

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 05/23/2013	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R000000	<p>This visit was for the State Residential Licensure Survey. This visit included the Investigation of Complaint IN00124345 and Complaint IN00129315.</p> <p>Complaint IN00124345-Substantiated-no deficiencies related to the allegation are cited.</p> <p>Complaint IN00129315-Substantiated. State residential deficiencies related to the allegation are cited at R217 and R275.</p> <p>Survey dates: May 20, 21 and 23, 2013.</p> <p>Facility number: 002999 Provider number : N/A AIM number : N/A</p> <p>Survey team: Michelle Hosteter, RN-TC Gloria Bond, RN Janet Stanton, RN</p> <p>Census bed type: Residential : 111 Total : 111</p>	R000000	<p><u>DISCLAIMER: Preparation and implementation of this plan of correction does not constitute admission or agreement by (facility name) of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated _____ . (Facility name) specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider. The facility reserves the right to challenge the findings by way of independent review procedures established by the agency.</u> Management meetings occur three times a week on an ongoing basis. These meetings review any pertinent quality issues during the meetings. They are a forum for discussion of quality improvement and survey is discussed, along with improvements that are noted to be needed either in the survey process, bi-annual inspection of community or quality assurance issues that need to be addressed as they occur.</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>Census payor type :</p> <p>Other: 111</p> <p>Total : 111</p> <p>Sample : 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on May 30, 2013.</p>						

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R000026	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents' rights and responsibilities. A copy of the residents' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on observation and interview, the facility failed to have the Resident Rights posted. This deficit practice had the potential to affect 111 of 111 residents residing in the facility.</p> <p>Findings include:</p> <p>During entrance on 5/20/13 at 10 a.m., it was noted there was no Resident Rights poster posted in any of the areas residents visited.</p> <p>During an interview with the Business Office Manager (BOM) on 5/23/13 at</p>	R000026	Resident Rights poster was ordered and will be posted in both AL and Keepsake unit. The Executive Director or designee will check to make sure the poster remains posted at least once per week for 30 days. Since the poster is very conspicuously located in the main hallway on both the AL and Keepsake side of the building it is easy to spot if it missing and will be easily monitored on an ongoing basis. A memo informing the residents of the location of the Resident Rights poster and the Survey inspection results was put on each resident's shelf next to thier	06/21/2013			

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	<p>1:15 p.m., he indicated the only resident rights he had posted were hung on the wall in the cafe area on the main floor. He indicated this is the only posted resident rights they have.</p> <p>In reviewing the information the BOM referred to, it was found the information was for residents regarding housing rights. not the required resident rights.</p>		door.				

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R000042	<p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys.</p> <p>Based on observation and interview, the facility failed to have all of the current survey information in the survey book posted in the front lobby area of building. This deficit practice had the potential to affect 111 of 111 residents residing in the building.</p> <p>Findings include:</p> <p>Upon entrance to the facility on 5/20/13 at 10 a.m., it was noted the survey book was located in the front lobby area.</p> <p>A review of the survey book on 5/20/13 at 10:30 a.m., indicated the most recent complaint survey dated 2/7/13 was not located in the survey book.</p> <p>The Business Office Manager reviewed the survey book on 5/23/13, and indicated in an interview at 1:15 p.m., the most recent complaint was not in the book and he did not know where it was.</p>	R000042	A copy of the latest survey was placed in the survey book located in the lobby so residents and visitor have easy access to the surveys. Unfortunately, pages often turn up missing. To prevent this another survey book will be kept behind the reception desk that will also be available for review. The Executive Director will check to make sure both books are up to date on a Bi-Annual Inspection basis ongoing from today. A memo informing the residents of the location of the Survey inspection results was put on each resident's shelf next to thier door.	06/21/2013			

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R000090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any</p>			

