

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155816	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
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NAME OF PROVIDER OR SUPPLIER ARLINGTON PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 18, 19, 20, 23, 24, and 25, 2016</p> <p>Facility number: 013005 Provider number: 155816 AIM number: 201256400</p> <p>Census bed type: SNF: 55 SNF/NF: 23 Residential: 14 Total: 92</p> <p>Census payor type: Medicare: 52 Medicaid: 18 Other: 22 Total: 78</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on May 31, 2016</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification State Licensure Survey (ID DWGK11) on May 25, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
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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 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's bathroom accommodated his individual needs, and failed to ensure a resident's call light was within reach for 2 of 3 residents reviewed during environment. (Resident #16 and #208)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #16 was reviewed on 5/19/16 at 2:00 p.m. The diagnoses for Resident #16 included, but were not limited to: flaccid hemiplegia affecting right dominant side and nontraumatic intracerebral hemorrhage.</p> <p>The 4/8/16 MDS (minimum data set) 30 day assessment indicated Resident #16 required extensive assistance of one person for toilet use and personal</p>	F 0246	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The board located below the sink that was inhibiting resident #16 was immediately removed. The certified nurses aides were re-educated to ensure that Resident #208 call light was in reach at all times. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by this deficient practice. Residents were assessed for being able to reach the faucet. Boards were removed if resident was unable to reach the faucet. Residents should be checked for safety before leaving the residents room including ensuring that the call light is accessible to the resident. Rounding will be completed to ensure that the</p>	06/13/2016
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	<p>hygiene. It indicated he had upper and lower extremity impairment on one side. It indicated his BIMS (brief interview for mental status) score was 15, indicating no cognitive impairment.</p> <p>An interview was conducted with Resident #16 on 5/19/16 at 2:30 p.m. Resident #16's wife, Family Member #11, was present during the interview. Family Member #11 indicated Resident #16 was unable to reach the sink or soap dispenser in his bathroom to wash his hands. At this time, Family Member #11 demonstrated the concern by pushing Resident #16's wheel chair into the bathroom, up to the sink. The foot pedal of the wheel chair hit a board, located underneath the sink. The board underneath the sink was covering the pipes, positioned on an angle, sloping downward toward the wall. The soap dispenser was located on the right side of the sink, close to mirror. Family Member #11 indicated Resident #16's right foot pedal hit the sloping board underneath the sink, before Resident #16 was able to reach the faucet or soap dispenser. Family Member #11 indicated she would get the soap and put it on a wash cloth for Resident #16, because he was unable to reach the soap and faucet with his left hand. Resident #16 was present during Family Member #11's demonstration, and</p>		<p>residents call lights are in reach. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-educate the Registered Nurses, Licensed Nurses and CNAs on the following campus guidelines: bathroom accommodation and guidelines on call light placement. How the corrective actions will be monitored to ensure the deficient practice will not recur: The following audits (Bathroom accommodation and Call light accessibility audits) for 5 residents will be conducted by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance of bathroom accommodation and call light accessibility. 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>agreed this was a problem for him.</p> <p>An observation of Resident #16's restroom was made with the Director of Maintenance (DM) and Director of Environmental Services (DES) on 5/23/16 at 11:30 a.m. Family Member #11 pushed Resident #16 in his wheel chair up to his bathroom sink. His foot pedals hit the sloping board underneath the sink, and Resident #16 could not reach the faucet with his left arm or the soap dispenser. The DM indicated he could move the soap dispenser to the opposite side and remove the sloping board from underneath. At this time, Family Member #11 indicated they informed a therapist, OT (Occupational Therapist) #12, of Resident #16's inability to reach the faucet and soap dispenser. Family Member #11 indicated OT #12 saw that Resident #16 could not reach them. The DM indicated this observation was the first he'd heard of the concern, did not receive a work order regarding the concern, and that therapy never informed him of this.</p> <p>An interview was conducted with the Acting Director of Therapy, Speech Therapist (ST) #13, on 5/23/16 at 11:50 a.m. The DM and DES were present for this interview. ST #13 indicated she didn't know anything about the concern</p>			
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	<p>with Resident #16's bathroom, and that none of her staff ever informed her. She indicated if staff had informed her, she could have communicated it to the maintenance and environmental departments via a work order.</p> <p>An interview was conducted with ST #13 on 5/23/16 at 11:55 a.m. She indicated OT #12 worked with Resident #16 the previous week, on 5/20/16. At this time, ST #13 reviewed OT #12's 5/20/16 treatment notes. The notes indicated, "Pt (patient) completed toilet > (to) w/c (wheel chair) transfer with min (minimal) assist with grab bar and mod (moderate) assist for toilet > w/c." The 5/20/16 treatment notes did not indicate Resident #16's inability to reach the faucet or soap dispenser. ST #13 indicated she would think after the toilet transfer, Resident #16 would wash his hand/hands, allowing the opportunity for observation of Resident #16's inability to reach the faucet and soap dispenser.</p> <p>An interview was conducted with CRCA (Certified Resident Care Assistant) #14 on 5/23/16 at 12:15 p.m. She indicated Resident #16 required one person assistance for toileting. She indicated she sometimes helped him off the commode. She indicated she would take a towel and put soap and water on it to wash his</p>			

