

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2012
NAME OF PROVIDER OR SUPPLIER LYND HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 2410 E MCGALLIARD RD MUNCIE, IN 47303		
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R0000	<p>This visit was for a Quality Assurance walk through.</p> <p>Survey dates: July 16 & 17, 2012</p> <p>Facility number: 004428 Provider number: 004428 AIM number: N/A</p> <p>Survey team: Karen Lewis, RN TC Ginger McNamee, RN</p> <p>Census bed type: Residential : 48 Total: 48</p> <p>Census payor type: Other: 48</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 20, 2012 by Bev Faulkner, RN</p>	R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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R0214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to evaluate a resident after receiving results of an abnormal chest x-ray for 1 of 7 residents reviewed for evaluations in a sample of 7. [Resident #17]</p> <p>Findings include:</p> <p>Resident #17's clinical record was reviewed on 7/16/12 at 4:00 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and dementia.</p> <p>The resident had one "Resident Services Notes" for the month of July, 2012. The note was dated 7/10/12 at 4:35 p.m., the note indicated a mobile x-ray company had called the facility with the results of a chest x-ray that had been performed earlier in the day on Resident #17. The results were a very slight lower lobe atelectasis (a collapsed or airless state of the lung). The note indicated a message was left for Resident #17's physician and</p>	R0214	<p>Corrective Action - The Physician's office was notified of the result of this radiology report. A message was left for the physician on 7-10-12 at 4:35pm and the Nurse Practitioner was notified on same date at 4:45pm (refer to EXHIBIT A). A late entry was entered into the Resident Service Notes indicating the same and there were no new orders received from physician. A follow up chest Xray was completed for verification of COPD indication. Identification - The facility shall identify other residents with potential to be affected as any resident who is receiving lab or xray orders. Nurses will document notification to physician and/or Nurse Practitioner in Resident Service Notes for all testing results received by facility. The facility follows documentation by exception policy and will document any and all changes in condition, testing results, physician/medical provider notifications to ensure the "deficient practice" does not recur. Monitoring - The Wellness</p>	08/31/2012			

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	<p>would be followed up with a call the next morning. The clinical record lacked any evaluation of the resident nor did it indicate a follow-up call was made to the physician.</p> <p>The 6/08, "Resident Care Services Resource Guide" was provided by the Administrator on 7/17/12 at 9:30 a.m., and indicated any change in a resident's health condition should be documented in the "Resident Services Notes" along with follow-up action taken. The guide indicated notes should be complete, making sure that everything significant to the resident's condition is recorded.</p> <p>During an interview with the Director of Nursing and Administrator on 7/16/12 at 4:35 p.m., additional information was requested. No additional information was provided.</p>		<p>Director. Residence Director and/or a designated Nurse will be responsible to ensure that all documentation is accurately entered into the Resident Service Notes by conducting random audits of chart documentation compared to lab and test results and changes in condition. Systemic changes will be in place by August 31, 2012. Addendum: Audits will be conducted at least weekly to ensure compliance. The number of audits will be determined by the number of diagnostic testing ordered during a particular week as each such test ordered will indicate that resident chart be reviewed/audited for accurate documentatio and necessary notifications. The facility contends that this review shall become routine practice with no specific end date.</p>		

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R0241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure sliding scale insulin coverage was given as ordered for 1 of 2 residents reviewed for sliding scale insulin coverage in a sample of 7. [Resident #18]</p> <p>Findings include:</p> <p>Resident #18's clinical record was reviewed on 7/16/12 at 2:25 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II and diabetic neuropathy.</p> <p>The resident's most recent signed recapitulation of physician's orders were for February, 2012. The orders were signed by the Nurse Practitioner and were not dated when signed. The orders indicated blood sugar checks were to be done every morning and as needed and were to be done by the resident. The orders indicated the resident could not self-administer medications. The resident had an order for Novolog sliding scale</p>	R0241	<p>Corrective Action - The resident identified, #18, was interviewed by Residence Director and indicated that he DID self-administer insulin on the five dates noted in the SOD. The resident willingly provided a statement to that effect (refer to EXHIBIT B). The facility will document all blood glucose results and amounts of insulin units administered (when indicated) in the MAR on specific documents now in place and identified for such results. Identification - The facility identifies any resident with orders for blood glucose monitoring and/or insulin administration as having potential to be affected by the "deficient practice." Corrective action, as described above, involves nurses documenting ALL blood glucose monitoring results and insulin administration (where indicated) in the MAR on specific documents now in place and identified for such results. The facility has implemented two new tools located in the MAR to record all blood glucose monitoring</p>	08/31/2012			

