

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2016
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NAME OF PROVIDER OR SUPPLIER BLOOM AT GERMAN CHURCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2250 HARVEST MOON DR INDIANAPOLIS, IN 46229
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: July 11 and 12, 2016</p> <p>Facility Number: 003916 Provider Number: N/A AIM Number: N/A</p> <p>Census Bed Type: Residential: 55 Total: 55</p> <p>Census Payor Type: Other: 55 Total: 55</p> <p>Sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on July 14, 2016</p>	R 0000	<p>Submission of this response and Plan of Correction is not a legal admission that the deficiency exists or, that the Statement of the 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 the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
R 0240 Bldg. 00	<p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with</p>			

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

TITLE

(X6) DATE

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

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	<p>activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician of out of range blood sugar readings and administer medications, as ordered, for 3 of 7 residents reviewed for following physician's orders. (Residents #32, #45, and #56)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #56 was reviewed on 7/11/16 at 2:00 p.m. The diagnoses for Resident #56 included, but were not limited to, diabetes mellitus.</p> <p>The 5/2/16 Resident Service Plan for Resident #56 indicated he needed diabetic care, with a goal to maintain his diabetes. It indicated the facility administered his medications. It indicated Resident #56 had significant dementia, and often did not eat enough to keep his blood sugars in check.</p> <p>The June, 2016 Physician's Orders for Resident #56 indicated blood sugar testing to be done 4 times daily at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m., effective 3/7/16. The orders indicated sliding scale Novolog (insulin) to be administered for blood sugar</p>	R 0240	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #56 no longer resides at this facility. Resident #32 physician orders have been reviewed. Resident #32 receives 2.5 mg of Lisinopril per physician orders. Resident # 45 receives Levothyroxine 25mcg 1 tablet daily per physician orders. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Physician orders for all residents residing at the facility have been reviewed. All residents are receiving medications and blood sugars are being called per physician orders. On July 25, 2016 all licensed staff received education regarding medication administration and blood sugar call orders. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: On July 25, 2016 all licensed nursing staff were educated regarding medication administration and following physician orders including physician call orders. All physician orders have been</p>	07/27/2016

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	<p>readings, effective 4/7/16, as follows:</p> <p>less than 100 = 0 Units 100-150 = 5 Units 151-200 = 6 Units 201 - 250 = 7 Units 251 - 300 = 8 Units 301 - 350 = 9 Units 351 - 400 = 10 Units 401 - 450 = 11 Units 451 - 550 = 12 Units greater than 550 = call M.D.</p> <p>The June, 2016 MAR (medication administration record) for Resident #56 indicated Resident #56 had a blood sugar reading of 572 at 9:00 p.m. on 6/11/16 and a reading of "HI" (reading too high to be read by the blood sugar testing machine) at 9:00 p.m. on 6/12/16.</p> <p>There was no information in the clinical record to indicate the M.D. was notified of the above 2 blood sugar readings on 6/11/16 or 6/12/16.</p> <p>The 6/13/16, 7:10 a.m. Resident Progress Note indicated, "Res. (Resident) sent to (name of hospital) (symbol for "with") blood sugar reading Hi. Res tested on 2nd machine, still registering Hi. MD notified..."</p> <p>The 6/13/16, 1:15 p.m. Resident</p>		<p>reviewed for accuracy. All new physician orders will be reviewed by an additional licensed staff member for accuracy. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place: The Director of Wellness or her designee will audit/monitor medication administration and physician orders weekly for 1 month, monthly for 3 months and quarterly for 3 quarters. The Director of Wellness or her designee will review glucose testing results for appropriate action weekly for 1 year. All results will be reviewed with the Executive Director. By what date will the systemic changes will be completed: July 27 2016 July 27, 2016</p>				

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	<p>Progress Note indicated, "Admitted to (name of hospital) (symbol for "with) hyperglycemia."</p> <p>The 6/13/16 Hospital Discharge Summary indicated the principal problem was poorly controlled type 1 diabetes mellitus with ketoacidosis (a serious diabetes complication where the body produces excess blood acids).</p> <p>An interview was conducted with the DOW (Director of Wellness) on 7/11/16 at 2:35 p.m. She indicated the physician was not notified of the high blood sugar readings on 6/11/16 or 6/12/16. She indicated the 6/13/16 day shift nurse determined Resident #56 needed sent out to the hospital, when she came in for work that morning.</p> <p>2. On 7/12/16 at 9:18 a.m., QMA (qualified medication assistant) #5 was observed preparing medication for Resident #32. Medication included, but was not limited to, lisinopril 5 mg (milligrams) tablet.</p> <p>On 7/12/16 at 9:20 a.m., the EMAR (electronic medication administration record) indicated the following order: lisinopril 5 mg tablet give 1/2 (half) tablet (2.5 mg) by mouth daily.</p> <p>On 7/12/16 at 9:22 a.m., QMA #5</p>			