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	<p>hands. She indicated she never saw him turn the faucet on. She indicated she'd offered many times to push him up to the sink to wash his hand/hands, but he would say 'No, I'm okay.' She indicated she thought he could reach the faucet, but she would have to take his foot pedals off to do so.</p> <p>An interview was conducted with COTA (Certified Occupational Therapy Assistant) #15 and ST #13 on 5/23/16 at 12:56 p.m. COTA #15 indicated it was hard for Resident #16 to reach his faucet and could not reach his soap dispenser. ST #13 indicated if Resident #16 had the ability to turn the faucet on himself, then that would be what therapy would want him to do.</p> <p>2. The clinical Record for Resident #208 was reviewed on 5/19/16 at 9:30 a.m. The diagnoses for Resident #208 included, but were not limited to, depression.</p> <p>The 5/20/16 falls care plan for Resident #208 indicated to keep his call light in reach at all times.</p> <p>An observation of Resident #208 was made on 5/19/16 at 9:38 a.m. His call light was on his night stand, not within reach.</p>			

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	<p>An interview was conducted with CRCA (Certified Resident Care Assistant) #6 on 5/19/16 at 9:41 a.m. She indicated Resident #208 was not able to reach his call light on the night stand. She then placed it over his abdomen, within reach.</p> <p>An observation of Resident #208 was made on 5/23/16 at 10:45 a.m. He was lying in bed. His call light was on the floor, underneath his bed, not within reach. Resident #208 indicated he did not know where his call light was, but if it was on the floor he wouldn't be able to use it.</p> <p>An observation of Resident #208 was made on 5/24/16 at 9:19 a.m. He was sitting in his wheel chair, in his room, with his breakfast tray in front of him. His call light was at the head of his bed, not within reach.</p> <p>An interview was conducted with LPN (Licensed Practical Nurse) #7 on 5/24/16 at 9:20 a.m. LPN #7 indicated Resident #208's call light was not within his reach, and whoever delivered his breakfast tray should have made sure it was within his reach.</p> <p>3.1-3(v)(1)</p>			