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	<p>subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on observation and interview, the facility failed to have all of the current survey information in the survey book posted in the front lobby area of building This deficit practice had the potential to affect 111 of 111 residents residing in the building.</p> <p>Findings include:</p> <p>Upon entrance to the facility on 5/20/13 at 10 a.m., it was noted the survey book was located in the front lobby area.</p> <p>A review of the survey book on 5/20/13 at 10:30 a.m., it was observed it did not have the most recent complaint survey dated 2/7/13 in the survey book.</p> <p>The Business Office Manager reviewed the survey book on 5/23/13, and indicated in an interview at 1:15 p.m., the most recent complaint was not in the book and he did not know where it was.</p>	R000090	A copy of the latest survey was placed in the survey book located in the lobby so residents and visitor have easy access to the surveys. Unfortunately, pages often turn up missing. To prevent this another survey book will be kept behind the reception desk that will also be available for review. The Executive Director will check to make sure both books are up to date on a Bi-Annual Inspection basis ongoing from today.A memo informing the residents of the location of the Survey inspection results was put on each resident's shelf next to thier door.	06/21/2013

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R000116	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure reference checks were completed prior to hiring for 1 of 1 employee files reviewed for reference checks in a sample of 5. (LPN # 2)</p> <p>Findings include:</p> <p>The employee records were reviewed on 5/23/13 at 10 a.m.</p> <p>The employee records form indicated LPN #2 was hired on 4/4/13.</p> <p>The form titled Confidential Reference Request forms were dated and signed on 4/20/13.</p> <p>In an interview with the DON on 5/23/13 at 11:15 a.m., she indicated the references are usually completed prior to someone starting the position.</p> <p>The DON provided a policy on 5/23/13 at 11:30 a.m., titled "Employee Hiring Process" dated</p>	R000116	<p>On employee LPN 1 the hire date provided to the surveyor was incorrect. The correct hire date was April 20, 2013. The reference checks were done timely on this particular nurse. We respectfully request this noncompliance be removed. Assuming this was a correct deficiency this is how it would be answered. Two reference checks are required prior to hire on each employee. The employee cannot go any further in the hiring process until the two reference checks are in the file. The supervisor is responsible for completing the reference checks. Once the reference checks are done the file is given to the receptionist who cannot proceed unless the file has reference checks. The employee files are then monitored by the business office manager for any missing items. A final check is done by the Executive Director before the file is deemed complete.</p>	06/21/2013			

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	3/17/11, which indicated, "...Department head reviews applications and checks references for applicants they may wish to hire...Prior to making an offer : two completed reference checks..."						

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R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p>			

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	<p>Based on record review and interview, the facility failed to ensure employees received their second step tuberculin test for 2 of 5 employee files reviewed for Tuberculin testing in a sample of 9. (Housekeeper #1, LPN # 1)</p> <p>Findings include:</p> <p>The employee records were reviewed on 5/23/13 at 10 a.m.</p> <p>Housekeeper #1's hire date was 3/25/13. The form titled Employee Mantoux/Chest X-Ray report indicated Housekeeper #1 had her first TB (Tuberculin) test done on 3/24/13. The second step test was completed on 5/13/13.</p> <p>LPN #1's hire date was 4/4/13. The form titled Employee Mantoux/Chest X-Ray report indicated the first TB test was completed on 9/20/13 and the second step TB test was completed on 5/19/13.</p> <p>The DON (Director of Nursing) indicated in an interview on 5/23/13 at 11:15 a.m., the second step TB test for these employees had not been done timely.</p> <p>The DON provided a policy on</p>	R000121	All PPD's were done immediately that needed to be completed. All employee files will be reviewed by the business office manager to ensure all ppd are completed and any that are not completed will be provided in a list format to the Director of Nursing and Executive Director for completion. To prevent this from happening again, all staff due for second stage PPD will be calendared in Outlook at the reception desk and sent to the Director of Nursing and Executive Director to ensure follow up. The Director of Nursing will be responsible for following up and making sure the second stage ppd is done timely. The Executive Director will monitor the employee files once completed, which includes the second step ppd being done on an ongoing basis.	06/21/2013			

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	5/23/13 at 11:30 a.m. titled "Employee Hiring Process" dated 3/17/11, which indicated, "...It is the employee's responsibility to ensure they complete their second stage PPD (Purified Protein Derivative) and submit a copy to the business office within three days after two weeks from the date of the first stage PPD. It is the department heads responsibility to make sure the employee completes this task...."			