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	<p>insulin coverage for blood sugars as follows: 141-180 = 1 unit 181 - 220 = 2 units 221 - 260 = 4 units 261 - 300 = 6 units 301 - 340 = 7 units 341 - 380 = 8 units 381 - 420 = 9 units 421 - 460 = 10 units greater than 460 = 12 units, call the physician for blood sugars less than 60 or greater than 500.</p> <p>Review of the "Blood Glucose Monitoring Tool" for July, 2012, indicated the facility was obtaining the resident's blood sugars. The tool lacked the before breakfast blood sugar result for 7/15/12.</p> <p>The tool indicated the resident's blood sugar was 150 before breakfast on 7/3/12, with no indication of sliding scale insulin coverage. The resident should have received 1 unit of coverage.</p> <p>The tool indicated the resident's blood sugar was 178 before breakfast on 7/8/12, with no indication of sliding scale insulin coverage. The resident should have received 1 unit of coverage.</p> <p>The tool indicated the resident's blood sugar was 155 before breakfast on 7/9/12, with no indication of sliding scale insulin</p>		<p>results and insulin administration (where indicated).Monitoring - The WD or Nurse Designee shall review the blood glucose monitoring and insulin administration tools on a daily basis to monitor and ensure that all results are accurately documented.All changes indicated will be in place on or before 8/31/2012Addendum: The facility reviews and assesses each resident on a scheduled basis (at least every 6 months) and always re-assesses residents with a change of condition. It is during these assessments that a residents' ability to self-administer medications is reviewed along with review by residents' physicians when they approve physician order sheets and sign off as to resident capabilities. The insulin administration tools will be in place ongoing at the facility. The Wellness Director or nurse designee will continue to monitor accuracy of the tools as long as the facility has any resident with insulin orders.</p>				

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	<p>coverage. The resident should have received 1 unit of coverage.</p> <p>The tool indicated the resident's blood sugar was 146 before breakfast on 7/10/12, with no indication of sliding scale insulin coverage. The resident should have received 1 unit of coverage.</p> <p>The tool indicated the resident's blood sugar was 141 before breakfast on 7/14/12, with no indication of sliding scale insulin coverage. The resident should have received 1 unit of coverage.</p> <p>Review of the July, 2012, "Medication Administration Record" and "Resident Service Notes" lacked an indication of insulin coverage being given for these results. This resulted in the resident not receiving insulin coverage for five of seven opportunities of blood sugars above 140.</p> <p>During an interview at 11:05 a.m., on 7/17/12, LPN #2 indicated sliding scale coverage should be documented on the Medication Administration Record and on the Blood Glucose Monitoring Tool.</p>						

