

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: May 28, 29, 30, 31, and June 3, 2013</p> <p>Facility number: 010758 Provider number: 155662 AIM number: 200229550</p> <p>Survey team: Lara Richards, RN, TC Heather Tuttle, RN Caitlyn Doyle, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF: 75 SNF/NF: 16 Total: 91</p> <p>Census payor type: Medicare: 26 Medicaid: 10 Other: 55 Total: 91</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 7, 2013, by Janelyn Kulik, RN.</p>	F000000	<p>Preparation and/or execution of the plan of correction in general, or these corrective actions in particular, does not constitute an admission or agreement of Nursing Care at Hartsfield Village of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal laws. It is the intention of this facility that this plan of correction serves as the facility's credible allegation of compliance with all regulatory guidelines.</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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F000157 SS=D	<p>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).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Physician was promptly notified of blood sugars below 60 for 1 of 1 residents reviewed for</p>	F000157	1. For resident #9, the Diabetic Flow sheets were reviewed. The resident's attending Physician was notified of the resident blood sugar patterns and no new orders were received. Nurses	07/03/2013			

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	<p>Notification of Change. (Resident #9)</p> <p>Findings include:</p> <p>The record for Resident #9 was reviewed on 5/30/13 at 11:26 a.m. The resident's diagnoses included, but were not limited to, diabetes and hyperglycemia.</p> <p>Review of the May 2013 Physician's Order Summary (POS), indicated a Physician's Order dated 5/2/12, which indicated the resident's blood sugar was to be checked at 6:30 a.m. and 4:30 p.m. The Physician was to be called if the blood sugar was above 250.</p> <p>Review of the diabetic flow sheets for the month April 2013, indicated the resident's blood sugar on 4/6 at 4:00 p.m., was 45, on 4/22 at 4:00 p.m., was 54, on 4/26 at 6:00 a.m., was 53 and on 4/29/13 at 4:00 p.m., was 49.</p> <p>Review of Nursing Notes for the above mentioned dates, indicated there was no documentation of Physician notification of the blood sugars below 60.</p> <p>Review of the diabetic flow sheet for the month of May 2013, indicated the resident's blood sugar on 5/1 at 4:00</p>		<p>responsible for failure in following the Hypoglycemic reaction policy were promptly re-educated verbally by ADON with subsequent reinforcement later in writing on 6-19-13 and 6-20-13. Resident # 9 was not affected by this alleged deficient practice.2. The facility determined that all residents with orders for blood glucose monitoring had the potential to be affected by this alleged deficient practice. The nursing management team reviewed the physician orders for blood glucose monitoring and requested parameters for physician notification for resident # 9. The policy for physician notification in the absence of parameters will be added to the Diabetic Flow sheet to trigger the nurse to notify the physician of hypoglycemic episodes.3. The licensed nursing staff will be offered re-education on the facility policy Hypoglycemic reaction and Routine Diabetic Care. They will be encouraged to receive notification parameters for diabetic residents and made aware of the new notification trigger that will be in print on the Diabetic Flow sheets. In-service education was offered on 6-19-13 and 6-20-13 to review policy and new triggers put in place to aid in compliance with the policy. Any further noncompliance with policy will result in counselling of the staff</p>				

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	<p>p.m. was 44, and on 5/14/13 at 5:00 p.m., was 49.</p> <p>Review of Nursing Notes for the above mentioned dates, indicated there was no documentation of Physician notification of the blood sugars below 60.</p> <p>Review of the current and undated hypoglycemic reaction policy, indicated the Physician was to be notified when the resident's blood sugar was below 60 unless there were specific call parameters.</p> <p>Interview with the Second Floor Unit Manager on 5/31/13 at 2:30 p.m., indicated the resident's Physician was to be notified of blood sugars less than 60.</p> <p>3.1-5(a)(2)</p>		<p>up to and including termination of employment.4. The DON/ADON/Designee will audit the Diabetic Flow sheets 3 days per week for 4 weeks following education sessions with the licensed nurses. The DON/ADON/Designee will conduct random audits of 5 resident Diabetic flow sheets weekly for 4 weeks thereafter. Results will be brought to the QA nurse for review and/or recommendations monthly and to QAPI committee quarterly if continued compliance concerns.5. DON responsible.</p>		

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to use the least restrictive restraint before placing a resident in a geri chair for 1 of 3 residents reviewed for accidents of the 3 residents who met the criteria for accidents. (Resident #24)</p> <p>Findings include:</p> <p>On 5/29/13 at 1:00 p.m., Resident #24 was observed sitting in a geri chair in the dining room. The resident was sitting upright with her feet touching the floor. A personal alarm was attached to the resident and to the chair.</p> <p>At 1:17 p.m., the resident was sitting in a geri chair with her legs reclined in the up position in front of the Nurses' station. The resident was sitting upright with a personal alarm attached to her and to the chair.</p> <p>On 5/30/13 at 7:47 a.m. and 1:42 p.m., the resident was observed sitting in a geri chair with her legs reclined in the up position. The</p>	F000221	<p>1. Resident # 24 was in a Geri Chair as a trial for her comfort and positioning. A Physical Restraint assessment was completed as well as a consent received from the family and resident. The resident was not affected by this alleged deficient practice and appears very comfortable in the Geri chair as ordered. DON requested a therapy screen for seating and positioning evaluation to be completed for alternative recommendations. Orders were received to discontinue the use of the Geri Chair on 6-18-13. Therapy will continue to offer support for seating and positioning for resident #24. Resident #24 will be up in the High Back Wheelchair for mobility as tolerated.2. The facility determined that all residents have the potential to be affected by this alleged deficient practice. No other residents were affected following chart review for those residents in Geri chairs.3. Licensed nurses were offered re-training on the policy and regulations for Physical restraints on 6-19-13 and 6-20-13.</p>	07/03/2013	

