

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/28/2014
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NAME OF PROVIDER OR SUPPLIER  BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 20, 21, 22, 23, 27 and 28, 2014</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Survey team: Tina Smith-Staats, RN, TC Ginger McNamee, RN Karen Lewis, RN ( May 20, 21, 22 and 23, 2014) Toni Maley, BSW</p> <p>Census bed type: SNF/NF: 16 SNF: 52 Residential: 52 Total: 120</p> <p>Census payor type: Medicare: 42 Medicaid: 11 Other: 67 Total: 120</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey on May 28, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F000242 SS=E	<p>Quality review completed by Debora Barth, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents had the right to participate in decision making regarding the number of showers or baths they would receive each week for 5 of 17 residents interviewed regarding bathing choices. (Residents #s 164, 99, 165, 161 and 22)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Resident #164 was determined to be interviewable during the stage one survey process. During a 5/20/14, 11:45 a.m., interview Resident #164 indicated she was offered only 2 showers a week. She would like to have 3 but the staff are too busy.</li> <li>Resident #99 was determined to be</li> </ol>	F000242	<p><b>F 242</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #99, #161 and #22 have been discharged. Resident #164 and #165 were re-interviewed regarding their personal preference for the number of showers or baths they would like to receive each week. Each resident's Personal Preference Form has been updated, along with the resident profile / assignment, to include any changes in each resident's preference.</p>	06/27/2014

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	<p>interviewable during the stage one survey process. During a 5/21/14, 8:22 a.m., interview Resident #99 indicated she was scheduled for 2 showers a week and did not have a choice in the decision making process.</p> <p>Resident #99's record was reviewed on 5/22/14 at 3:05 p.m., Resident #99's current diagnoses included, but were not limited to, aftercare for a right hip fracture, macular degeneration and hypertension. Resident #99 was admitted to the facility 3/12/14. Resident #99 did not have a physician's order that would limited the amount of showers/baths she could have each week. Resident #99's record lacked any documentation regarding the number of showers/baths she would desire each week.</p> <p>3. Resident #165 was determined to be interviewable during the stage one survey process. During a 5/21/14, 8:31 a.m., interview Resident #165 indicated she was told she would have 2 showers a week. She was not given a choice for more.</p> <p>The clinical record for Resident #165 was reviewed on 5/27/14 at 8:56 a.m. The Resident Preferences and Activities Profile, dated 4/18/14, indicated it was "very important" for the resident to</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents and/or family members will be re-interviewed regarding their personal preference for the number of showers or baths they would like to receive each week. Each resident's Personal Preference Form has been updated, along with the resident profile / assignment, to include any changes in each resident's preference.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Nursing staff on the following: 1). Bill of Residents Rights 2). Guidelines for Bathing Preference 3). Personal Preference Form</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance on 5 residents per hallway: 1).</p>	

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	<p>choose her own bathing preference.</p> <p>4. Resident #161 was determined to be interviewable during the stage one survey process. During a 5/20/14, 3:21 p.m., interview Resident #161 indicated he was told he would get 2 showers a week when he came to the facility.</p> <p>The clinical record for Resident #161 was reviewed on 5/22/14 at 8:56 a.m. The Resident Preferences and Activities Profile, dated 4/1/14, indicated it was "very important" for the resident to choose his own bathing preference.</p> <p>5. Resident #22 was determined to be interviewable during the stage one survey process. During a 5/20/14, 11:25 a.m., interview Resident #22 indicated she was told she would have 2 showers a week and not asked how many she desired.</p> <p>6. The 5/28/14, CNA assignment sheets for the entire facility indicated 68 of 68 residents were scheduled for 2 baths or showers a week. No resident was scheduled for more than two baths or showers a week.</p> <p>During a 5/28/14, 9:29 a.m., interview, CNA #2 indicated residents receive 2 showers/baths a week.</p>		<p>Review the Personal Preference Form to ensure the preference for number of baths / showers per week is complete. 2). Interview those same residents / family members to ensure their personal preference for the number of showers or baths they would like to receive each week is documented and occurring.</p> <p>The results of the audit / observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p>				