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R0297	<p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on observation and record review, the facility failed to ensure a routine medication was available for 1 of 4 residents observed for medication administration. (Resident #23)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident # 23 was reviewed on 7/16/12 at 11:45 a.m.</p> <p>Diagnoses for Resident #23 included, but were not limited to Alzheimer's dementia, hypertension, and depression.</p> <p>During the medication administration observation on 7/16/12 at 9:00 a.m., with LPN #1, Resident #23 did not receive routine Miralax.</p> <p>Resident # 23 had a physician's order, dated 12/2/09, for Miralax powder, give 1 capful (17 Grams) orally in 6 ounces of liquid (dissolved) every morning.</p> <p>During an interview with the Director of</p>	R0297	<p>Corrective Action - Resident #23 received the accurate dose at the next scheduled interval. The resident was monitored for any signs or symptoms of distress related to this one missed dose of Mirilax. The facility will ensure that medications for this and all residents are available at scheduled administration intervals. Identification - The facility identifies all residents who receive medications as having the potential to be affected by the "deficient practice" and will ensure that medications are re-ordered at any time there are no less than three doses remaining of given medication. The facility will re-order, or notify resident responsible parties who refill medications for their respective residents, when there are no less than three doses of a given medication remaining. The Wellness Director and/or designated nurse, will montior all medications on a daily basis during routine medication pass intervals to ensure adequate dosage amounts are available and re-order as indicated above.</p>	08/31/2012			

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	<p>Nursing on 7/16/12 at 12:45 p.m., she indicated Resident #23 uses PRN Pharmacy and the facility orders the resident's medications.</p> <p>During an interview with the Director of Nursing on 7/16/12 at 3:35 p.m., she indicated she calls the pharmacy if a medication is missing the refill sticker. She indicated she called the pharmacy today to double check if the Miralax had been ordered. The Miralax had not been ordered.</p>		<p>Effective date of systemic chage will be on or before 8/31/2012Addendum: As indicated above, the monitoring will continue daily on an ongoing basis as a routine practice at this facility by Wellness Director and/or Nurse designee.</p>		

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurate in regards to blood glucose monitoring and medication orders for 2 of 7 resident reviewed for complete and accurate clinical records in a sample of 8. [Resident #'s 18, #36]</p> <p>Findings include:</p> <p>1. Resident #18's clinical record was reviewed on 7/16/12 at 2:25 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II and diabetic neuropathy.</p> <p>The resident's most recent signed recapitulation of physician's orders were for February, 2012. The orders were signed by the Nurse Practitioner and were not dated when signed. The orders indicated blood sugar checks were to be done every morning and as needed and</p>	R0349	<p>1. Corrective Action - The Blood glucose result for resident #18 was documented for 7-15-12 on 7-17-12 by LPN who had failed to record it from her diary on 7-15-12. The facility will ensure all blood glucose results are immediately documented upon receiving the result utilizing a new tool found in the MAR that is identified as the blood glucose monitoring document. Identification - The facility identifies residents with orders for blood glucose monitoring as having the potential to be affected by the "deficient practice." The facility has developed a tool located in the MAR, and identified, to record all blood glucose monitoring results for each resident with such orders. The Wellness Director and/or Nurse designee or Residence Director shall hold responsibility for monitoring the blood glucose monitoring documentation tool on a daily basis to ensure accuracy of result documentation. Effective date of</p>	08/31/2012			

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	<p>were to be done by the resident. The orders indicated the resident could not self-administer medications.</p> <p>Review of the "Blood Glucose Monitoring Tool" for July, 2012, indicated the facility was obtaining the resident's blood sugars. The tool lacked the before breakfast blood sugar result for 7/15/12.</p> <p>The resident had a 6/11/12, telephone order to "Increase Lantus [insulin] by 3 units each week until BS [blood sugar] is controlled." The order lacked parameters indicating where the blood sugar level should be to be considered controlled.</p> <p>Review of June 2012, Medication Administration Record [MAR] indicated "Increase Lantus by 3 units q [every] Monday if B.S. remain over 200 and notify [name of doctor.]"</p> <p>The resident's clinical record indicated the facility did not begin monitoring the resident's blood sugar until June 19, 2012.</p> <p>The 6/08, "Medication and Pharmacy Services Resource Guide" was provided by the Administrator on 7/17/12 at 9:30 a.m. The guide indicated the results of the blood sugar monitoring was to be recorded by initialing on the resident's</p>		<p>change on or before 8/31/2012.2. Corrective Action - Resident #36 current medications have been cross referenced with the Physician Order on file in the Resident record and clarifications, changes and deletions will be made through communications with physician. Identification - The facility identifies any resident that self-administers medications as having the potential to be affected by the "deficient practice."The facility Wellness Director or Nurse designee will review current medications for all self-administering residents and complare to the physician order sheet on file in the Resident record to ensure accuracy of all orders on a monthly basis. Any discrepancies will be immediately communicated to the residents' physician for clarification order. Monitoring - The Wellness Director or nurse designee will monitor the corrective change on a monthly basis by comparing the pharmacy-produced physician order documents to what each self-administering resident is currently taking to ensure orders are accurate and match medications being taken.Effective date on or before 8/31/2012Addendum:The monthly monitoring will continue on an ongoing basis as a routine practice at this facility.</p>				