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	<p>resident was sitting upright with a personal alarm attached to her and to the chair.</p> <p>On 5/31/13 at 9:46 a.m., the resident was observed sitting in a high back wheelchair in front of the Nurses' station. The resident was sitting upright with her feet touching the floor. The resident had a personal alarm attached to her and to the wheelchair. At 10:58 a.m., the resident was observed sitting in a high back wheelchair that was reclined. The resident had her right leg crossed over her left leg with her left leg resting on a foot pedal. At 2:47 p.m., the resident was sitting in a geri chair in front of the Nurses' station. The resident was sitting upright with her feet touching the floor. At that time, LPN #4 asked the resident if she would like to be put in her wheelchair. The resident indicated "please" and then lifted her feet up off the ground. The LPN then proceeded to push her geri chair to her room to place her in the high back wheelchair. At 3:29 p.m., the resident was observed sitting in a high back wheelchair in front of the Nurses' station. The resident was sitting upright with her right leg crossed over her left leg with her left leg and foot resting on a foot pedal.</p>		<p>Residents will require a therapy screen for seating and positioning prior to the use of a Geri Chair or any form of restraint. Nursing to therapy communication tools will be brought to AM interdisciplinary meetings to improve communication of therapy screen requests.4. The DON/ADON/Designee will review Physician orders daily 5 times per week to assure that Geri chairs are not ordered prior to a therapy seating and positioning evaluation. This will assure that our residents are evaluated for the least restrictive measures. Results of noncompliance will be brought to QA nurse for review and corrective action monthly and QAPI committee quarterly for review and/or recommendations. 5. DON responsible.</p>				

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	<p>The record for Resident #24 was reviewed on 5/29/13 at 1:18 p.m. The resident's diagnoses included, but were not limited to, stroke, left sided hemiplegia (weakness), dementia with agitated features and anxiety disorder.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 3/19/13, indicated the resident was cognitively impaired. The resident was a one person physical assist for transfers as well as locomotion on and off the unit. The resident used a wheelchair for mobility. The resident did not have any falls since the prior assessment and no physical restraints were being used.</p> <p>A Nurses' note dated 2/4/13 at 7:25 p.m., indicated the resident was wandering in the hall by propelling herself in her wheelchair.</p> <p>A Nurses' note dated 2/8/13 at 9:55 p.m., indicated the resident self propels in the wheelchair.</p> <p>A Nurses' note dated 2/17/13 at 9:40 p.m., indicated the resident self propelled herself down the hallway to look out the courtyard door. There was no attempt to exit. The resident</p>				

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	<p>was approached multiple times by staff to move to the D hall living room to look out the window to the courtyard. The resident had agreed to move after the third attempt.</p> <p>A Nurses' note dated 5/11/13 at 1:50 p.m., indicated the resident had been some what agitated and was wandering the halls for most of the shift.</p> <p>A Nurses' note dated 5/22/13 at 3:40 p.m., indicated a call was received from the receptionist indicating the resident had wheeled herself outside of the double doors in the lobby area during activities. The note indicated the receptionist told the nurse the resident was brought back in immediately by a staff member. The nurse had paged the doctor and was waiting on a return call. The family was notified of the incident.</p> <p>A Physician's Order dated 5/23/13 at 3:30 p.m., indicated the resident may use a geri chair.</p> <p>A Physician's Order dated 5/24/13 at 1:20 p.m., indicated an order clarification was obtained indicating the resident may use a geri chair for comfort and positioning.</p>			

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	<p>A Nurses' note dated 5/24/13 at 7:55 p.m., indicated the resident was up in the geri chair with no distress noted with ongoing hourly checks.</p> <p>A care plan dated 9/27/12 and updated on 12/21/12 and 3/19/13, indicated the resident was a potential for falls related to taking a daily antidepressant. Resident received, when necessary, antianxiety medication, and had a history of falls and poor safety awareness. The Nursing interventions included to follow mobility orders, assist with all transfers, alarm on and functioning. On 5/23/13, the intervention of the resident using a geri chair for comfort and positioning was added.</p> <p>A physical restraint assessment was completed on 5/28/13, (five days after the resident was placed in the geri chair). The assessment indicated a new order for a geri chair for comfort and positioning. The resident may be at risk for injury starting on 5/23/13 due to poor safety awareness. The current mobility status indicated up as tolerated and the geri chair was being used for comfort and positioning. The resident had a risk for falls with injuries requiring medical attention due to general weakness, disorientation or confusion, history of</p>			

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	<p>falls and incontinence. No alternatives to reduce or avoid the restraints were used.</p> <p>A rehabilitation screening was completed on 5/6/13. The screening indicated the resident was not currently in a restraint, the resident currently had problems with bed mobility and transfers and needed assistance with mobility. There was no documentation indicating the resident was having problems with positioning or support in the wheelchair.</p> <p>The Physical Restraint and Side Rail Use Policy was received from the Director of Nursing (DoN) on 6/3/13 at 11:00 a.m. She indicated the policy was current. The policy was reviewed at that time and indicated, "Periodic assessments shall address the resident's status in an effort to reduce or eliminate restraints whenever possible and assure the least restrictive method is used which allows the resident to function at their highest practicable level."</p> <p>Interview with the Director of Nursing (DoN) on 5/30/13 at 8:03 a.m., indicated the resident was put in a geri chair for positioning, comfort, support and safety and it was a trial</p>				