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	<p>obtained Resident #32's blood pressure via wrist blood pressure device prior to administration of lisinopril.</p> <p>An interview was conducted with QMA #5 on 7/12/16 at 9:23 a.m. She indicated Resident #32 was supposed to receive a whole tablet of lisinopril 5 mg. She then proceeded to give Resident #32 the medicine cup that contained a whole tablet of lisinopril 5mg to administer by mouth with water.</p> <p>On 7/12/16 at 9:25 a.m., QMA #5 reviewed the EMAR that indicated Resident #32 was supposed to receive only a half tablet of lisinopril 5 mg tablet. She indicated she administered only a half tablet and proceeded to open Resident #32's pill bottle that had whole and half tablets of lisinopril 5 mg.</p> <p>On 7/12/16 at 11:10 a.m., physician orders were reviewed for Resident #32. Orders included the following, "...lisinopril tab [tablet] 5mg give 1/2 [half] tablet [2.5 mg] by mouth daily...." Order was initiated on 4/19/16.</p> <p>An interview was conducted with DOW (Director of Wellness) on 7/12/16 at 11:12 a.m. She indicated she expected nursing staff to follow physician orders as written.</p>			

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	<p>A Service Plan, dated 7/1/16, was provided by DOW on 7/12/16 at 12:45 p.m. Service Plan indicated the following, "...Action: Facility medication administration...Staff will order, store and dispense all medications...."</p> <p>3. On 7/11/16 at 12:40 p.m., the clinical record was reviewed for Resident #45. Diagnoses included, but were not limited to, hypothyroidism.</p> <p>On 7/12/16 at 11:10 a.m., physician orders, signed 6/12/16, were provided by the DOW. Physician orders indicated the following order, "...levothyroxine tab 25 mcg give 1 tablet by mouth every day...Dx: hypothyroidism...." The order was initiated on 6/1/16.</p> <p>On 7/11/16 at 2:30 p.m., the June, 2016 and July, 2016 EMAR (electronic medication administration record) for Resident #45 was provided by the DOW (Director of Wellness). It indicated Resident #45 had an order for levothyroxine tab (tablet) 25 mcg (micrograms) give 1 tablet by mouth every day. The EMAR indicated the medication was administered on the following days:</p> <p>6/12/16</p>			

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R 0273	<p>6/19/16 6/26/16 7/3/16 7/10/16</p> <p>On 7/12/16 at 8:58 a.m., an interview was conducted with the DOW. She indicated the computer made the order appear incorrectly to be administered on a weekly basis instead of a daily basis.</p> <p>A Service Plan, dated 6/9/16, was provided by the DOW on 7/12/16 at 12:45 p.m. It indicated the following, "...Notes: [Resident Name] will have all meds ordered, stored, dispensed by nursing...."</p> <p>A policy titled "Medications", date of issue: May, 2012, was provided by the DOW on 7/12/16 at 11:14 a.m. The policy indicated the following, "...Procedure:...5. The Nurse, or designee, must refer to the Medication Administration Record (MAR) to obtain correct medication, time, dosage, and route of administration as ordered by the physician for each individual resident...."</p> <p>410 IAC 16.2-5-5.1(f)</p>			

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Bldg. 00	<p>Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the kitchen was maintained in a cleanly fashion and in good repair. This had the potential to affect 55 residents that dine from the kitchen.</p> <p>Findings include:</p> <p>During an observation, on 7/12/16 at 10:15 a.m., two vents were observed with gray debris in between the slats and a fan near the serving line was observed with black debris within the fan and in a circle on the ceiling around the fan. Near the dishwasher, a black substance spanned the length of the wall near the metal rim from the dishwasher. Two deep gouges with missing plaster were observed near the dishwasher. One gouge was finger length in size and the other gouge was observed to be golf ball size.</p> <p>During an interview with the Dietary Manager (DM), on 7/12/16 at 10:25 a.m., the DM indicated the gouges had been near the dishwasher for about 2 weeks.</p> <p>The Executive Director (ED), on 7/12/16</p>	R 0273	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: All residents residing at the facility and utilizing the dining services have the potential to be affected. All vents have been cleaned including the two identified vents. The black substance near the dishwasher has been removed and the two deep gouges have been repaired.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing at the facility and utilizing the dining services have the potential to be affected. The two identified vents have been cleaned. The black substance near the dishwasher has been removed and the two deep gouges have been repaired.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The entire kitchen area was cleaned. All employees working in the affected area were educated on July 25, 2016 on proper cleaning techniques for ceiling vents and</p>	07/27/2016			