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to revise a careplan for 1 of 3 residents reviewed for activities of daily living (ADL) (Resident #100).</p> <p>Findings include:</p> <p>The clinical record for Resident #100 was reviewed on 5/24/16 at 11:45 a.m. The diagnoses for Resident #100 included, but were not limited to, dysphagia,</p>	F 0280	<p>What corrective actions will be accomplished for those residents founds to have been affected by the deficient practice: Resident #100's ADL and nutritional careplans were reviewed and updated as appropriate.</p> <p>How other residents having the potential to be affected by the same</p>	06/13/2016
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	<p>physical debility, gastro esophageal reflux disease (GERD), and hyperkalemia.</p> <p>The Admission MDS (minimum data set) assessment, dated 4/15/16, indicated Resident #100 had "no natural teeth or tooth fragments (edentulous)" and Resident #100 only needed supervision for eating. The MDS also indicated dental care related to the Resident being edentulous, was triggered for a careplan.</p> <p>The 4/22/16 MDS assessment indicated Resident #100 was extensive assist with eating.</p> <p>During an observation, on 5/24/16 at 12:25 p.m., Resident #100 was observed eating without dentures in.</p> <p>On 5/24/16 at 12:51 p.m., Speech Therapy (ST) #5 indicated Resident #100 has not had any dentures in during therapy, so he asked facility staff about dentures and was told that Resident #100 never had dentures and was not interested in dentures.</p> <p>A review of the careplans for Resident #100, including ADL and nutritional careplans, did not include an intervention of dental care for Resident #100.</p>		<p>deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by this deficient practice. All residents that are edentulous, have loose fitting dentures or broken teeth care plans were reviewed. Their ADL and nutritional careplans were reviewed and updated as appropriate.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-educate the MDS Coordinator, MDS Assistant, and nursing leadership on the following campus guidelines: Guidelines on updating careplans.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: The following audits (Updating careplans) for 5 residents will be conducted</p>	

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F 0309 SS=D	<p>During an interview with the Director of Nursing (DON), on 5/25/16 at 12:50 p.m., the DON indicated she did not see any interventions in Resident #100's careplans related to dental care.</p> <p>On 5/25/16 at 1:00 p.m., the MDS Assistant indicated dental care was overlooked as an intervention/careplan. The MDS Coordinator indicated, at this time, dental care could've been added to a nutrition careplan or an ADL careplan when it triggered from the Admission MDS.</p> <p>A policy titled, Interdisciplinary Team Care Plan Guideline, dated 6/2015, was received from the DON on 5/25/16 at 12:50 p.m. The policy indicated, "...d. Care plans to address acute problems are to be written on the appropriate Circumstance form. Problems that become on-going or chronic, will then be addressed in the comprehensive care plan...."</p> <p>3.1-35(d)(2)(B)</p>		<p>by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure that all residents that are edentulous, have loose fitting denture or broken teeth care plans will be reviewed.</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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Bldg. 00	<p>HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to timely address a resident's recognized skin condition for 1 of 3 residents reviewed for pressure ulcers. (Resident #153)</p> <p>Findings include:</p> <p>The clinical record for Resident #153 was reviewed on 5/19/16 at 11:16 a.m. The diagnoses for Resident #153 included, but were not limited to, pressure ulcers. She was admitted to the facility on 3/3/16.</p> <p>The 3/3/16 admission assessment for Resident #153 indicated she had skin impairment. It indicated her skin impairment risk factors were as follows: decreased activity level; immobility, cannot independently change positions; incontinence, skin exposed to moisture; poor nutrition; poor skin integrity; predisposing disease; and age over 85.</p> <p>The 3/9/16 pressure ulcer risk care plan for Resident #153 indicated, "Conduct a</p>	F 0309	<p>What corrective actions will be accomplished for those residents founds to have been affected by the deficient practice: The shower sheets for Resident #153 will be reviewed on shower days to ensure that skin conditions are identified in a timely manner.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by this deficient practice. Shower sheets will be reviewed by charge Nurses and Unit Managers to ensure that skin conditions are identified in a timely manner.</p> <p>What measures will be put in place or what</p>	06/13/2016