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	<p>period. The DoN had indicated the resident had bad positioning and support in her wheelchair. The DoN further indicated the resident had safety concerns with wanting to wheel herself out of the door in the wheelchair. Continued interview with the DoN on 5/30/13 at 11:27 a.m., indicated she recognized the geri chair as a restraint, but felt it was the last resort due to the resident's safety, positioning and support in her wheelchair.</p> <p>Interview with the Physical Therapy Director on 5/31/13 at 8:20 a.m., indicated he was not in the discussion for the resident being transferred to a geri chair. He indicated the last documented screen was done on 5/6/13 and he did not have any documentation of any positioning or support problems for the resident in her wheelchair.</p> <p>Interview with the DoN on 5/31/13 at 8:41 a.m., indicated the resident was in the geri chair for a trial period due to the resident having positioning problems in her wheelchair. She indicated the resident had neck positioning and leaning problems while in her wheelchair.</p> <p>Further interview with the DoN on</p>						

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	<p>5/31/13 at 11:58 a.m., indicated she was unable to find any documentation regarding any assessment that was done for the resident prior to switching to the geri chair. The DoN indicated she was unable to find any documentation of the resident having problems with positioning or support.</p> <p>3.1-3(w) 3.1-26(a)</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review, and interview, the facility failed to maintain each resident's dignity related to posting of personal care signs in resident rooms and referring to residents as "Feeder" and "Honey" for 2 of 3 residents reviewed for Dignity of the 4 residents who met the criteria for Dignity. (Residents #70 and #76)</p> <p>Findings include:</p> <p>1. On 5/28/13 at 12:29 p.m., Resident #76 was observed sitting in a merriwalker in front of the Nurses' Station. At that time, all of the other residents were in the main dining room on the Special Care Unit eating lunch.</p> <p>Interview with the Assistant Director of Nursing (ADoN) at that time, as to why the resident was not in the dining room, indicated she stated "I believe she is a Feeder."</p> <p>Interview with the ADoN on 6/3/13 at</p>	F000241	<p>1. The residents # 70 and # 76 were not affected by this alleged deficient practice. The care sign hanging in the room of resident #70 was removed from the room and placed in a private area. The resident and family was notified that the care signs would no longer be out in the room. The 2 staff members involved with resident #76 in the Special Care unit were verbally re-educated promptly regarding only addressing residents by their preferred names. 2. The facility has determined that all residents have the potential to be affected by this alleged deficient practice. All care signs were removed and placed in private areas. Families of residents with care signs posted were notified via phone call or in person and a memo was placed at the reception window for further clarification. Residents who elect to be called names other than the given names will be care planned.3. The staff members involved with this situation were re-educated and an inservice was offered on 6-19-13 and 6-20-13 to address nursing staff regarding Dignity and the regulations that</p>	07/03/2013			

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
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	<p>12:00 p.m., indicated she was unaware she could not refer to residents as "feeders".</p> <p>On 5/31/13 at 12:11 p.m., CNA #1 was observed assisting the resident into the dining room. At that time, the resident was in the merriwalker and the CNA wanted to place her in a regular dining room chair. The CNA stopped at the resident's table and said to the resident "come on 'honey bun' let's sit in this chair."</p> <p>Interview with the Special Care Unit Manager on 5/31/13 at 12:21 p.m., indicated referring to residents as "honey" and not by the resident's name was not acceptable.</p> <p>2. On 5/28/13 at 8:25 a.m., a sign was observed posted on the wall above Resident #70's bed. The sign indicated "pullups on days, briefs at night."</p> <p>Interview with Resident #70 on 5/31/13 at 11:50 a.m., indicated the resident knew there was a sign posted above her bed but was not sure what it said. The sign was then read out loud to the resident. Resident #70 indicated, "oh, that's not a good sign." The resident indicated she did not put up the sign or ask anyone to put it up. The resident</p>		<p>support full recognition of the resident's individuality. Staff were made aware to monitor for posted care signs in visible areas and place inside resident closet door. 4. The DON/ADON/designee will complete Random Dignity Rounds 3 times per week for 6 weeks and monthly thereafter for 6 months to assure compliance to F241. Results of compliance rounds will be brought to the QA nurse monthly and the QAPI Committee meeting quarterly for review and/or recommendations.5. DON responsible.</p>				

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	<p>indicated she did not know who put the sign up. The resident indicated the sign bothered her and she should probably take it down.</p> <p>The record for Resident #70 was reviewed on 5/30/13 at 1:43 p.m. The quarterly Minimum Data Set (MDS) assessment dated 4/5/13, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 14, which indicated she was cognitively intact.</p> <p>The current plan of care dated 4/3/13, indicated the resident had specific preferences posted in her room. The Nursing international included accommodate preference as applies.</p> <p>Interview with CNA #3 on 5/30/13 at 11:30 a.m., indicated staff had put up the sign above the resident's bed. CNA #3 was unsure if the sign was put up due to family request or if the resident had requested the sign.</p> <p>Interview with CNA #2 on 5/31/13 at 9:30 a.m., indicated the sign was put up by staff. The CNA indicated the resident had probably requested the sign to be put up as a reminder.</p> <p>Interview with LPN #1 and LPN #2 on 5/31/13 at 2:03 p.m., indicated the</p>						