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R000214	<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 interview and record review, the facility failed to evaluate the individual needs related to weight gain and admission, for 2 of 7 residents reviewed for evaluations in a sample of 7. (Residents #47 and #116)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #47 was reviewed on 5/21/13 at 10:30 A.M. Diagnoses included, but were not limited to, advanced vascular dementia, diabetes, hypertension, atrial fibrillation, and depression.</p> <p>The "Monthly Vital Sign" record had documentation of monthly weights at follows: 6/24/12--142 pounds 12/12/12--157 pounds 1/20/13--159 pounds 2/21/13--158.8 pounds March, 2013--168 pounds 4/17/13--169 pounds</p>	R000214	The residents affected were referred to the attending physician for evaluation. To identify other residents, all the residents were reweighed and the scales were checked for accuracy by making sure the scale was set for zero before weighing. Weights are tracked by the Director of Nursing and any five pound weight gain or loss will be referred to the physician for review. All direct care staff were instructed on the appropriate use of the scales and when to reweigh during an inservice conducted by 6/21/2013. All nurses will be inserviced on proper notification to physician on any five pound weight loss or gain by a resident. Community performs monthly weights on residents and only does weekly weights if orders by physician. Director of Nursing will review all physician orders on an ongoing basis to ensure compliance. The Director of Nurse will review the monthly weights on an ongoing basis to ensure the physician is notified of any five pound weight loss or gain.	06/21/2013			

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	<p>An evaluation of the resident's increasing weights over the past year, to determine individual needs related to the weight gain, was not found.</p> <p>In an interview during the daily conference on 5/21/13 at 3:30 P.M., the Executive Director and Director of Nursing indicated they had noticed the weight gain. Both indicated the resident "eats everything." They were given the opportunity to submit any documentation that an evaluation of the resident's weight gain had been done.</p> <p>At the final exit on 5/23/13, no additional information/evidence was provided for review.</p> <p>2. The closed clinical record for Resident #116 was reviewed on 5/20/13 at 11:00 A.M. The resident was admitted to the facility on 11/26/12 and was discharged to another facility on 3/30/12. Admission diagnoses included, but were not limited to, diabetes, hypertension, obesity, bilateral hearing loss, dementia, and recurrent falls.</p> <p>An evaluation of the resident's individual needs, completed prior to</p>						

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	<p>his admission on 11/26/12, was not found.</p> <p>In an interview on 5/21/13 at 3:30 P.M., the Director of Nursing indicated pre-admission evaluations were completed on a "Pre Move In Notification" form, and this resident's form was probably in his financial file in the business office.</p> <p>On 5/23/13 at 9:00 A.M., the Director of Nursing provided a copy of the "Pre Move In Notification" form for Resident #116.</p> <p>The form was dated 11/26/12 at 5:00 P.M., the day the resident moved into the facility.</p>						

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to provide follow up services in regards to swallowing and diet concerns for 1 of 7 records reviewed for follow-up services in a sample of 7. (Resident B)</p>	R000217	All residents have the potential to be affected. Nursing immediately identified the two other residents who were seen by speech therapy for swallowing issues. The diet orders of those two residents were then reviewed by the attending physician. The diet orders were then clarified by the physician on 5/29/2013. All	06/21/2013			