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	<p>medication/treatment record on the appropriate day. The guide indicated the residence must have proper physician's orders before providing assistance with any medication or treatment and indicated all residents must have a Physician Plan of Care. The guide indicated the following steps are involved in taking a phone order: write down the complete order as given by the physician or his/her nurse, including the medication name, date, route of administration, frequency, reason being given, time(s) of administration, strength and dose.</p> <p>2. Resident #36's clinical record was reviewed on 7/16/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, anemia, vitamin B12 deficiency, and hyperlipidemia.</p> <p>The last signed recapitulation of Physician's Orders was dated 2/16/12. The most recent unsigned recapitulation of the Physician's Orders on the resident's record included, but were not limited to: lisinopril [for blood pressure] 10 mg one tablet orally everyday; lisinopril-HCTZ [for blood pressure] 10-12.5 mg one tablet orally everyday; digoxin [a heart medication] 125 mg one tablet everyday; trilipix DR [a cardiovascular medication] 135 mg one capsule orally once a day at</p>						

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	<p>5:00 p.m.; Lantus [insulin to control blood sugar] solostar 100 u/ml inject 36 units every evening; metformin HCL [a diabetic medication] 500 mg one tablet orally two times a day at 7:00 a.m. and 7:00 p.m.</p> <p>During an interview with Resident #36 on 7/16/12 at 10:15 a.m., she indicated the lisinopril and lisinopril HCTZ were discontinued five or six months ago. She indicated the trilipix DR and digoxin were discontinued in May, 2012. She indicated the doctor thought the medications were causing her potassium to be too high. She indicated she takes 36 units of Lantus insulin in the evening and metformin before breakfast and before dinner. The resident provided her most recent "Client Medication Report" with the directions for her medications and indicated they were provided by the home health agency she used. She indicated the orders were given to the home health agency from her family doctor.</p> <p>The resident had a 2/21/12, "Folstein Mini Mental Status Examination" indicating the resident had no cognitive impairment. The resident was identified as interviewable by the Director of Nursing on 7/16/12 at 9:07 a.m.</p> <p>The resident had a "Medication</p>			

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	<p>Self-Administration Assessment" on 4/25/12, and was determined to be competent to order, store, and administer her own medications.</p> <p>During an interview with the Director of Nursing on 7/16/12 at 10:30 a.m., she indicated she was not aware of the resident's order changes.</p> <p>The 6/08, "Medication and Pharmacy Services Resource Guide" was provided by the Administrator on 7/17/12 at 9:30 a.m. The guide indicated "...For residents who self-administer: 1. Quarterly, or monthly depending on state regulations, the Wellness Director will review the Medication Administration Record with the self-medicating resident to determine any changes in the medication regimen that have occurred during the quarter or month. This should occur during the review for self-administration. 2. If a medication change is reported, the Wellness Director will confirm those changes with the resident's physician and will make the necessary changes on the Medication Administration Record based upon the physician's order.... When residents self-manage all or part of their medications, they should be given a copy of their medication record(s) to review for accuracy. Ask the resident to notify the nurse or other designated staff of any</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/17/2012	
NAME OF PROVIDER OR SUPPLIER LYND HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 2410 E MCGALLIARD RD MUNCIE, IN 47303			
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	order changes that have not been incorporated onto the medication record(s)...."						