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	<p>sign in the resident's room was put up due to a family request. LPN #1 indicated staff does not put up signs like that unless it was a family request.</p> <p>Interview with the Social Services Assistant on 5/31/13 at 3:00 p.m., indicated she was not sure why the sign was posted in the resident's room, but she believed it was a family request. She indicated she would speak to the Social Services Director and look at her documentation regarding the sign.</p> <p>Interview with the Social Services Assistant on 5/31/13 at 3:30 p.m., indicated the sign was requested to be put up by the resident's daughter upon admission and was care planned.</p> <p>3.1-3(t)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written related to wheelchair alarms not in use for 1 of 3 residents reviewed for Accidents of the 3 residents who met the criteria for Accidents. (Resident #144)</p> <p>Findings include:</p> <p>On 5/30/13 at 9:18 a.m., 10:05 a.m., 10:43 a.m., 2:40 p.m., 3:20 p.m., and 4:14 p.m., Resident #144 was observed in her wheelchair. There was no wheelchair alarm in use at the above times.</p> <p>At 10:43 a.m., the resident's wheelchair alarm was on top of her mattress in her room. At 4:30 p.m., the personal alarm was on top of the resident's bedside stand in her room.</p> <p>The record for Resident #144 was reviewed on 5/30/13 at 10:06 a.m. The resident's diagnoses included, but were not limited to, osteoporosis and right hip fracture with open</p>	F000282	<p>1. The nursing management team met with the 2nd floor nursing and care staff on 6-4-13 and a fall risk assessment was completed for Resident #144. Appropriate revisions were made to the care plan to reflect current safety interventions. The care cards were updated to reflect the changes and communicated to the care staff. Staff responsible for assuring that the alarm was in place for resident #144 on 5-30-13 were counselled on 6-4-13. Resident #144 was not affected by this alleged deficient practice.2. All residents with orders for alarms have the potential to be affected by this alleged deficient practice. The nursing management team reviewed the MDS assessments/care plans/care cards for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate. 3. Re-education for nursing staff was offered on 6-19-13 and 6-20-13, regarding the regulations for Accidents and Supervision and the use of the care plans/care cards. Nurse</p>	07/03/2013	

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	<p>reduction and internal fixation.</p> <p>Review of the Nursing progress notes dated 4/30/13 at 5:00 p.m., indicated the resident was found on the bathroom floor. The resident's family requested a personal alarm at this time. Review of the Falls committee meeting for the fall on 4/30/13, indicated the alarm was ordered.</p> <p>Review of the Nursing progress notes dated 5/6/13 at 10:30 a.m., indicated at 8:00 a.m., the resident was in her room having her breathing treatment in her wheelchair. Staff were in the doorway and heard the alarm sounding. When staff turned around, the resident was between the bed and her wheelchair. Staff witnessed the resident lower herself to the floor.</p> <p>The Falls committee meeting related to the resident's fall on 5/6/13, indicated the resident had a personal alarm, was receiving Physical and Occupational therapy and was on a prompted toileting plan. The committee recommended to lay the resident down immediately after the morning meal.</p> <p>The plan of care dated 4/15/13, indicated the resident may be at risk for falls related to history of falls, had</p>		<p>aides are to communicate to the nurses if residents are removing their bed/chair alarms. If residents are removing their own alarms, the physicians will be notified and new interventions will be implemented as appropriate.</p> <p>4. The DON/ADON/Designee will complete safety rounds 3 times per week for 6 weeks and weekly for 6 months to assure that the appropriate assistive devices are in place from the care plan/care card to avoid accidents. Results of the Safety Rounds will be brought to QA nurse monthly and to the QAPI committee quarterly for review and/or recommendations. 5. DON responsible.</p>				

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	<p>an unsteady gait, balance deficits and took a daily antidepressant medication.</p> <p>One of the Nursing interventions indicated to follow mobility orders as prescribed. The "comment" section of the care plan dated 4/30/13, indicated the resident's alarm was on and functioning.</p> <p>Review of the CNA assignment sheet on 5/31/13 at 2:13 p.m., indicated the resident was to have a bed and wheelchair alarm at all times.</p> <p>Interview with CNA #4 on 5/31/13 at 2:13 p.m., indicated the alarms were listed on the CNA assignment sheet. She indicated the resident was to have a wheelchair and bed alarm at all times.</p> <p>Interview with the Assistant Director of Nursing on 5/31/13 at 2:18 p.m., indicated the resident was to have a bed and chair alarm.</p> <p>3.1-35(g)(2)</p>				

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to holding the administration of Insulin when there were no Physician Orders to do so for 1 of 1 resident review for IDDM (Insulin Dependent Diabetes Mellitus) for the 10 residents reviewed for unnecessary medications. (Resident #9)</p> <p>Findings include:</p> <p>The record for Resident #9 was reviewed on 5/30/13 at 11:26 a.m. The resident's diagnoses included, but were not limited to, diabetes and hyperglycemia.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated 4/18/13, indicated the resident was not alert and oriented. The resident needed extensive assist with two person assist for bed mobility, transfers, toilet</p>	F000309	<p>1. The one nurse identified as responsible for holding the insulin and obtaining the resident blood sugar without a physician's order was promptly re-educated verbally on 5-31-13 with subsequent reinforcement later in writing on 6-19-13. As a new nurse, she was instructed that her nursing judgement would require the support of a physician's order. Resident #9 was not affected by this alleged deficient practice and his physician was notified on 5-31-13.2. All residents with orders for insulin could have been affected by this alleged deficient practice. After review of current residents receiving insulin, no other residents were affected. 3. In-service education was offered to nurses on 6-19-13 and 6-20-13 to review policy for Routine Diabetic Care and nursing requirements to obtain physician orders to hold insulin in every case. The inservice also reviewed when performing a finger stick blood sugar test would be appropriate as a nursing intervention with Hypoglycemia.</p>	07/03/2013			