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	<p>Findings include:</p> <p>The record review for Resident B was completed on 5/23/13 at 11 a.m. Diagnoses included, but were not limited to, dementia, depression, Alzheimer, and chronic kidney disease.</p> <p>This resident was admitted to the facility on 4/4/12. The resident started to have a decline 1/11/13 and was admitted to hospice.</p> <p>The nursing notes indicated, "...12/31/12... Staff reported over weekend resident started spitting out food and medications... 1/7/13 at 11 p.m. feed for dinner doc[documented] not hold head up-leans her head back as far as she can she coughed numerous times when saliva, liq [liquid], food, ran down her throat when you tell her to hold her head up she will for a short moment-lungs clear [sign for after] dinner...3/4/14-5:30 p.m. [sign for at] dinner table-congestion [sign for and] gurgling throat full of sputum-taken to room [sign for and] suctioned...."</p> <p>There was a physician's order dated 2/17/12 for Speech therapy to evaluate due to difficulty swallowing. The evaluation was completed</p>		<p>diet order changes were then forwarded immediately to dietary for their notification by the Keepsake Unit Manager. All future speech therapy evaluations/recommendations will be forwarded immediately, upon receipt, to the attending physician for their review. The Keepsake Unit Manager and the Director of Nursing will track all speech therapy recommendations for follow-up by the physician. The Director of Nursing reviews re-writes or is the second review on re-writes and will monitor diet orders monthly on an ongoing basis y reviewing the re-writes and order changes. In addition, the Director of Nursing is provided a copy of all physician orders for review and will monitor them on an ongoing basis for diet orders. The physical therapist in charge of the therapy department is now attending morning management meetings at least once per week and discusses caseload and condition of residents with the managers. This is ongoing. The Director of Nursing will inservice all nurses on the facility policy for notification of physician by 6/21/2013.</p>				

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	<p>12/21/12 and was written on physician progress notes and indicated, "Pt [patient] seen by SLP [Speech Language Pathology] for dysphagia evaluation today. Oral mech [mechanical] exam and trials of liquids [sign for and] solids determined the best diet for pt's [patients] safety. Thin liquids okay. Separate textures-NO "mixed" textures recommended. When serving broth based soup, strain solids and serve separately. Also, crush medication and place in applesauce or other puree consistency...."</p> <p>The hospice documentation in the chart had a notation on 1/22/13 indicating, "... assist feed. separate textures, appetite [arrow up arrow down]...."</p> <p>The physician recapitulation for March 2013 indicated the resident was on a regular diet, and there was no information regarding crushing medications and adding to applesauce or other pureed texture. There was no other documentation from the facility regarding follow through with speech therapy recommendations.</p> <p>In an interview with the Director of</p>						

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	<p>Nursing on 5/23/13 at 1 p.m., she indicated she could not find any documentation regarding follow up with the speech therapy recommendations from dietary, the physician or nursing. She indicated hospice usually is the one responsible for following up with the speech therapy recommendations if the resident is on hospice.</p> <p>This state Residential tag relates to Complaint IN00129315.</p>						

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R000275	<p>410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.</p> <p>Based on record review and interview, the facility failed to follow up on speech therapy recommendations regarding a change of diet for 1 of 7 records reviewed for follow-up services in a sample of 7. (Resident B)</p> <p>Findings include:</p> <p>The record review for Resident B was completed on 5/23/13 at 11 a.m. Diagnoses included, but were not limited to, dementia, depression, Alzheimer, and chronic kidney disease.</p> <p>This resident was admitted to the facility on 4/4/12. The resident started to have a decline 1/11/13 and was admitted to hospice.</p> <p>There was a physician's order dated 12/17/12 for Speech therapy to evaluate due to difficulty swallowing. The evaluation was completed 12/21/12 and was written on physician progress notes and indicated, "Pt [patient] seen by SLP [Speech Language Pathology] for dysphagia evaluation today. Oral</p>	R000275	<p>All residents have the potential to be affected by the deficient practice. Nursing immediately identified all other residents with swallowing issues that had been evaluated by speech therapy. Two residents were identified and the diet orders of those residents reviewed and clarified by the attending physician. The Keepsake Unit Manager immediately notified dietary of any changes to the resident diets. All future speech therapy recommendations will be forwarded immediately to the attending physician for their review. The Director of Nursing and the Keepsake Unit Manager will then track all speech therapy recommendations for follow-up with physician. The Director of Nursing reviews re-writes or is the second review on re-writes and will monitor diet orders monthly on an ongoing basis y reviewing the re-writes and order changes. In addition, the Director of Nursing is provided a copy of all physician orders for review and will monitor them on an ongoing basis for diet orders. The physical therapist in charge of the therapy department is now attending morning management meetings at least once per week and discusses caseload and condition</p>	06/21/2013			