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	<p>systematic skin inspection on me weekly. Pay particular attention to the bony prominences." It indicated, "Report any signs of skin breakdown (sore, tender, red, or broken areas).</p> <p>An interview was conducted with the ADHS (Assistant Director of Health Services) on 5/19/16 at 11:19 a.m. She indicated Resident #153 had an unstageable pressure ulcer to her left heel.</p> <p>An interview was conducted with UM (Unit Manager) #8 on 5/24/16 at 12:49 p.m. He indicated skin assessments were conducted weekly with showers, and documented on the shower sheets.</p> <p>The March, April, and May, 2016 shower sheets for Resident #153 were provided by the ADHS on 5/24/16 at 2:00 p.m. The 3/7/16 and 3/10/16 shower sheets indicated there was problem area on Resident #153's left heel, but did not specify as to what the problem was. The shower sheets instructed the nurse to document on any problem areas.</p> <p>There was no information in the clinical record indicating the problem area to Resident #153's left heel was documented or addressed after her 3/7/16 or 3/10/16 showers, until a 3/19/16 progress note.</p>		<p>systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and CNAs on the following campus guidelines: Guidelines on skin assessments and shower sheets.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: The following audits (Skin Assessments and Shower Sheets) for 5 residents will be conducted by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance with addressing a residents skin condition in a timely manner based on skin assessments and shower sheets. 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>The 3/19/16, 12:35 p.m. progress note indicated, "Res (resident) has pressure area on left heel current measurements and treatments in place MD and family notified."</p> <p>An interview was conducted with the ADHS on 5/24/16 at 11:54 a.m. She indicated Resident #153's left heel wound was found on 3/19/16.</p> <p>An interview was conducted with the ADHS on 5/25/16 at 9:35 a.m. She indicated there was no verification Resident #153's left heel was addressed after her 3/7/16 and 3/10/16 showers, until 3/19/16. She indicated she was responsible for tracking wounds in the facility, and no one informed her of Resident #153's left heel concern after the 3/7/16 or 3/10/16 showers.</p> <p>The Weekly Skin Assessment Guideline was provided by the ADHS on 5/24/16 at 2:00 p.m. It indicated, "Purpose: To monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated."</p> <p>3.1-37(a)</p>				

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F 0314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to record weekly measurements of pressure ulcers, provide a pressure ulcer intervention of wearing boots while in bed, and ensure an initial Physician's Order was in place for wearing boots while in bed for 1 of 3 residents reviewed for pressure ulcers (Resident #58)</p> <p>Findings include:</p> <p>1a. The clinical record for Resident #58 was reviewed on 5/23/16 at 2:35 p.m. The diagnoses for Resident #58 included,</p>	F 0314	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #58 orders were reviewed, order for boots was clarified and added to the residents profile for staff to view and check off each shift. Each week measurements are documented in the events weekly until the wound is healed. MD assessed resident's wounds and a letter of unavoidability has been obtained. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be</p>	06/13/2016