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	<p>use, personal hygiene, bathing, and locomotion on the unit. The resident received insulin injections seven days a week.</p> <p>Review of the May 2013 Physician's Order Summary, indicated a Physician's Order dated 5/2/12, which indicated the resident's blood sugar was to be checked at 6:30 a.m. and 4:30 p.m. The Physician was to be called if the blood sugar was above 250.</p> <p>Review of Physician's Orders dated 4/10/13, indicated the resident was to receive Levemir (a long acting insulin) 20 units daily at 9:00 p.m. Review of Physician Orders dated 1/18/13, indicated the resident also received Novolin 70/30 (a long acting insulin) 40 units daily at 7:30 a.m. Another Physician Order dated 1/18/13, indicated the resident also received Novolin 70/30 insulin 5 units every p.m. (5:00 p.m.) and not to give if blood sugar was less than 100.</p> <p>Review of the Medication Administration Record (MAR) for the month of March 2013, indicated the Levemir insulin was held on 3/15 at 9:00 p.m., due to a blood sugar of 88. The Levemir insulin was also held on 3/25/13 due to a blood sugar of 91.</p>		<p>4. The DON/ADON/Designee will review the Medication Administration Records/Diabetic Flow sheets 3 times per week for 4 weeks and then 5 random records weekly for 4 weeks to assure that the the physician orders for insulin and blood sugar readings are followed as ordered. The results of the audit will be brought to the QA nurse monthly and the QAPI committee quarterly for review and/or recommendations with any reports of noncompliance.5. DON responsible.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013	
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	<p>Further review indicated there was no order to obtain the resident's blood sugar at 9:00 p.m. and no specific order to hold the Levemir insulin.</p> <p>Review of the Nurses' Notes for 3/15 and 3/25/13, indicated there was no documentation indicating the resident was having a diabetic reaction such as hypoglycemia (low blood sugar) to check his blood sugar at those times.</p> <p>Review of the MAR for the month of April 2013, indicated the Levemir insulin was held on 4/2/13 due to a blood sugar of 89. On 4/6/13, the Levemir insulin was held at 9:00 p.m. due to a blood sugar of 100. On 4/10/13 at 9:00 p.m., the Levemir insulin was held due to a blood sugar of 64. On 4/19/13 at 9:00 p.m., the Levemir insulin was held due to a blood sugar of 97.</p> <p>There was no order to obtain the resident's blood sugar at 9:00 p.m. and no specific order to hold the Levemir insulin.</p> <p>Review of Nurses' Notes for 4/2, 4/6, and 4/10/13, indicated there was no documentation indicating the resident was having a diabetic reaction to take his blood sugar at 9:00 p.m.</p>						