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	<p>During a 5/28/14, 9:32 a.m., interview, CNA #3 indicated residents receive 2 showers/baths a week.</p> <p>During a 5/28/14, 9:38 a.m., interview, CNA #4 indicated residents receive 2 showers/bath a week.</p> <p>During a 5/27/14, 9:15 a.m., interview, the Director of Nursing indicated the preference questionnaire at admission did not address the number of baths or showers a resident would desire each week. The standard number offered was two. However, residents may have the number they desire. She additionally indicated every current resident was scheduled for 2 baths or showers a week.</p> <p>During an interview on 5/23/14 at 2:13 p.m., the Activity Director indicated residents were not asked their preference in regards to the number of showers or bathes they preferred. She further indicated she thought Nursing was responsible for collecting this information from the residents. Review of a current, 12/5/12, facility policy titled "Residents Rights", which was provided by the Director of Nursing on 5/27/14 at 2:45 p.m., indicated the following: "You have the right to...participate in planning care and treatment or changes in care and treatment...."</p>			

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F000282 SS=D	<p>3.1-3(u)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the nursing staff failed to ensure a laboratory test was obtained timely as ordered by the physician for 1 of 5 residents reviewed for laboratory testing related to medication use. (Resident #111)</p> <p>Findings include:</p> <p>The clinical record for Resident #111 was reviewed on 5/22/14 at 7:39 a.m. Diagnoses for Resident #111 included, but were not limited to, diabetes mellitus, hypertension, and Parkinson's disease.</p> <p>An "Extended Care Facility progress note," dated and signed by the physician on 5/2/14, indicated Resident #111 was to have a Hemoglobin A1C (a blood glucose laboratory test) and a fasting Basic Metabolic Profile (BMP) "with next blood draw." The progress not was not dated or initialed by a nurse.</p>	F000282	<p><b>F 282</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #111 lab tests were obtained 5/27/14.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all resident MD progress notes for past 30 days to ensure the note was reviewed by a nurse and any orders were transcribed and implemented, including lab testing.</p> <p><b>Measures put in place and</b></p>	06/27/2014

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	<p>The clinical record for Resident #111 lacked any results for a Hemoglobin A1C or a BMP ordered by the physician on 5/2/14.</p> <p>During an interview with the Assistant Director of Nursing (ADoN) on 5/22/14 at 8:36 a.m., she indicated the nurses are to review the physician progress notes for any new orders and then date and initial as "noted" on the progress note.</p> <p>During an interview with the ADoN on 5/23/14 at 9:40 a.m., additional information was requested related to the lack of May 2014 Hemoglobin A1C and BMP lab results for Resident #111.</p> <p>The facility failed to provide any additional information as of the exit on 5/28/14.</p> <p>3.1-35(g)(2)</p>		<p><b>systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus standard: Reviewing and Transcribing orders from Physician Progress Notes</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of Physician Notes to ensure the note was reviewed by a nurse and any orders were transcribed and implemented, including lab testing.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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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 administer sliding scale insulin as ordered by the physician for 1 of 2 residents reviewed for sliding scale insulin administration. (Resident #111)</p> <p>Findings include:</p> <p>The clinical record for Resident #111 was reviewed on 5/22/14 at 7:39 a.m.</p> <p>Diagnoses for Resident #111 included, but were not limited to, diabetes mellitus,</p>	F000329	<p><b>F 329</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #111 MAR (Medication Administration Record) was reviewed to ensure sliding scale insulin is being administered and documented as ordered by the physician.</p>	06/27/2014			