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	<p>mech [mechanical] exam and trials of liquids [sign for and] solids determined the best diet for pt's [patients] safety. Thin liquids okay. Separate textures-NO "mixed" textures recommended. When serving broth based soup, strain solids and serve separately. Also, crush medication and place in applesauce or other puree consistency...."</p> <p>The nursing notes indicated, "...12/31/12... Staff reported over weekend resident started spitting out food and medications...1/7/13 at 11 p.m. feed for dinner doc[documented] not hold head up-leans her head back as far as she can she coughed numerous times when saliva, liq [liquid], food, ran down her throat when you tell her to hold her head up she will for a short moment-lungs clear [sign for after] dinner...3/4/14-5:30 p.m. [sign for at] dinner table-congestion [sign for and] gurgling throat full of sputum-taken to room [sign for and] suctioned...."</p> <p>The physician recapitulation for March 2013 indicated the resident was on a regular diet, and there was no information regarding crushing medications and adding to applesauce or other pureed texture.</p>		<p>of residents with the managers. This is ongoing. All nurses will be inserviced on notification of physician by the Director of Nursing as of 6/21/2013.</p>				

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	<p>There was no other documentation from the facility regarding follow through with speech therapy recommendations.</p> <p>The hospice documentation in the chart had a notation on 1/22/13 indicating, "... assist feed. separate textures, appetite [arrow up arrow down]...."</p> <p>In an interview with the Director of Nursing on 5/23/13 at 1 p.m., she indicated she could not find any documentation regarding follow up with the speech therapy recommendations from dietary, the physician or nursing.</p> <p>This state Residential tag relates to Complaint IN00129315.</p>			

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NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
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R000349	<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 interview and record review, the facility failed to maintain accurate and complete documentation of fluid intake, for 1 of 1 resident who had a physician's order for a fluid restriction, in a sample of 7 residents reviewed. (Resident #48)</p> <p>Findings include:</p> <p>The clinical record for Resident #48 was reviewed on 5/21/13 at 1:10 P.M. Diagnoses included, but were not limited to, compression fractures with spinal stenosis of the thoracic and lumbar vertebrae, dementia, macular degeneration, chronic kidney disease, and hyponatremia (low blood sodium). The resident was moved to the secured/locked Alzheimer's unit on 7/25/12, and was able to ambulate with stand-by assistance and use of a walker.</p>	R000349	<p>The residents fluid restriction order was immediately evaluated by the attending physician and the fluid restriction was discontinued as of 5/21/2013. Nursing audited all other resident charts for any fluid restriction orders and none were found. All new admits into the facility will be reviewed per nursing and physician asked to clarify any orders for fluid restriction. Any residents with fluid restrictions will have a fluid intake sheet and nursing will log intake every shift. The charge nurses will be responsible for logging the fluid intake for each resident on fluid restrictions for their shift. The Unit Managers will review the intake sheets every 72 hours for completion. The intake logs on each resident on fluid restriction orders will be audited by the Director of Nursing weekly to ensure compliance. The Director of Nursing will inservice all nurses on appropriate documentation in the MAR by 6/21/2013.</p>	06/21/2013			

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NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
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	<p>On 7/13/12, the attending physician gave an order for "2000 cc [cubic centimeters] fluid restriction per day."</p> <p>The order was listed on the MAR (Medication Administration Record) for January, February, March, and April, 2013. The boxes for daily documentation were blank for all days, each month.</p> <p>The May, 2013 MAR had nurse initials in the boxes for each shift, each day, but there were no amounts listed for how much fluid was consumed at each time. There was no documentation of fluids provided and consumed between meals.</p> <p>In an interview on 5/21/13 at 1:30 P.M., QMA #4 indicated she was not sure if fluid consumption was documented for this resident. She stated "We know how much she gets."</p> <p>In an interview on 5/21/13 at 3:30 P.M., the Director of Nursing indicated she would need to review the resident's clinical record, since she had only been in her position for about 1 month.</p> <p>At the final exit on 5/23/13, no documentation related to actual fluid</p>						

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	consumption by the resident was provided for review.			