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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	<p>Review of the MAR for the month of May 2013, indicated the Levemir insulin was held on 5/7/13 at 9:00 p.m., due to the resident's blood sugar was less than 100. On 5/8/13 at 9:00 p.m., the Levemir insulin was held due to a blood sugar of 91. Review of Physician's Orders at those times, indicated there were no orders to hold the Levemir insulin.</p> <p>Interview with the Second Floor Unit Manager on 5/31/13 at 2:30 p.m., indicated there was no Physician Order to hold the Levemir insulin at 9:00 p.m. nor was there an order to obtain a 9:00 p.m. blood sugar.</p> <p>3.1-37(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written related to wheelchair alarms not in use for 1 of 3 residents reviewed for Accidents of the 3 residents who met the criteria for Accidents. (Resident #144)</p> <p>Findings include:</p> <p>On 5/30/13 at 9:18 a.m., 10:05 a.m., 10:43 a.m., 2:40 p.m., 3:20 p.m., and 4:14 p.m., Resident #144 was observed in her wheelchair. There was no wheelchair alarm in use at the above times.</p> <p>At 10:43 a.m., the resident's wheelchair alarm was on top of her mattress in her room. At 4:30 p.m., the personal alarm was on top of the resident's bedside stand in her room.</p> <p>The record for Resident #144 was reviewed on 5/30/13 at 10:06 a.m. The resident's diagnoses included, but were not limited to, osteoporosis</p>	F000323	<p>1. The nursing management team met with the nursing and care staff on 6-4-13 and a fall risk assessment was completed for Resident #144. Appropriate revisions were made to the care plan to reflect current safety interventions. The care cards were updated to reflect the changes and communicated to the care staff. Staff responsible for assuring that the alarm was in place for resident #144 on 5-30-13 were counselled on 6-4-13. Resident #144 was not affected by this alleged deficient practice.2. All residents with orders for alarms have the potential to be affected by this alleged deficient practice. The nursing management team reviewed the MDS assessments/care plans/care cards for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate. 3. Re-education for the nursing staff was offered on 6-19-13 and 6-20-13 regarding the regulations for Accidents and Supervision and the use of the</p>	07/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013
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	<p>and right hip fracture with open reduction and internal fixation.</p> <p>Review of the Nursing progress notes dated 4/30/13 at 5:00 p.m., indicated the resident was found on the bathroom floor. The resident's family requested a personal alarm at this time. Review of the Falls committee meeting for the fall on 4/30/13, indicated the alarm was ordered.</p> <p>Review of the Nursing progress notes dated 5/6/13 at 10:30 a.m., indicated at 8:00 a.m., the resident was in her room having her breathing treatment in her wheelchair. Staff were in the doorway and heard the alarm sounding. When staff turned around, the resident was between the bed and her wheelchair. Staff witnessed the resident lower herself to the floor.</p> <p>The Falls committee meeting related to the resident's fall on 5/6/13, indicated the resident had a personal alarm, was receiving Physical and Occupational therapy and was on a prompted toileting plan. The committee recommended to lay the resident down immediately after the morning meal.</p> <p>The admission Minimum Data Set (MDS) assessment dated 4/12/13,</p>		<p>care plans/care cards. Nurse aides are to communicate to the nurses if residents are removing their bed/chair alarms. If residents are removing their own alarms, the physicians will be notified and new interventions will be implemented as appropriate. 4. The DON/ADON or designee will complete safety rounds 3 times per week for 6 weeks and weekly for 6 months, to assure that the appropriate assistive devices are in place from the care plan/care card to avoid accidents. Results of the Safety Rounds will be brought to QA nurse monthly and to the QAPI committee quarterly for review and/or recommendations with any concerns of noncompliance. 5. DON responsible.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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	<p>indicated the resident required limited assistance with transfers with one person assist. The MDS also indicated the resident had a fall in the last month prior to admission and had a fracture related to a fall in the last 6 months.</p> <p>The plan of care dated 4/15/13, indicated the resident may be at risk for falls related to history of falls, had an unsteady gait, balance deficits and took a daily antidepressant medication.</p> <p>One of the Nursing interventions indicated to follow mobility orders as prescribed. The "comment" section of the care plan dated 4/30/13, indicated the resident's alarm was on and functioning.</p> <p>Review of the Fall risk assessment dated 4/6/13, indicated the resident scored a "15" which was a high risk for falls. The Fall risk assessments dated 4/25 and 5/24/13, indicated the resident scored a "13" which again was a high risk for falls.</p> <p>Review of the CNA assignment sheet on 5/31/13 at 2:13 p.m., indicated the resident was to have a bed and wheelchair alarm at all times.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2013
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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	<p>Interview with CNA #4 on 5/31/13 at 2:13 p.m., indicated the alarms were listed on the CNA assignment sheet. She indicated the resident was to have a wheelchair and bed alarm at all times.</p> <p>Interview with the Assistant Director of Nursing on 5/31/13 at 2:18 p.m., indicated the resident was to have a bed and chair alarm.</p> <p>3.1-45(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medication related to a gradual dose reduction for psychotropic medication and monitoring and obtaining laboratory tests for a resident who was taking an anticoagulant medication for 2 of 10 residents reviewed for unnecessary medications. (Residents #65 and #85)</p>	F000329	<p>1. a. Immediately after identifying the missing PT/INR for resident # 85, the physician was notified and the lab was drawn on 5-31-13. Resident # 85 was not affected by this alleged deficient practice. b. The physician for resident #65 was notified that the resident was due for a GDR for the Zolof and the Haldol. Resident will be evaluated, and medications reduced unless physician finds the GDR contraindicated. Physician was advised of the regulation requiring a progress note explaining any</p>	07/03/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
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	<p>Finding include:</p> <p>1. The record for Resident #85 was reviewed on 5/29/13 at 2:09 p.m. The resident's diagnoses included, but were not limited to, dementia with psychosis, bilateral emboli (blood clots), left lower deep vein thrombosis (blood clot of leg) and high blood pressure.</p> <p>Review of Physician Orders dated 5/10/13, indicated the resident was to receive Coumadin (an anticoagulant, a medication used to thin the blood) 5 milligrams (mg) daily. Another Physician's Order dated 1/4/11 and on the May 2013 order recapitulation, indicated the resident was to have a Protime (PT) and an International Normalized Ratio (INR) weekly on Tuesdays. The Physician was to be called with the results.</p> <p>Review of the laboratory results indicated on 5/7/13, the resident's PT and INR were high, the Physician was notified and new orders were obtained to hold the Coumadin and repeat the test on 5/10/13.</p> <p>On 5/10/13, the PT/INR were completed. The PT was 29.2 and the INR was 2.9. New orders were obtained for Coumadin 5 mg daily</p>		<p>contraindication. Resident #65 was not affected by this alleged deficient practice. 2. a. The facility determined that all residents with orders for laboratory services have the potential to be affected by this alleged deficient practice. The nursing management team had a meeting with the Laboratory leadership team on 6-13-13 and a whole house audit of all resident records for laboratory orders will be conducted the week of 6-17-13. b. The facility determined that all residents with orders for psychactive medications have the potential to be at risk for this alleged deficient practice. After review of all physician orders for psychoactive medications no other residents were affected by this alleged deficient practice. 3. a. The licensed staff were offered re-education on 6-19-13 and 6-20-13 regarding the standards to review the original MD orders when reviewing lab results to assure that all of the results were present as ordered. The copies of the MD orders will be saved in an accordion file by date month to month. This will serve as a system to double check the orders were followed upon receipt of the lab results. The nurses will notify the MD of any labs not done and obtain orders as needed. b. The nursing management and social services</p>		

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
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	<p>and repeat the PT/INR on 5/21/13.</p> <p>On 5/21/13, a PT/INR was completed and the results were called to the Physician. Continued review of the laboratory results indicated there was no PT/INR completed on 5/28/13.</p> <p>Interview with the Special Care Unit Manager on 5/31/13 at 8:46 a.m., regarding the PT/INR order that was to be drawn weekly on Tuesdays, indicated the documentation in the lab computer indicated the standing order for the PT/INR was canceled. She indicated she was unaware why the weekly PT/INR standing order was canceled.</p> <p>Interview with the Special Care Unit Manager on 5/31/13 at 9:15 a.m., indicated the lab was notified of the problem. The Lab Technician indicated the test was delayed due to Memorial Day, however, the Unit Manager indicated it was supposed to be done on Tuesdays and had nothing to do with Memorial Day. The Special Care Unit Manager further indicated the weekly standing order was not discontinued by the facility, the lab indicated their system was down on Tuesday and it must have been missed. She further indicated the monthly labs were audited by her,</p>		<p>team reviewed the regulation requirements for gradual dose reduction with the consultant pharmacist on 6-21-13. The nursing management team in collaboration with social services compiled a spreadsheet of all residents with physician orders for psychoactive medications. This list will be updated with any new orders and the date ordered to track for gradual dose reduction by regulations. The Behavior team will meet monthly to review medical records and make recommendations for reductions as appropriate. The physician will be notified of recommendations and orders will be obtained for reductions unless contraindicated. The physicians were notified of regulatory requirement for a progress note to be included in the medical record when GDR is contraindicated. 4. a. The DON/Designee/Medical records team will review and audit lab orders daily 5 times per week for 6 weeks then weekly thereafter for 3 months. The lab will continue to share their results of whole house compliance audit with DON/ADON every month. Results of audits will be brought to QA nurse monthly for review and quarterly to our QAPI committee for review and/or recommendations. b. The DON/ADON/Designee will audit the use of psychoactive medications every month for 6 months. Results of the audit will</p>				