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	<p>hypertension, and Parkinson's disease.</p> <p>Current signed physician's orders for Resident #111 included, but were not limited to, the following orders:</p> <p>a. Levemir (insulin) inject 50 units subcutaneous every morning. The original date of this order was 5/22/14.</p> <p>b. Novolog (insulin) inject 12 units subcutaneous twice daily at 7:00 a.m. and noon within 15 minutes of a meal. The original date of this order was 1/10/14.</p> <p>c. Novolog (insulin) inject 9 units subcutaneous daily with supper. The original date of this order was 1/10/14.</p> <p>d. Monitor blood sugar results before each meal and at bed time. The original date of this order was 12/19/13.</p> <p>e. Administer Novolog sliding scale insulin according to blood sugar results as listed below,</p> <p>0 -120 = 0 units 121 - 150 = 2 units 151 - 200 = 4 units 201 - 250 = 6 units 251 - 300 = 8 units 301 - 350 = 10 units 351 - 400 = 12 units</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with orders for sliding scale insulin coverage to ensure it is administered and documented as ordered by the physician.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following: 1). Guidelines for Accuchecks 2). Blood Sugar Monitoring</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 5 times per week times 8 weeks, then weekly times 4 months to ensure compliance: 1). sliding scale insulin administered as ordered and documented 2). accurate documentation of sliding scale order on MAR.</p>	

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	<p>401 - 999 = 12 units Call physician if above 400 or below 60 The original date of this order was 12/19/13.</p> <p>A health care plan, current on 5/22/14, indicated Resident #111 had an acute care need of diabetes. Interventions for this need included, but were not limited to, administer medications as ordered by physician and watch for hypo/hyperglycemia.</p> <p>Review of the March, April, and May 2014 Medication Administration Records (MAR) indicated Resident #111 received the incorrect dose of sliding scale insulin on the following dates and times:</p> <p>March 5, at bed time, the blood sugar result was 186, 2 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>March 9, before supper, the blood sugar result was 122, no insulin was documented as having been given, the resident should have received 2 units.</p> <p>March 13, before breakfast, the blood sugar result was 197, 2 units of insulin was documented as having been given, the resident should have received 4 units.</p>		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	<p>March 22, before supper, the blood sugar result was 198, 2 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>March 26, before lunch, the blood sugar result was 307, no insulin was documented as having been given, the resident should have received 10 units.</p> <p>March 27, before breakfast, the blood sugar result was 145, no insulin was documented as having been given, the resident should have received 2 units.</p> <p>April 5, before breakfast, the blood sugar result was 150, no insulin was documented as having been given, the resident should have received 2 units.</p> <p>April 8, before breakfast, the blood sugar result was 297, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>April 8, before supper, the blood sugar result was 161, 6 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>April 9, before breakfast, the blood sugar result was 194, no insulin was documented as having been given, the resident should have received 4 units.</p>			

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	<p>April 12, before breakfast, the blood sugar result was 170, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>April 18, before breakfast, the blood sugar result was 124, no insulin was documented as having been given, the resident should have received 2 units.</p> <p>April 20, before breakfast, the blood sugar result was 157, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>April 21, at bed time, the blood sugar result was 133, no insulin was documented as having been given, the resident should have received 2 units.</p> <p>April 22, before breakfast, the blood sugar result was 260, no insulin was documented as having been given, the resident should have received 8 units.</p> <p>April 27, before breakfast, the blood sugar result was 137, no insulin was documented as having been given, the resident should have received 2 units.</p> <p>May 7, before breakfast, the blood sugar result was 177, no insulin was documented as having been given, the</p>			

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	<p>resident should have received 4 units.</p> <p>May 12, before breakfast, the blood sugar result was 226, no insulin was documented as having been given, the resident should have received 6 units.</p> <p>May 13, before breakfast, the blood sugar result was 181, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>May 14, before breakfast, the blood sugar result was 164, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>May 17, before supper, the blood sugar result was 351, 10 units insulin was documented as having been given, the resident should have received 12 units.</p> <p>May 21, before breakfast, the blood sugar result was 162, no insulin was documented as having been given, the resident should have received 4 units.</p> <p>During an interview with the RN Consultant on 5/22/14 at 1:09 p.m., she indicated blood sugar results and sliding scale insulin administration were to be documented on the MAR.</p> <p>During an interview with the Assistant</p>						

