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 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

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R000000	This visit was for the Investigation of Complaint IN00137654. Complaint IN00137654-Substantiated. State Residential deficiencies related to the allegation are cited at R0036 and R0241. Survey date: October 15, 2013 Facility number: 013069 Provider number: 013069 AIM number: N/A Survey team: Caitlyn Doyle, RN, TC Regina Sanders, RN Census bed type: Residential: 67 Total: 67 Census Payor type: Other: 67 Total: 67 Sample: 4 These Residential State findings are cited in accordance with 410 IAC 16.2. Quality review completed on October	R000000	Residences at Deer Creek (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	18, 2013, by Janelyn Kulik, RN.			

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R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure a resident's Physician was notified of a change in a resident's status, related to bilateral feet edema for 1 of 3 residents reviewed for Physician notification in a sample of 4. (Resident #B) Findings include: The record for Resident #B was reviewed on 10/15/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, CHF (congestive heart failure) and COPD (chronic obstructive pulmonary disease). Review of the Medical Progress Note dated 9/27/13 at 5:20 p.m., indicated the resident was noted to have slight congestion on inspiration to the lower lung lobes and 2+ pitting edema to	R000036	Resident MD was notified on 10/4/2013 of previous assessment. A review of all 24 hour reports was completed to ensure that any resident with a change in condition was reported to the physician and resident's legal representative. An electronic medical records system has been implemented since the date of this finding. Alerts and messaging module sends alerts and creates a twenty four hour report identifying residents with changes of condition. The Director of Resident Services or designee will review alerts and messages daily and verify that changes in a resident's condition is reported to the physician and legal representative.	10/28/2013

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	both feet. The Medical Progress Note dated 9/27/13 at 5:20 p.m., indicated the nurse paged the Cardiologist per family request at that time. A Progress note entry, dated 9/27/13 at 6 p.m., indicated the Physician had not returned the call from the facility. An Progress note dated 9/27/13 with no time documented, indicated there was no return call from the Physician. The Medical Progress Notes lacked documentation to indicate the facility had continued to attempt to notify the resident's Physician until 10/3/13, which was 6 days after the initial attempt. The next progress note, dated 10/3/13 at 7:25 a.m., indicated the resident was coughing up copious amounts of clear thick mucous, had rapid breathing, wheezes and congestion of the lungs. The Progress Note indicated the resident's Physician was notified and the resident was transferred to the hospital. A Hospital Note dated 10/3/13, indicated the resident was diagnosed with heart failure exacerbation.			

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	Interview with the Director of Resident Services on 10/15/13 at 12:40 p.m., indicated there was no evidence in the chart to indicate the resident's Physician had been notified of the change in condition. She indicated the Physician should have been notified within 24 hours of the change in condition. A facility policy on change in condition, dated 1/1/13, and received as current from the Director of Resident Services, indicated "...Physician notification will occur with all change in condition identified within 24 hours or as soon as possible but at least within 24 hours..." This State Residential tag relates to Compliaint IN00137654.			

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R000241	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. Based on record review and interview, the facility failed to ensure medications were administered as ordered by the residents' Physicians for 3 of 4 residents reviewed for medication administration in a total sample of 4. (Residents #B, #C, and #E) Findings include: 1. Resident #C's record was reviewed on 10/15/13 at 11:55 a.m. The resident's diagnosis included, but was not limited to, Dementia. The Physician's Recapitulation Orders, dated 08/2013, included the following orders: Clonidine (high blood pressure medication) 0.1 mg (milligram) twice a day Zocor (cholesterol medication) 20 mg daily Azopt (glaucoma eye drops) 1%, one drop into both eyes twice daily	R000241	The physician was notified of the medication documentation omission. No adverse effects to the resident were noted. Resident C: Blood pressure check within normal limits, resident assessed, MD notified of documentation omissions. Resident E: Assessed with no concerns identified. M.D. notified of medication documentation omissions. Resident B: Assessed with no current areas of concern. M.D. previously notified of medication omission. Medication administration records were reviewed for all residents to ensure that all medications have been administered per physician order. No other medication errors were identified. The Electronic Medication Administration record system has been implemented since the date of this finding. The licensed nurse or QMA are to review missed medication report after each medication pass and address as needed.The Director of Resident Services or Designee will review missed medication report three times per week.	10/28/2013

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	A Physician's Order, dated 09/05/13 included an order for Depakote (anti-seizure/bipolar medication) ER (extended release) 250 mg, three times a day. The Medication Administration Record (MAR), dated 09/2013, indicated the Clonidine was not administered to the resident on September 7 and 15, 2013 in the evening. The MAR indicated the Depakote was not administered to the resident, "midday" on September 17, 2013, the Zocor was not administered on September 12, 2013, and the Azopt eye drops were not administered on September 12, 2013 in the morning. During an interview on 10/15/13 at 12:15 p.m., the Director of Resident Services indicated if the medications were given, the medications should have been initialed on the MAR by the nurse. 2. Resident #E's record was reviewed on 10/15/13 at 10:25 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and depression. An assessment for self-administration			