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	<p>but were not limited to; fracture of right pubis, muscle weakness, osteoporosis, difficulty walking and cerebral infarction.</p> <p>A Progress Note, dated 4/05/2016 at 4:58 p.m., indicated, "Weekly wound note: Left heel unstage [sic-unstageable] wound...Right heel stage II fluid filled blister...Right buttock unstage [sic-unstageable] wound...Prevenatitive [sic] measurements in place include; [namebrand of boot] boot to bilateral heels...."</p> <p>A Progress Note, dated 4/12/2016 at 5:35 p.m., "Weekly wound note: Left heel unstage wound...Right heel stage II fluid filled blister...Right buttock wound...Prevenatitive [sic] measurements in place include; [namebrand of boot] boot to bilateral heels..."</p> <p>A Progress Note, dated 4/19/2016 at 5:03 p.m., indicated, "Weekly wound note: Left heel unstage [sic] pressure wound...Right heel stage II pressure wound...Right buttock 2x3x0.1 [sic]. 100% slough. No drainage. Pain noted at site. Pain controlled with medication and offloading. Shows signs of deterioration...."</p> <p>A Physician's Order, dated 5/3/16, indicated bilateral boots on while in bed.</p>		<p>taken: All residents with wounds will be monitored weekly for measurements. Interventions will be monitored weekly during clinically at risk meeting. Residents that enter the facility that develop wounds will be monitored weekly and, if appropriate, a letter of unavailability will be requested from the Medical Staff. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and CNAs on the following campus guidelines: Guidelines on weekly measurements and preventative interventions. How the corrective actions will be monitored to ensure the deficient practice will not recur: The following audits (Weekly wound measurement and preventive interventions audit) for 5 residents will be conducted by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance with weekly wound measurements and preventative interventions. 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>A review of the Physician's Orders from April 2016, did not indicate an order for bilateral boots on while in bed. There was no documentation in the clinical record to indicate the staff was consistently monitoring/ensuring the boots were on while the Resident was in bed until the Physician's Order was in place on 5/3/16.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 5/25/16 at 11:25 a.m., the ADON indicated there was not an order until 5/3/16 for the boots to worn while in bed and there was no other way to ensure the boots were in place while the Resident was in bed.</p> <p>1b. During the following observations, Resident #58 was observed in bed without bilateral boots on: 5/23/16 at 2:32 p.m., 5/24/16 at 2:25 p.m., 5/24/16 at 3:00 p.m.</p> <p>During an interview with the ADON, on 5/24/16 at 2:39 p.m., the ADON indicated Resident #58 did not refuse wearing the bilateral boots in bed, but if she were to refuse the boots, there would be documentation in the progress notes.</p> <p>At 3:00 p.m., on 5/24/16, the ADON</p>			

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	<p>asked Resident #58 if she refused to wear the boots that day, when she observed Resident #58 without her boots on and Resident #58 indicated she did not. The ADON further indicated to Resident #58 that she (Resident #58) did not refuse to wear the boots while in bed and Resident #58 agreed with the ADON. The ADON also indicated the Resident might've just returned from being out of the facility, so that might be why the Resident did not have her boots on.</p> <p>On 5/24/16 at 3:07 p.m., the Director of Nursing indicated if a Resident refused treatment, such as wearing boots while in bed, it would be documented in the progress notes.</p> <p>During an interview with Receptionist #1, on 5/24/16 at 3:42 p.m., she indicated Resident #58 returned to the facility at 1:00 p.m. that day.</p> <p>There was no documentation in the Progress Notes, that Resident #58 refused to wear her boots while she was in bed, during the above observations.</p> <p>A Pressure Ulcer careplan, dated 4/26/16, indicated the following intervention, use boots to relieve pressure on the heels.</p> <p>1c. A [Re]Admission Assessment, dated</p>			

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	<p>4/26/16 at 4:19 p.m., indicated in the skin impairment section, "Yes (Complete appropriate Wound Circumstance for further assessment)...."</p> <p>A Skin Integrity Event, dated 4/26/16 and recorded 5/3/16, indicated the following note, "right buttock healed in areas and separated into 3 separate areas. Medial right buttock stage III wound. Right stage III wound and lateral right buttock stage III wound." The Event indicated, "...Description right buttocks stage III...Location: right buttock...."</p> <p>A Skin Integrity Event, dated 4/27/16, indicated "...[Re]Admission skin assessment-right coccyx...location: Right Coccyx x 3..." was completed by RN #20. The measurements indicated 2 cm x 1 cm x 0.01 cm. There was no other description/measurements to indicate if the above measurements was for one of the specific areas on the "coccyx" or all the areas combined.</p> <p>On 5/24/16, at 3:20 p.m., a wound/treatment observation was made with the ADON. There were two separate wounds noted on Resident #58's right buttocks. The ADON indicated the "right" buttocks wound healed while the medial and lateral wounds remained. The ADON indicated the medial wound</p>			