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	<p>Director of Nursing on 5/23/14 at 9:40 a.m., additional information related to the sliding scale insulin documentation was requested.</p> <p>The facility failed to provide any additional information as of the exit on 5/28/14.</p> <p>Review of the current, undated facility policy, titled "Guidelines for Accuchecks", provided by the Administrator on 5/23/14 at 2:25 p.m., included, but was not limited to, the following:</p> <p>"...Procedure:...</p> <p>...5. Results shall be recorded on the appropriate form with insulin administered per physician...."</p> <p>Review of the current facility policy, dated 2012, titled "Blood Sugar Monitoring", provided by the Administrator on 5/23/14 at 2:25 p.m., included, but was not limited to, the following:</p> <p>"...DOCUMENTATION GUIDELINES...</p> <p>...If insulin is ordered based on a sliding scale document the type and amount of insulin administered and the site of injection...."</p>						

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F000356 SS=C	<p>3.1-37(a)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p>			
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	<p>Based on observation and interview, the facility failed to ensure the list of "nursing staff on duty" was posted and updated on a daily basis as required. This had the potential to effect 68 residents who resided in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 5/20/14, at 9:12 a.m., the "nursing staff on duty" posting was not observed. During additional observations on 5/21/14 at 7:55 a.m., 5/21/14 at 10:12 p.m., 5/21/14 at 2:17 p.m., 5/22/14 at 7:40 a.m., and 5/22/14 at 8:50 a.m., the "nursing staff on duty" posting was not observed. On 5/22/14 at 9:44 a.m., the "nursing staff on duty" posting was observed on the wall near the Prairie Farms Road nurses station. The only posted nursing hours visible were for the skilled nursing unit and no other unit. The additional unit nursing staff on duty was on a separate page behind the skilled nursing staff on duty posting.</p> <p>During an interview with the RN Consultant on 5/23/14 at 8:47 a.m., she indicated the "nursing staff on duty" should have been updated and posted daily. She further indicated all nursing staff for each unit should have been visible and not behind another unit when</p>	F000356	<p><b>F 356</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The list of nursing staff on duty is posted on a daily basis in the Health Campus.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing leadership team on the following: Guideline for Staff Posting</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audit will be conducted by the DHS or designee 2 times per week times</p>	06/27/2014			

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F000514 SS=D	<p>posted.</p> <p>Review of the current, undated facility policy, titled "Guidelines for Staff Posting", provided by the Administrator on 5/23/14 at 2:25 p.m., included, but was not limited to, the following:</p> <p>"...Procedure:</p> <p>1. Prior to the beginning of each shift, the number and amount of hours of licensed nurses [RN and LPN] and the number and hours of unlicensed nursing personnel who provide direct care to residents will be posted....</p> <p>...3. Staffing sheets should be posted in a common area easily visible upon entry to the campus...."</p> <p>3.1-17(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically</p>		<p>8 weeks, then monthly times 4 months to ensure compliance: Ensure the nurse staffing information is posted for the day.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure residents' clinical records contained complete and accurate documentation for 1 of 2 residents reviewed for complete documentation regarding insulin. (Resident #46).</p> <p>Findings include:</p> <p>Resident #46's clinical record was reviewed on 5/22/14 at 10:07 a.m. The resident's diagnoses included, but were not limited to, left cerebellar ischemic infarct, atrial fibrillation, severe oropharyngeal dysphagia, severe microcytic anemia, moderate to severe protein total calorie malnutrition and diabetes mellitus.</p> <p>The record indicated the resident had an order, dated 4/17/14, for accu check with insulin sliding scale before meals and at bedtime.</p> <p>Review of the resident's clinical record lacked documentation of the amount of insulin given for a blood sugar of 256</p>	F000514	<p><b>F 514</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #46 MAR (Medication Administration Record) was reviewed to ensure sliding scale insulin is being administered and documented as ordered by the physician.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with orders for sliding scale insulin coverage to ensure it is administered and documented as ordered by the physician.</p> <p><b>Measures put in place and systemic changes made to</b></p>	06/27/2014