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
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	<p>however, there was no system to audit the weekly labs and Nursing should have caught the missing PT/INR.</p> <p>2. The record for Resident #65 was reviewed on 5/29/13 at 2:21 p.m. The resident's diagnoses included, but were not limited to, dementia with associated psychotic features and/or agitated features, insomnia, and anxiety.</p> <p>Review of the Physician's Recapitulation Orders dated May 2013, indicated an order for Sertraline (Zoloft and antidepressant medication) 100 milligrams (mg) daily at bedtime, originally ordered on 10/6/11.</p> <p>Review of the Pharmacy recommendation dated 2/17/12, indicated recommendations to change the doses of the Zoloft and Haldol medications. Review of the Physician's response indicated to continue the same order and was this was signed by the Physician on 2/21/12.</p>		<p>be brought to QA nurse monthly and QAPI committee quarterly for review and/or recommendations. The consultant pharmacist will continue to complete drug regimen reviews monthly and work in collaboration with the Behavior Team to make recommendations to physicians for Gradual Dose Reductions.5. DON responsible.</p>		

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
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	<p>Review of the Medication Administration Records (MAR) for the months of 3/2012 through 5/2013 indicated the resident received the Zolofit medication 100 mg at bedtime daily.</p> <p>Continued record review indicated documentation of an attempted or refused GDR (gradual dose reduction) was lacking since 2/21/12.</p> <p>Review of the Physician's Recapitulation Orders dated May 2013, indicated an order for Haloperidol (an antipsychotic medication) 0.25 mg twice daily, originally ordered on 4/9/12.</p> <p>Review of the MAR for the months of 4/2012 through 5/2013, indicated the resident received the Haloperidol medication 0.25 mg twice daily.</p> <p>Continued record review indicated documentation of an attempted or refused GDR (gradual dose reduction) was lacking since 4/9/12.</p> <p>Review of the psychoactive medication monthly flow record for May 2013, indicated the resident had no repetitive complaints, no increased anxiety, and no visual hallucinations.</p>				

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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	<p>Review of the psychoactive medication monthly flow record for April 2013, indicated the resident had no symptoms or behaviors.</p> <p>Interview with the DoN (Director of Nursing) on 6/3/13 at 1:20 p.m., indicated the resident had failed psychotropic medication reductions that were attempted on 2/16/13, with all the medications being reordered on 3/5/13. She indicated a GDR was due for the Haldol on 4/9/13, but since there were recent medication changes, the Physician would probably not want to attempt a Haldol reduction at that time, however, the DoN indicated she could not find documentation of that rationale. The DoN indicated her records showed the resident was not due for a Sertraline GDR until August 2013 but again, was unable to find documentation to support this.</p> <p>3.1-48(b)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2013	
NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	1. The nurse identified as LPN #3 was promptly re-educated on	07/03/2013			

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
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	<p>ensure the glucometer was cleansed after each resident use for 1 of 2 glucometers observed. This had the potential to affect the 3 insulin dependent diabetics who resided on the "E" unit. (Resident #82)</p> <p>Findings include:</p> <p>On 5/30/13 at 4:48 p.m., LPN #3 was observed checking Resident #82's blood sugar. Prior to obtaining the blood sugar as well as after, the LPN did not clean the glucometer. She put the glucometer back in the case and gave the resident her insulin.</p> <p>Interview with the LPN at 5:08 p.m., indicated there was one glucometer for the unit. She indicated the resident was the only glucometer at 4:00 p.m., and she would clean the glucometer later on in her shift.</p> <p>Review of the manufacturer's guidelines related to cleaning and disinfecting the glucometer on 6/3/13 at 10:00 a.m., which was provided by the Director of Nursing, indicated the meter should be cleansed and disinfected between patient use.</p> <p>Interview with the Assistant Director of Nursing on 6/3/13 at 2:10 p.m., indicated the LPN should have</p>		<p>the proper procedures for glucometer disinfection. Resident #82 was not affected by this alleged deficient practice.2. The facility determined that all residents requiring finger stick glucose monitoring have the potential to be affected by this alleged deficient practice. 3. Licensed nursing staff were offered re-education on 6-19-13 and 6-20-13 on the facility's policy for Glucometer disinfection and practice guidelines. In-service training included observation of nurses performing the procedure. Sanitation wipes are kept in convenient locations to improve compliance with sanitation of glucometers. 4. The DON/ADON/Designee will complete random audits 3 times per week for 4 weeks of nurses performing glucometer disinfection to ensure that nurses are following procedure. Results of the audit will be brought to QA nurse weekly for review and/or recommendations for continued monitoring.5. DON responsible.</p>		

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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	<p>cleaned the glucometer as soon as she was done rather than waiting.</p> <p>3.1-18(b)(1)</p>			

