

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 08/21/2012
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NAME OF PROVIDER OR SUPPLIER HEARTH AT JUDAY CREEK LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6330 N FIR RD GRANGER, IN 46530
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R0000	<p>This visit was for a State Licensure Survey. This visit included the Investigation of Complaint IN00111766.</p> <p>Complaint IN00111766 - Substantiated. State deficiencies related to the allegations are cited at R029 and R349.</p> <p>Survey dates: August 20 and 21, 2012</p> <p>Facility number: 012229 Provider number: 012229 AIM number: N/A</p> <p>Survey team: Janelyn Kulik, RN, TC Chris Greeney, QMRP</p> <p>Census bed type: Residential: 99 Total: 99</p> <p>Census payor type: Other: 99 Total: 99</p> <p>Sample: 11</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/27/12 by Suzanne</p>	R0000	<p>This plan of correction is submitted as required by law. It is not an admission of noncompliance; rather, it serves as the facility's credible allegation of compliance.</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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	Williams, RN				

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R0029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.</p> <p>Based on record review and interview, the facility failed to ensure a resident was treated with respect and dignity, related to assessing a resident without explaining to the resident what was going to be done, for 1 of 11 residents sampled (Resident #B).</p> <p>Findings included:</p> <p>Resident #B was interviewed on 8/20/12 at 3:45 p.m. She indicated in June she was sitting at her desk, and someone knocked once on her door and then just entered for apartment. Nurse #1 and CNA #2 came into the apartment indicating they wanted Resident #B. Resident #B indicated there was one on each side of her and they each grabbed one of her arms; it was like being restrained. She asked what they were doing, and told them to stop. She also indicated she could not move her arms. The staff told her they could not tell her what they were doing. She told them to let her go and to tell her what was going on, now. One of the staff members indicated they had been told there were black and blue marks all over her arms. The staff then called someone, and then</p>	R0029	<p>Nurse #1 and CNA #2 were counseled regarding resident rights and providing an explanation to the resident prior to performing an assessment or assisting with care. The CNA assignment sheets and service plan for Resident #B have been updated to notify staff to knock and wait until invited to enter the resident's apartment. Adult Protective Services conducted a mandatory Resident Rights & Abuse in-service on July 19 and 20, 2012 for all staff. They also conducted a meeting with the residents on the same topic on July 20, 2012. Continual monitoring for potential resident rights issues will take place on an individual basis, during department staff meetings, during daily stand-up meetings, and through the daily review of the 24 hour shift report. The Administrator and Director of Nursing will confer to review any alleged resident rights violation as they may occur. Results will be monitored and reviewed at the quarterly Quality Assurance meeting for continued compliance.</p>	09/08/2012			

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	<p>told her it was a mistake. She indicated she had informed the Administrator and told her she was upset. The Administrator indicated she would get back to her but all she was ever told was it was a mistake or misunderstanding.</p> <p>The resident's record was reviewed on 8/21/12 at 10:35 a.m. Her diagnoses included, but were not limited to, mild anemia, hypokalemia, hypertension, and vertigo.</p> <p>There was no documentation in the resident's records of the incident.</p> <p>Review of the resident's Assessment and Care Plan for Indiana Assisted Living Facilities, dated 11/10/11, indicated the resident's judgement and memory were good and she made sound decisions.</p> <p>Review of a Short Portable Mental Status Questionnaire (SPMSQ) dated 11/20/11, indicated a score of 0. A score of 0-2 indicated intact intellectual functioning.</p> <p>During interview with CNA #2 on 8/21/12 at 9:45 a.m., she indicated she had gone with Nurse #1 to be a witness to a resident with bruising. She did not know they were going to assess Resident #B, but thought her roommate. She was not in the room when Nurse #1 initially</p>						

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	<p>started talking to Resident #B. When she came in the room, she lifted the resident's arm in the palm of her hand, and she saw no bruising. The resident asked her what was going on, and she explained to the resident, they had been told she had some bruising and they needed to look at her arms. She further indicated she had not heard Nurse #1 explain what he was going to do to the resident, but she had not been in the room. She did indicate it appeared the resident did not know what was going on when she approached her to look at her arm.</p> <p>Interview with the Administrator on 8/21/12 at 10:25 a.m., indicated she was aware of the situation and that Resident #B came to her, and she was very upset. She never indicated she had been restrained. She indicated she spoke to staff and multiple staff had tried to apologize to the resident and explain they had assessed the wrong resident. She indicated the staff member who asked Nurse #1 to assess the resident does have an accent and the names of the residents are similar. It was a misunderstanding. When staff tried to explain and apologize, the resident did not believe that was what had happened.</p> <p>This State Residential finding relates to Complaint IN00111766.</p>						

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R0092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to ensure a fire and disaster drill was in conjunction with the local fire department at least every six months.</p> <p>Findings include:</p> <p>On 8/21/12 at 12:00 p.m. the fire drill inservices were reviewed for 2011 and January 2012 to July 2012. There was no indication the fire department had been involved in any of the fire drills or</p>	R0092	<p>The Administrator has contacted the local fire department and arranged for them to be present in the facility on September 11, 2012 for a fire drill. Going forward, a fire and disaster drill will be held in conjunction with the local fire department at least every six months.</p> <p>This will be monitored and reviewed at the quarterly Quality</p>	09/11/2012			

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	<p>inservices provided to the staff.</p> <p>Interview with the Administrator on 8/21/12 at 1:00 p.m., indicated the facility believes the fire department had been involved, but they had no documentation and could not indicate which drills or inservices the fire department would have conducted.</p> <p>Interview with the Director of Nursing on 8/21/12 at 2:30 p.m., indicated there was no additional information to provide in regard to the fire department being involved in any of the fire drill inservices.</p>		Assurance meeting for continued compliance.				