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	<p>at 10:50 a.m., indicated the black substance was within the wall and could not be cleaned. He further indicated the kitchen was going to be remodeled shortly, but did not indicate a specific timeframe.</p> <p>On 7/12/16, at 12:00 p.m., the two vents were observed with the same gray debris in between the slats and the fan was observed as above.</p> <p>The DM indicated, on 7/12/16 at 12:05 p.m., the vents were supposed to be cleaned with the oven hood and the facility had a company come out to the facility to do so recently. The DM indicated it appeared the vents were not cleaned appropriately since the DM indicated he could visualize the gray debris in between the slats within the vents. As the DM observed the black debris lining the fan and the ceiling, the DM indicated the fan above the serving line was to be cleaned monthly by dietary staff. The DM indicated he will provide the cleaning logs and service invoice at this time.</p> <p>An Invoice provided by the DM, on 7/12/16 at 12:10 p.m., indicated the kitchen exhaust was cleaned on 7/6/16. The invoice did not indicate the vents were cleaned at the same time. A</p>		<p>walls in the dish room. Cleaning schedules have been revised to include ceiling vents and walls in the dish room. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e.what quality assurance program will be put into place: The Dietary Service Director or his designee monitor cleaning 5 times weekly for 4 weeks then weekly for 11 months. By what date the systemic changes will be completed. July 27, 2016</p>				

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R 0414 Bldg. 00	<p>document titled Cleaning List, for July 2016, provided by the DM, on 7/12/16 at 12:05 p.m., had a hand-written note, dated 7/10/16, that indicated, "Cleaned walls in dish room by table." The fan was not included on the Cleaning Lists for June 2016 or July 2016. .</p> <p>The ED and DM indicated on 7/12/16 at 12:17 p.m., the expectation was that kitchen was kept in a cleanly, orderly fashion.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, staff failed to perform hand hygiene in between resident contact during medication administration for 3 of</p>	R 0414	What corrective actions will be accomplished for those residents found to have been affected by the deficient	07/27/2016

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	<p>5 residents reviewed for medication administration. (Resident #31, Resident #32, and Resident #35)</p> <p>Findings include:</p> <p>1. On 7/12/16 at 9:22 a.m., QMA (qualified medication assistant) #5 obtained Resident #32's blood pressure via wrist device prior to administration of medication. She was utilizing her left hand to Resident #32's back to assist him with sitting up on the side of the bed. QMA #5 did not perform hand hygiene after administering medication to Resident #32. The blood pressure device was not cleansed after use.</p> <p>On 7/12/16 at 12:45 p.m., a Service Plan for Resident #32, dated 7/1/16, was provided by the DOW (Director of Wellness). The Service Plan indicated the following, "...Action:...Facility medication administration...Staff will order, store and dispense all medications...."</p> <p>On 7/12/16 at 9:30 a.m., QMA #5 proceeded with medication administration for Resident #31. QMA #5 prepared and administered medication to Resident #31 without performing hand hygiene before or after medication administration.</p>		<p>practice: Resident #31, #32, #35 receive medication from employees who perform proper hand hygiene. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents residing at the facility who receive medication from staff have the potential to be affected by this practice. All staff were educated on July 25, 2016 on proper hand hygiene during medication administration. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility's Medication Administration Policy and Infection Control Policy, including hand hygiene has been reviewed and all employees were educated on July 25, 2016 on Infection Control, Hand Washing and proper hand hygiene. All licensed staff were educated on July 25, 2016 on Medication Administration. How the corrective actions will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place: The Director of Wellness or her designee will audit/monitor medication administration to include proper hand hygiene 5 times weekly for one</p>				

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	<p>On 7/12/16 at 12:45 p.m. a Service Plan for Resident #31, dated 7/1/16, was provided by the DOW. The Service Plan indicated the following, "...Action:...Caregiver administration and/or observation...Notes: Nursing to order, store and dispense all medications..."</p> <p>On 7/12/16 at 9:36 a.m., QMA #5 proceeded with medication administration for Resident #35. QMA #5 prepared Resident #35's medication and went into the room to obtain Resident #35's blood pressure while utilizing her hands to apply blood pressure device to Resident #35's wrist. Blood pressure device was not cleansed before and after contact with Resident #35. QMA #5 administered medication to Resident #35 without performing hand hygiene before or after medication administration.</p> <p>On 7/12/16 at 12:45 p.m., a Service Plan for Resident #35, dated 6/9/16, was provided by the DOW. The Service Plan indicated the following, "...Action:...Caregiver administration and/or observation...Notes: [Resident Name] prefers the nursing staff to order, store and dispense all medications..."</p>		<p>month,weekly for 3 months and monthly for 3 quarters. All results will be reviewed with the Executive Director. By what date the systemic changes will be completed: July 27, 2016</p>	

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	<p>An interview was conducted with QMA #5 at 7/12/16 at 9:40 a.m. She indicated you should sanitize your hands in between contact with residents and wash hands if they are visibly soiled.</p> <p>An interview was conducted with the DOW on 7/12/16 at 11:11 a.m. She indicated staff should wash their hands before starting medication administration and sanitize their hands in between resident contact. If staff are physically touching the residents they should wash their hands.</p> <p>A Policy titled "Hand Washing", date of issue: May, 2012, was provided by DOW on 7/12/16 at 11:14 a.m. The policy indicated the following, "...Antimicrobial Hand Gels:...2. Use alcohol-based rubs after any direct contact with any resident, after having direct contact with a resident's skin, after having contact with bodily fluids, wounds or broken skin, after touching equipment or furniture near the resident, and after removing gloves...4. Hand rubs should be used before and after each resident...."</p>			