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321			
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F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the kitchen was clean related to dirty and rusty return ceiling vents, dirty floors, dirty pipes, dirty walls, and dirty garbage cans for 1 of 1 kitchens. This had the potential to affect 89 of 91 residents who resided at the facility. (The main Kitchen)</p> <p>Findings include:</p> <p>1. On 5/28/13 at 8:49 a.m., during the Brief Kitchen Sanitation tour, the following was observed:</p> <p>A. There were rust stains and dried food spillage on the garbage disposal under the dish machine. The ceiling light located next to the dish machine was rusty with rust stains noted around the trim. The ceiling light was also noted to be buckling. The white trim around the dish machine hood was rusty. The white brick noted behind the entire dish machine was black stained and dirty.</p> <p>Interview with the Dietary Food Manager at the time, indicated the</p>	F000465	<p>1. Corrections from previous timeframes cannot be made. No residents were affected by this alleged deficient practice. a. Upon noticing the areas of concern, the dirty floors, dirty pipes, dirty walls and dirty garbage cans were immediately cleaned. The dirty and rusty return ceiling vents were cleaned and painted with rustolium. The facility has since ordered replacements of aluminum non-rust return and non-return vents which will be replaced by 7-3-13. Anti-rust stripping was added to all ceiling trim in the dish room to avoid future rusting issues. The rust stains and dried food spillage on the garbage disposal was immediately cleaned and added to the daily routine cleaning list. Ceiling light was immediately replaced. White trim around the dish machine hood was repainted with rustolium and the white brick behind the entire dish machine was cleaned, painted and placed on daily checklist and a routine or as needed painting schedule. b. The black electrical cords, area under the steam table, floor pedal, floor behind the stove and convection oven, insulated and silver metal pipe located above the stove were</p>	07/03/2013			

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321		
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	<p>areas of rust were coming from the steam from the dish machine.</p> <p>B. There were eight return ceiling vents that were rusty.</p> <p>C. There were two ceiling vents that were observed with a heavy accumulation of black dust and dirt.</p> <p>D. Two white garbage cans located under the hand washing sinks were dirty.</p> <p>2. On 5/31/13 at 10:49 a.m., during the Main Kitchen Sanitation tour the following was observed:</p> <p>A. There was a three foot section under the steam table that had adhered dirt and grease. The black electrical cords located under the steam table also had an accumulation of dust and grease.</p> <p>B. The floor pedal by the steam table was dirty with grease build up .</p> <p>C. There was adhered dirt and grease on the floor behind the stove and the convection oven.</p> <p>D. The insulated pipe and silver metal pipe located up above the stove had a heavy accumulation of dust and</p>		<p>all immediately cleaned of dirt and grease. The crumbs were immediately swept up under the food prep sink when noticed.2. All residents could have been affected by this deficient practice, however, in this instance, no residents were affected.3. Policies and procedures for cleaning and sanitation were reviewed. Daily and Weekly cleaning lists were revised for the kitchen requiring a signature for accountability once complete. An in-service will be conducted 6-26-13 to review cleaning, sanitizing and the revised Daily Cleaning Schedule. Any staff member found deficient in the practice following formal education will be counselled up to and including termination of employment based on facility protocol.4. Cleaning rounds will be conducted daily 7 times per week after each meal by the cook on duty. Random audits will be conducted 5 x per week by the Consultant Dietician/Dietary Manager/Assistant Manager/Designee and recorded on the monthly calendar. Results of the audits with be brought to the QAPI Committee meeting quaterly for review and/or recommendations.5. Dietary Manager responsible</p>		

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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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	<p>grease.</p> <p>E. There were crumbs in the corner on the floor under the food prep sink.</p> <p>Interview with the Dietary Food Manager at the time, indicated all the above was in need of cleaning.</p> <p>3.1-19(f)</p>			

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F000502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained as ordered related to a transferrin level for 1 of 1 residents reviewed for pressure ulcers of the 1 who met the criteria for pressure ulcers. (Resident #106)</p> <p>Findings include:</p> <p>The record for Resident #106 was reviewed on 5/29/13 at 2:21 p.m. The resident's diagnoses included, but were not limited to, decubitus ulcer and iron deficiency anemia.</p> <p>A Physician's order dated 5/24/13, indicated the resident was to have an albumin, prealbumin, and transferrin (blood tests to monitor nutrition) level drawn to check for malnutrition.</p> <p>Review of the laboratory results dated 5/28/13, indicated the resident's albumin level was within normal limits at 3.5 and her prealbumin level was low at 13. There was not a transferrin level available for review.</p>	F000502	<p>1. Immediately after the transferrin level was found missing, the Physician was notified and a STAT lab was obtained. Resident # 106 was not affected by the 6 day delay in the laboratory service. 2. The facility determined that all residents with orders for laboratory services have the potential to be affected by this alleged deficient practice. The nursing management team had a meeting with the Laboratory leadership team on 6-13-13 and a whole house audit of all resident records for laboratory orders will be conducted the week of 6-17-13. Nursing management requested that the transferrin level be added to the computer requisition and this was done 6-14-13. 3. The licensed staff were offered re-education on 6-19-13 and 6-20-13 regarding the standards to review the original MD orders when reviewing lab results to assure that all of the results were present as ordered. The copies of the physician orders will be saved in an accordion file by date month to month. This will serve as a system to double check the orders were followed upon receipt of the lab results. The nurses will</p>	07/03/2013	

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	<p>Interview with the Assistant Director of Nursing on 6/3/13 at 11:45 a.m., indicated the transferrin level was missed by the lab and a STAT(immediate) level was going to be drawn today. Continued interview with the Assistant Director of Nursing, indicated the missed lab should have been caught by facility staff when the lab results came in.</p> <p>3.1-49(a)</p>		<p>notify the MD of any labs not done and obtain orders as needed. 4. The DON/Designee/Medical records team will review and audit lab orders daily 5 times per week for 6 weeks then weekly thereafter for 3 months. The lab will continue to share their results of whole house compliance audit with DON/ADON every month. Results of audits will be brought to QA nurse monthly for review and quarterly to our QAPI committee for review and/or recommendations.5. DON responsible.</p>	