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	of medications, dated 08/05/13, indicated the nurse would administer the resident her medications. The Service Plan, dated 08/01/13, indicated the resident had mild cognitive impairment, made familiar decisions, needed guidance 1-3 times a day, required assistance to administer medications, was on hospice, had a decline in cognition, and deterioration in her health status. A) A Physician's Telephone Order, dated 08/20/13, indicated to discontinue the Ativan (anti-anxiety medication) 0.25 mg (milligrams) and to administer Xanax (anti-anxiety medication) 0.25 mg twice a day. The MAR, dated 08/2013, indicated the resident received the Ativan 0.25 mg on 08/21/13 in the evening and 08/22/13 in the morning. During an interview on 10/15/13 at 10:45 a.m., the Director of Resident Services indicated the Ativan was documented as given after it had been discontinued. B) The Physician's Recapitulation Orders, dated 10/2013, indicated the following orders: Celexa (anti-depressant) 10 mg			

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	daily-originally ordered 06/16/13 Tramadol (pain medication) 50 mg daily-originally ordered 07/13/13 Xanax 0.25 mg twice daily-originally ordered 08/20/13 ipratropium (breathing medication) one vial three times daily-originally ordered 08/07/13 The MAR, dated 09/2013 indicated the Celexa was not administered on September 3, 11, 12, and 27, 2013, the Tramadol was not administered on September 3, 11, 12, and 27, 2013, the ipratropium was not administered in the morning on September 3, midday on September 2, 3, 11, and 12, 2013, and on the evening of September 5, and 18, 2013. The 09/2013 MAR and the, "Individual Resident Control Medication Record Sheet", dated 09/06/13 through 09/23/13, indicated the Xanax had not been administered on September 3 in the a.m., September 7 in the p.m., September 12 both a.m. and p.m., September 24 in the a.m. and September 25 in the p.m., 2013. During an interview on 10/15/13 at 10:40 a.m., the Director of Resident Services indicated the Hospice Nurse			

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	may have given the medication on the above dates. The Director of Resident Services indicated on 10/15/13 at 10:45 a.m., the medications were not signed out as given and the Xanax had not been signed out on the controlled medication record sheet. During a telephone interview with the Hospice Nurse, on 10/15/13 at 11:45 a.m., she indicated they do not give the medications when they visit the resident, but because the resident has a lot of anxiety, they make sure the medications are given as ordered and timely when they are at the facility. She indicated they were scheduled to be with the resident on Mondays and Fridays. She indicated at times would mix the resident's Miralax (laxative) for her, because it is kept in the room and it is an over the counter medication, and will then tell the nurse the resident took the Miralax. C) A Physician's Telephone Order, dated 09/10/13, indicated an order for Anusol HC (hemorrhoid cream), apply three times a day and as needed. The MAR, dated 09/2013, lacked documentation to indicate the Anusol			

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	cream had been administered to the resident three times a day as ordered by the physician. During an interview on 10/15/13 at 10:40 a.m., the Director of Resident Services indicated the resident did the Anusol cream herself, but she would need to verify that. During an interview on 10/15/13 at 10:45 a.m., the Director of Resident Services indicated the resident had informed her the Hospice Nurse administered the Anusol cream when the resident wanted it, but the resident had not received the medication three times a day. During an interview on 10/15/13 at 11:20 a.m., Resident #E stated, "I think they give me my medicines". The resident indicated there was one nurse who would put the Anusol Cream on but the nurse is no longer working. She indicated she was not getting the Anusol Cream three times a day. A facility policy, dated 12/01/12, titled, "Preperation for Medication Administration", received from the Director of Resident Services as current, indicated, "...Medications are administered in accordance with			

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	written orders of the attending physician...r. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. at the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented..." 3. The record for Resident #B was reviewed on 10/15/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, CHF (congestive heart failure) and COPD (chronic obstructive pulmonary disease). Review of the Physicain Recapitulation Orders, dated 09/2013, indicated an order for furosemide (a diuretic medication) 20 mg (milligrams) daily. The Medication Administration Record (MAR), dated 09/2013, indicated the resident had not received the furosemide medication on 9/30/13. Interview with the Director of Resident Services on 10/15/13 at 11:20 a.m., indicated the furosemide had not			

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	been given as ordered on 9/30/13. This State Residential tag relates to Compliaint IN00137654.			