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	<p>before lunch on 4/21/14 and a blood sugar of 258 at bedtime on 4/17/14.</p> <p>During an interview on 5/27/14 at 2:48 p.m., with the Nurse Consultant and the Administrator, it was indicated the amount of insulin to be given per the sliding scale should always be documented on the Medication Administration Record. No further information was provided.</p> <p>A Clinical Procedure (Procedure 220), dated 2012, entitled Blood Sugar Monitoring was provided by the Administrator on 5/23/14 at 2:25 p.m. and indicated:</p> <p>"Blood Sugar Monitoring Basic Responsibility: Licensed Nurse... Purpose: To monitor blood glucose level ...Documentation Guidelines Documentation may include: Date, time, blood glucose level. Method of testing. If insulin is ordered based on a sliding scale document the type and amount of insulin administered and site of injection. If blood glucose level is above or below normal range, document the time the physician was notified. Signature and title."</p> <p>3.1-50(a)(1)</p>		<p><b>ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following: 1). Guidelines for Accuchecks 2). Blood Sugar Monitoring</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 5 times per week times 8 weeks, then weekly times 4 months to ensure compliance: 1). sliding scale insulin administered as ordered and documented 2). accurate documentation of sliding scale order on MAR.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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R000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 20, 21, 22 ,23, 27 and 28, 2014</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Survey team: Tina Smith-Staats, RN, TC Ginger McNamee, RN Karen Lewis, RN ( May 20, 21, 22 and 23, 2014) Toni Maley, BSW</p> <p>Census bed type: SNF/NF: 16 SNF: 52 Residential: 52 Total: 120</p> <p>Census payor type: Medicare: 42 Medicaid: 11 Other: 67 Total: 120</p> <p>Residential Sample: 7</p>	R000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the annual survey on May 28, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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R000091	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to have a policy related to reviewing physician's progress notes resulting in a delay in treatment for 1 of 7 residents reviewed in a sample of 7. (Resident #R42)</p> <p>Findings include:</p> <p>Resident #R42's clinical record was reviewed on 5/28/14 at 8:40 a.m. Her diagnoses included, but were not limited to, dementia, anxiety and depression.</p> <p>The resident's current Physician's orders</p>	R000091	<p><b>R 091</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #R42 - MD was contacted regarding Namenda and clarification order was received.</p> <p><b>Identification of other residents having the potential to be</b></p>	06/27/2014

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	<p>indicated the resident received Namenda (for dementia) 10 mg tablet by mouth two times a day.</p> <p>Review of a 5/12/14 Psychiatry Progress Note indicated the resident was to continue the Namenda XR 21 mg every morning.</p> <p>Review of the May, 2014 Medication Administration Record indicated the resident was receiving Namenda 10 mg two times a day.</p> <p>During an interview with Director of Nursing on 5/28/14 at 9:45 a.m., she indicated the nurse was to review the doctor's progress note after the doctor's visit for any order changes. She indicated the nurse was to date and initial the note after she had reviewed it. She indicated the 5/12/14, Psychiatry Note had not been dated and initialed by a nurse as having been reviewed. She indicated she had contacted the doctor and he wanted the medication changed to Namenda XR 21 mg by mouth every morning to start when the present supply was exhausted at the current dose.</p> <p>During an interview with the RN Consultant on 5/28/14 at 2:29 p.m., she indicated the nurses should have clarified the order after the psychiatry visit. She</p>		<p><b>affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all resident MD progress notes for past 30 days to ensure the note was reviewed by a nurse and any orders/clarifications needed were transcribed and implemented.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus standard: Reviewing and Transcribing orders from Physician Progress Notes</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of Physician Notes to ensure the note was reviewed by a nurse and any orders/clarifications needed were transcribed and implemented, including lab testing.</p>				

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R000145	<p>indicated the facility did not have a policy related to reviewing the physician's progress notes and writing clarification orders.</p> <p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on record review and interview, the facility failed to ensure bed alarms functioned properly to alert staff for 1 of 3 residents reviewed for falls in a sample of 7. (Resident #R42)</p> <p>Findings include:</p> <p>Resident #R42's clinical record was reviewed on 5/28/14 at 8:40 a.m. Her diagnoses included, but were not limited to, dementia, anxiety and depression.</p> <p>The resident's current physician's orders included an order for a clip alarm/sensor pad to bed to alert staff of unassisted transfers related to Alzheimer's disease and to check function and placement</p>	R000145	<p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p><b>R 145 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident R42 - bed alarm is in place and functioning properly. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will observe all bed and chair alarms in place to ensure they are functioning properly. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following: Falls Management Program Guidelines and Hourly</p>	06/27/2014

