

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2015
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NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to Complaint IN00175557 completed on 6/25/15</p> <p>This visit was in conjunction with the Investigation of Complaints IN00178902 and IN00179746.</p> <p>Complaint IN00175557- Not corrected.</p> <p>Survey dates: August 6, 7, and 10, 2015</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Census bed type: SNF: 49 SNF/NF: 10 Total: 59</p> <p>Census payor type: Medicare: 32 Medicaid: 10 Other: 17 Total: 59</p> <p>Sample: 6</p> <p>This deficiency also reflects State findings cited in accordance with 410</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0279 SS=D Bldg. 00	<p>IAC 16.2-3.1.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop health care plans related to discharge planning for 3 residents who had been discharged from the facility (Residents B, C, and D) and for 1 resident (Resident F) who had chosen Do Not Resuscitate code status. 4 of 6 residents reviewed for care plans.</p> <p>Findings include:</p> <p>The record of Resident B was reviewed</p>	F 0279	<p>F 279</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Residents #B, C and D have been discharged. Resident #F's Care Plan was reviewed and revised to reflect the resident's individual</p>	08/18/2015
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	<p>on 8/06/15 at 11:00 A.M. Diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, bronchitis, and hypertension.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 7/08/15 indicated Resident B was cognitively impaired, required extensive assistance from staff for bed mobility, transfers, and activities of daily living, and did not ambulate. The M.D.S. also indicated Resident B was on anti-coagulation medication, and Resident B's expectation was to return to the community.</p> <p>Health care plans for Resident B indicated identified problems which included, but were not limited to, abnormal bleeding, altered cardiac output, coronary artery disease, atrial fibrillation with a risk for falls, and potential for pain.</p> <p>Resident B's record contained no discharge care plan, including, but not limited to, assessment of ongoing medical needs, assistance with arranging home health care or ongoing therapy, anticipation of ongoing needs for daily care and assistance, or the requirements for, and obtaining of, necessary durable medical equipment.</p>		<p>discharge plan and code status.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review and revise all resident Care Plans revised to reflect the resident's individual discharge plan and code status.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits will be conducted by the DHS or designee on 5 residents 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: resident Care Plans reflect the resident's individual discharge plan and code status.</p>	

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	<p>The record of Resident C was reviewed on 8/07/15 at 3:15 P.M. Diagnoses included, but were not limited to, aspiration pneumonia, anemia, chronic obstructive pulmonary disease, prolapsed bladder, a history of urinary tract infection and sepsis, and hypertension.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 6/03/15 indicated Resident C was mildly cognitively impaired, required extensive assistance from staff for bed mobility, transfers, and activities of daily living, did not ambulate, and had an indwelling urinary catheter. The M.D.S. also indicated Resident was on supplementary oxygen, and was in "almost constant" pain, and Resident C's expectation was to return to the community.</p> <p>Health care plans for Resident B indicated identified problems which included, but were not limited to, visual deficits, psychotropic medication use, hypertension, breathing problems, risk for falls, and potential for pain.</p> <p>Resident C's record contained no discharge care plan, including, but not limited to, assessment of ongoing medical needs, assistance with arranging home health care or ongoing therapy,</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>anticipation of ongoing needs for daily care and assistance, or the requirements for, and obtaining of, necessary durable medical equipment.</p> <p>The record of Resident D was reviewed on 8/07/15 at 2:00 P.M. Diagnoses included, but were not limited to, a history of falls, hypoxia, chronic obstructive pulmonary disease, leukocytosis, and acute systolic heart failure.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 7/21/15 indicated Resident D required extensive assistance from staff for bed mobility, transfers, and activities of daily living, and ambulated with the assistance of staff. The M.D.S. also indicated Resident B's expectation was to return to the community.</p> <p>Health care plans for Resident D indicated identified problems which included, but were not limited to, complications from benign prostatic hypertrophy, altered breathing problems, altered cardiac output, diuretic medication use, osteoporosis, risk for falls, and potential for pain.</p> <p>Resident D's record contained no discharge care plan, including, but not</p>			

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	<p>limited to, assessment of ongoing medical needs, assistance with arranging home health care or ongoing therapy, anticipation of ongoing needs for daily care and assistance, or the requirements for, and obtaining of, necessary durable medical equipment.</p> <p>The record of Resident F was reviewed on 8/07/15 at 11:45 A.M. Diagnoses included, but were not limited to, dysphagia, hypertension, depression, hypothyroidism, aspiration pneumonia, and fever.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 7/21/15 indicated Resident F was significantly cognitively impaired, required extensive assistance from staff for bed mobility, transfers, and activities of daily living, and used a wheelchair for ambulation.</p> <p>Resident F's record contained an "State of Indiana Out Of Hospital Do Not Resuscitate Declaration and Order" form dated 10/29/14. It indicated Resident F had a Do Not Resuscitate (DNR) code status.</p> <p>Resident F's record contained no Health Care Plan for a code status of Do Not Resuscitate including, but not limited to, identification of any special</p>			

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	<p>circumstances affecting code status, end of life care directions, family notification instructions, or funeral contact information.</p> <p>A facility policy titled "Interdisciplinary Team Care Plan Guideline" dated 1/08 obtained from the Director of Health Services on 08/07/15 at 2:35 P.M. indicated:</p> <p>Purpose: To ensure appropriateness of services and communication that will meet the resident's needs...</p> <p>Procedure...The initial plan of care included on the Admission Nursing Assessment will be initiated within 24 hours and completed within 72 hours of admission...Change in Condition' form may be utilized to reflect changes, additions, or discontinuation...or to reveal a new problem area."</p> <p>This deficiency was cited on 6/25/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(a)</p>			