p.m. Diagnoses included, but were not limited to, hypertension, osteoporosis, outlet obstruction due to BPH (benign prostatic hypertrophy), neurogenic bladder, and Foley (indwelling urinary) catheter.</p> <p>Review of Physician 's Orders since admission 12/1/15 lacked an order for</p>			

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	<p>any indwelling urinary catheter or catheter care.</p> <p>Review of the Service Plan indicated the resident had an indwelling catheter, provide pericare, catheter care and empty catheter bag as needed. Coordination of services indicated the resident received Home Health services.</p> <p>A Home Health visit note dated 12/4/15 indicated, "Foley 16F (catheter size)/ 30 ml (milliliters) (bulb size). Pt. (patient) states it was changed on 11/30/15."</p> <p>Interview with the Health and Wellness Director (HWD) on 12/29/15 at 9:15 a.m. indicated Home Health does all catheter care including catheter changes and the facility staff only empties the catheter bag, which is included on the RCA (Resident Care Assistant) Care Profiles printed daily. She further indicated the Home Health Physician 's Orders should have been in the resident ' s chart and also added to the POS and MAR (Medication Administration Record).</p> <p>Follow up interview with the HWD on 12/29/15 at 9:45 a.m. indicated she had Home Health send over their orders, had written a verbal order in the resident 's chart, and also added the order to the upcoming POS at this time.</p>			

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R 0356 Bldg. 00	<p>A policy titled "Coordination of Services with Outside " was provided by the HWD on 12/29/15 at 12:15 p.m. and deemed as current. The policy indicated," Outsiders who provide services to residents will supply documentation of services delivered for the resident ' s record "</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to maintain a current</p>	R 0356	What corrective actions(s) will be accomplished for those	01/22/2016
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	<p>emergency file for 2 of 5 residents whose records were reviewed. (Residents #5 and #6)</p> <p>Findings include:</p> <p>1. Resident #5's record was reviewed on 12/28/15 at 10:15 a.m. Diagnoses included, but were not limited to, hypertension, hypothyroidism, coronary artery disease, depression, anxiety, and left hip fracture.</p> <p>Review of the facility's emergency binder lacked all information except a picture for Resident #5.</p> <p>Interview with the Executive Director (ED) on 12/28/15 at 2:30 p.m., indicated all residents should have had information posted in the emergency binder upon admission.</p> <p>2. Resident #6 's record was reviewed on 12/28/15 at 3:30 p.m. Diagnoses included, but were not limited to, hypertension, osteoporosis, outlet obstruction due to BPH (benign prostatic hypertrophy), neurogenic bladder, and Foley (indwelling urinary) catheter.</p> <p>Review of the facility's emergency binder lacked all information for Resident #6.</p>		<p>residents found to have been affected by the alleged deficient practice</p> <ul style="list-style-type: none"> The ED met with the HWD and documented the corrective action related to the proper technique of keeping the emergency book complete and readily available at all times. <p>What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice</p> <ul style="list-style-type: none"> No resident emergency forms will be pulled until ready to replace with an updated form, allowing the emergency book to be readily available when needed. <p>What measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur?</p> <ul style="list-style-type: none"> Health and Wellness Director created a new admission check list to be completed upon admission per nurse and will be reviewed by Health and Wellness Director. The Executive Director and the Health and Wellness Director will review each move in. <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> Health and Wellness Director and ED will monitor weekly. <p>By what date the systemic changes will be completed?</p>				

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	Interview with the Executive Director (ED) on 12/28/15 at 2:30 p.m., indicated all residents should have had information posted in the emergency binder upon admission.		· January 22, 2016				