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R0241	<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 physician prescribed medications were administered as ordered by the physician for 1 of 11 sampled residents related to giving the proper dose of insulin (Resident #58).</p> <p>Findings include:</p> <p>The record of Resident #58 was reviewed on 8/20/12 at 12:45 p.m. His diagnoses, included, but were not limited to, diabetes mellitus.</p> <p>Review of the Physician Order Statement (POS) dated August 2012, indicated the following orders: Novolog (medication used for high blood sugars) inject 6 units subcutaneous twice a day (breakfast and lunch); hold if blood sugar is less than 80. Novolog inject 10 units subcutaneous every evening (dinner); hold if blood sugar less than 80. Novolog, if blood sugar between 60 and 80, give 3 units at breakfast and lunch.</p>	R0241	<p>The insulin orders for Resident #58 were clarified. Although the medication error was not discovered at the time of administration, the family and physician were notified upon discovery of the medication error. All insulin orders were reviewed for all residents to ensure accuracy of orders and administration. Nurses were immediately inserviced upon discovery of the medication error. The Director of Nursing or designee will review the medication administration record for all residents on sliding scale insulin weekly for six weeks and then quarterly thereafter. Results will be monitored and reviewed at the quarterly Quality Assurance meeting for continued compliance.</p>	09/08/2012			

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	<p>Novolog, if blood sugar between 60 and 80, give 4 units at dinner.</p> <p>The resident was to have his blood sugar checked before meals and at bedtime.</p> <p>Review of the Medication Administration Record for June 2012 and the Blood Glucose Monitoring Record, dated June 2012, indicated on 6/6/12 the resident's blood sugar was 78 at 8:00 a.m. The resident was not given any insulin and should have received 3 units of Novolog. On 6/18/12 at 8:00 a.m., the resident's blood sugar was 70. The resident received 6 units of Novolog and 3 units of Novolog. The resident should have only received 3 units of Novolog.</p> <p>Review of the Medication Administration Record for July 2012 and the Blood Glucose Monitoring Record dated July 2012, indicated on 7/5/12 at 8:00 a.m. the resident's blood sugar was 76. He was given 6 units of Novolog, and he should have received 3 units of Novolog.</p> <p>Interview with the Director of Nursing on 8/21/12 at 1:30 p.m., indicated she was not aware of the wrong insulin dose being given, and no additional information was provided.</p>						

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R0349	<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 record review and interview, the facility failed to ensure a resident's record was complete for 1 of 11 residents sampled, related to not documenting medication administration for a resident when his care giver was unable to provide medications (Resident #C).</p> <p>Findings include:</p> <p>The record of Resident # C was reviewed on 8/21/12 at 6:30 a.m. His diagnoses included, but was not limited to, dementia, atrial fibrillation (abnormal heart beat), cerebrovascular accident (CVA, stroke), coronary artery disease, hypercholesterolemia, osteoarthritis, and congestive heart failure.</p> <p>Review of the resident's record indicated there were no Medication Administration Records for April 2012.</p> <p>Review of the Assessment and Care Plan</p>	R0349	<p>Resident #C's wife currently oversees his medication administration.</p> <p>In a situation where the caregiver is unable to provide medication administration and staff is requested to assist with medication administration, per state regulations, the individual administering the medication shall document the administration in the individual's medication and/or treatment records that indicate time, name of medication or treatment, dosage (if applicable), and name or initials of the person administering the drug or treatment.</p> <p>The Director of Nursing or designee will ensure that a medication administration record is initiated and completed in the rare instance that a caregiver is</p>	09/08/2012			

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	<p>for Indiana Assisted Living Facilities dated 4/20/12, indicated the resident's wife sets up a weekly pill box and will oversee the resident receiving his medication. He was independent with medication management. He had cognitive function with short term memory which was fair since his stroke. His judgment and memory were generally good, but he needed monitoring and guidance.</p> <p>His Short Portable Mental Status Questionnaire (SPMSQ) dated 11/20/11, indicated he had moderate intellectual impairment.</p> <p>Interview with the resident's wife on 8/20/12 at 3:45 p.m., indicated in April of 2012 she went out of state and had Resident #C's medications set up. She informed staff that they were set up to ensure he received his medications. On the 4th day of her trip she received a call asking for permission to give the resident his medications. She indicated he went four days without his medication, and "I told them before I left." "I am so glad nothing happened."</p> <p>Interview with the Administrator on 8/21/12 at 1:00 p.m., indicated Resident #C's wife was on vacation in April, and she was not sure how or if Resident #C</p>		<p>unable to provide medication administration.</p> <p>Results will be monitored and reviewed at the quarterly Quality Assurance meeting for continued compliance.</p>				

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	<p>received his medication.</p> <p>Interview with the Director of Nursing on 8/21/12 at 1:30 p.m., indicated if Resident #C's wife was gone, the staff should give the resident his medication. She indicated since she became the Director of Nursing approximately a month ago she has put a system in place to ensure residents who self medicate could have their medications reconciled.</p> <p>Interview with the Director of Nursing on 8/21/12 at 2:30 p.m., indicated there had been a process to reconcile medications previous to her taking over and it was completed yearly. She further indicated she had no documentation Resident #C received his medications in April while his wife was out of town.</p> <p>This State Residential finding relates to complaint IN00111766.</p>						