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R000354	<p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview, the facility failed to ensure transfer information was documented for 1 of 2 closed records reviewed in a sample of 7. (Resident # 117)</p> <p>Findings include:</p> <p>The record review for Resident #117 was completed on 5/21/13 at 10:30 a.m. Diagnoses included, but were not limited to, anemia, chronic obstructive pulmonary disease and high blood pressure.</p> <p>The nursing notes dated 1/26/13 at 8 p.m. indicated the physician was</p>	R000354	The Director of Nursing immediately reviewed all the charts of residents who had been admitted to the hospital or were currently out of the facility. Transfer information was in place in all four charts. The closed charts of the last six residents discharged from the facility were also audited and transfer information or death provisionals found intact for each chart. Also intact were nurses notes detailing the reason for transfer to hospital or another facility. In the case of residents who were deceased, a death provisional was in place, a note detailing the death and notification of mortuary. To ensure compliance from this point forward, the Director of Nursing	06/21/2013			

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	<p>notified regarding low oxygen saturations. The physician gave an order to send the resident to the hospital. On 1/27/13 at 3 p.m. the hospital was called regarding the resident's condition. The hospital indicated the resident was on Intravenous antibiotics for pneumonia. The resident had aspirated and was now on honey thick liquids and chopped food.</p> <p>There was no information in the record regarding the transfer of the resident to the hospital.</p> <p>In an interview with the DON (Director of Nursing) on 5/23/13 at 9:15 a.m., she indicated she was unable to locate any information regarding the transfer of Resident #117 to the hospital.</p>		<p>will audit all closed charts within 30 days after the resident is discharged for compliance. The Director of Nursing will monitor the closed charts on an ongoing basis. All closed charts will be kept in a systematic order and a disposition of records log will be maintained by the Director of Nursing. The facility policy on resident transfer information will be reviewed and updated as needed by 6/21/2013. All nurses will be inserviced on facility policy for resident transfers and the required transfer information by 6/21/2013. The Director of Nursing will audit the charts of all residents transferred or LOA weekly to ensure compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
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R000408	<p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview the facility failed to have a diagnostic chest x-ray completed for 1 out of 7 residents reviewed for chest x-rays to be done within 6 months of admission. (Resident #15)</p> <p>Findings include:</p> <p>The record for Resident #15 was reviewed on 5/20/2013 at 2 p.m. Diagnosis included, but were not limited to, osteoarthritis, HTN (hypertension), hypothyroidism (low thyroid function), reflux esophagitis.</p> <p>The record lacked documentation of a chest x-ray being done within 6 months of admission.</p> <p>During an interview with the DON(Director of Nursing) on 5/23/2013 at 9:05 a.m., she indicated she was not able to locate a record of a chest x-ray for Resident #15.</p>	R000408	<p>The Director of Nursing immediately contacted the residents former physician and cardiologist to request a copy of the admit chest xray from 10/2012. chest x-ray copies from 12/2012 were received, but they were unable to locate one prior to admit. A residents have the potential to be affected by the deficient practice. The Director of Nursing completed an audit of all resident charts by 5/31/2013 to ensure chest xrays were intact on all other residents. All new admissions will be required to produce a chest xray that was completed within 6 months of their admission to the facility. The Director of Nursing will assure that all required health screen information will be received prior to resident being admitted. The Director of Nursing will review new resident charts within 72 hours of admission for required documentation. All current resident charts will be audited in an on-going basis to ensure complince.</p>	06/21/2013			