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R000273	<p>every shift. This order was initiated 2/3/14.</p> <p>Review of a 4/23/14, "Fall Circumstance, Assessment and Intervention" form indicated the resident was found on the floor in her room. The form indicated the resident had been ambulating and slipped. The form indicated "Equipment inspection: Safety equipment in place and functioning at time of incident?" The question was answered as no. The form indicated the wheelchair brakes were not locked. Review of the 4/23/14 "Accident/Incident Report" indicated the bed and chair alarms were checked for function and the bed alarm was replaced.</p> <p>During an interview with the Director of Nursing on 5/28/14 at 9:45 a.m., additional information was requested related to the circumstances of the fall.</p> <p>During an interview with the Administrator, Director of Nursing, and RN Consultant on 5/28/14 at 2:20 p.m., no additional information was provided.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas</p>		<p><b>Rounding How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observe to ensure bed and chair alarms are in place and functioning properly. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>(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> <p>Based on observation and interview, the facility failed to ensure sanitizer testing was completed on the three compartment sink in the Legacy Kitchen. This deficient practice had the potential to impact 21 Residential residents who resided on the Legacy Unit.</p> <p>Findings include:</p> <p>During the 5/28/14, 8:15 a.m., kitchen sanitation tour of the Legacy Kitchen, Cook #1 was washing pots, pans and cooking utensils in the three compartment sink. During an interview at this time, Cook #1 indicated the items washed in the three compartment sink were not sent through the dishwasher. She additionally indicated the items were sanitized using a sanitizer solution in the third compartment of the sink. She stated she was out of test strips to test sanitizer strength and had been out of this supply for at least a month. She indicated she had not requested test strips from the Dietary Manager and did not know if the manager was aware Legacy Kitchen needed more sanitizer test strips.</p> <p>During a 5/28/14, 8:30 a.m., interview, Cook #1 indicated 21 residents resided</p>	R000273	<p>R273</p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b></p> <p>It is the mission of this facility to always maintain in accordance with state and local sanitation and safe food handling standards by ensuring sanitizer testing is completed on our three compartment sink in the Legacy Kitchen. The Director of Food Services tested the sink during the survey and the sink was found to be in proper range for sanitation.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and</b></p> <p><b>corrective actions taken:</b></p> <p>This practice had the potential to impact 21 Residential residents who resided on the Legacy Unit. The Director of Food Services tested the sink during the survey and the sink was found to be in proper range for sanitation.</p>	06/27/2014			

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	<p>on the Legacy Unit and received meals prepared in the Legacy Kitchen.</p> <p>Review of the kitchen daily test logs for 4/11/14 through 5/28/14 indicated the sanitizer in the three compartment sink had not been documented as tested on any day for this 47 day period.</p> <p>During a 5/28/14, 8:45 a.m., interview with the Dietary Manager, she indicated she had not been notified by Legacy Kitchen staff that they needed more tests strips for the three compartment sink. She additionally indicated the sanitizer test strips were in the facility in the Main Kitchen and could have been immediately delivered to the Legacy Kitchen. She stated she did random spot checks of the kitchen daily test logs for the Legacy Kitchen and had not noted the lack of sanitizer testing in the three compartment sink.</p> <p>Review of a current, undated, facility policy titled "3-Compartment Sink", which was provided by the Dietary Manager on 5/28/14 at 10:40 a.m., indicated the following: "Fill sanitizer sink to water fill line. Quat Sanitizer should read minimum of 200 ppm [parts per million] on test strip. Check solution reading at room temperature.</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b></p> <p>DFS will in-service dietary department on <b>Sanitizer Testing</b> which includes the purpose, frequency and documentation.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted by the DFS/ designee daily times 4 weeks, then two times weekly times 4 weeks, then weekly times 4 weeks, then monthly times 3 months to ensure compliance. The results of the audit /observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.</p>				

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R000349	<p>...Immerse dishes in the 3rd sanitizing sink solution for a minimum of 60 seconds."</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 follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to insure resident records were documented with complete information for 1 of 7 records reviewed in a sample of 7. (Resident #R42)</p> <p>Findings include:</p> <p>Resident #R42's clinical record was reviewed on 5/28/14 at 8:40 a.m. Her diagnoses included, but were not limited to, dementia, anxiety and depression.</p> <p>The resident's current physician's orders included an order for a clip alarm/sensor pad to bed to alert staff of unassisted</p>	R000349	<p><b>R 349 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #R42 - additional information regarding the falls on 4/15/14 and 4/23/14 were added as a late entry into the clinical record.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with falls for the past 30 days to ensure the resident records are documented with complete information related to the circumstances of the fall.</p>	06/27/2014

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	<p>transfers related to Alzheimer's disease and to check function and placement every shift. This order was initiated 2/3/14.</p> <p>Review of a 4/15/14 "Fall Circumstance, Assessment and Intervention" form indicated the resident was found on the floor in her room. The form indicated the resident had slipped. Safety equipment was in place, wheelchair brakes were locked and the chair fit the resident properly. The answer to "Bed wheels locked?" had the "Y" for yes circled with a line drawn through it and the "N" for no was not circled. The form indicated quarter side rails might be helpful for the resident. The "Incident/Accident Report" for the fall indicated the alarms were functioning properly and to ensure the bed was in the lowest position.</p> <p>Review of a 4/23/14 "Fall Circumstance, Assessment and Intervention" form indicated the resident was found on the floor in her room. The form indicated the resident had been ambulating and slipped. The form indicated "Equipment inspection: Safety equipment in place and functioning at time of incident?" The question was answered as no. The form indicated the wheelchair brakes were not locked. Review of the 4/23/14 "Accident/Incident Report" indicated the</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Accident and Incident Reporting Guidelines <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents with falls, per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of fall circumstance form and accident/incident report to ensure the resident records are documented with complete information related to the circumstances of the fall. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>bed and chair alarms were checked for function and the bed alarm was replaced.</p> <p>Review of the nurse's notes for the fall on 4/15/14 indicated the resident was found on the floor, the family and doctor were made aware of the fall and there were no new orders. There was no nurse's note entry related to the fall on 4/23/14.</p> <p>During an interview with the Director of Nursing on 5/28/14 at 9:45 a.m., additional information was requested related to the circumstances of the fall.</p> <p>During an interview with the Administrator, Director of Nursing, and RN Consultant on 5/28/14 at 2:20 p.m., no additional information was provided.</p> <p>The 10/2012, revised Assisted Living Guidelines "Accident and Incident Investigation and Reporting" procedure was provided on 5/28/14 at 2:29 p.m., by the RN Consultant and indicated the following:</p> <p>"Purpose: To ensure all accidents, incidents and allegations of abuse involving residents, visitors, or employees are investigated and reported to the facility administration. Procedure:</p> <ol style="list-style-type: none"> <li>1. All accidents, incidents, and occurrence defined by state regulatory</li> </ol>			

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	<p>agencies shall be reported to the department supervisor as soon as it is discovered or when information of an occurrence is learned. 2. An Accident and Incident Form shall be completed for known accidents, incidents and abuse allegations....8. Investigative action shall be initiated by the staff by completing the appropriate "Circumstance and Reassessment form" and forwarded to the Director of Health Services....10. The administrative staff shall complete the investigation, by completion of the "Interdisciplinary Team" section of the Circumstance and Reassessment for and/or State Agency form as required. 11. The following data shall be included in the Accident and Incident form (front and back) and/or the Circumstance and Reassessment form: a. Date and time the accident, incident or abuse allegation took place. b. Nature of the injury/illness. c. Circumstances surrounding the occurrence. d. Where the occurrence took place....h. Determination of the root cause....m. Corrective action taken. N. Documentation in medical record completed, recorded on the 24 hour report.</p>				