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	<p>was "0.5 x 0.5" and the lateral wound was "0.5 x 0.5."</p> <p>No measurements were located in the clinical record for the medial and lateral buttocks wounds until 5/17/16 after Resident #58's readmission on 4/26/16.</p> <p>During an interview with the ADON, on 5/25/16 at 9:50 a. am., the ADON indicated she did not have any measurements for the medial and lateral wounds until 5/17/16 and she did not take measurements of Resident #58's wounds until 5/3/16, even though Resident #58 readmitted on 4/26/16. The ADON indicated the Skin Integrity Event, dated 4/26/16 and recorded 5/3/16, was measurements for 5/3/16. The ADON also indicated the measurements completed by RN #20, on 4/27/16, for the "coccyx" was actually for the buttocks but she was unsure if the measurements were for the medial, lateral, and "right" buttocks combined or one specific area.</p> <p>A policy titled, Pressure/Stasis/Diabetic Wound Condition Guidelines, no date, was received from the ADON, on 5/24/16 at 2:00 p.m. The policy indicated, "Purpose: To provide weekly documentation of wound measurements and condition...a. complete event for each impairment area...4.</p>			

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F 0329 SS=D Bldg. 00	<p>Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed...."</p> <p>3.1-40(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>			

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	<p>Based on interview and record review, the facility administered a resident's diuretic medication in excessive dosages and failed to ensure unnecessary doses of insulin were not administered, as indicated by a physician's order, for 2 of 5 residents reviewed for unnecessary medications (Resident #38 and #209)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #209 was reviewed on 5/19/16 at 9:52 a.m. The diagnoses for Resident #209 included, but were not limited to, congestive heart failure.</p> <p>The 5/24/16 diuretic medication care plan for Resident #209 indicated to administer her diuretic medication per order.</p> <p>The physician's order for Resident #209 indicated a 10 mg tablet of Torsemide (diuretic medication) to be taken twice daily with a start date of 5/6/16.</p> <p>The May, 2016 MAR (medication administration record) for Resident #209 indicated the above medication was given, as ordered, between 5/7/16 and 5/20/16, for a total of 26 administrations.</p> <p>The 5/22/16 event in Resident #209's</p>	F 0329	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #209 medication was immediately discontinued and removed from medication cart. MD immediately notified and stat labs were obtained and reviewed with no adverse effects noted. Resident #38 's sliding scale insulin order was reviewed and the orders were clarified and updated as appropriate.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The contents of the medication carts were reviewed against MARs. Licensed nursing staff and QMA's in-service was held regarding the 5 rights of medication administration. The nurses identified as administering the incorrect medication were counseled</p>	06/13/2016

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	<p>clinical record indicated torsemide was ordered at 10 mg, but was delivered from the pharmacy at 100 mg, and wasn't noticed until 5/20/16.</p> <p>An interview was conducted with the Director of Health Services (DHS) on 5/25/16 at 11:50 a.m. She indicated the pharmacy sent the wrong dose of torsemide to the facility. She indicated they sent 100 mg pills, instead of the ordered 10 mg pills. She indicated nursing staff should have caught the error during administrations. She indicated the bubble pack container indicated the torsemide tablets were 100 mg each, and nursing staff should have checked the actual medication against the MAR for each administration.</p> <p>2. The clinical record for Resident #38 was reviewed on 5/25/16 at 11:15 a.m. The diagnoses for Resident #38 included, but were not limited to, diabetes mellitus, surgical amputation, and legal blindness.</p> <p>A Physician's Order, dated 4/29/16, indicated Humalog 5 units was to be administered 3 times a day. Special Instructions with the order indicated, "Ensure blood sugar is more than 100 before administering."</p> <p>The May MAR (medication administration record) indicated the</p>		<p>on the responsibilities of medication administration. All residents with sliding scale insulin orders were reviewed and clarified to ensure that unnecessary dosages of insulin were not administered.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee began immediate reeducation with Licensed Nurses and QMAs on the following campus guidelines: Medication administration.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: The following audits (Medication administration audit) for 5 residents will be conducted by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance with medication administration. The results of the audit observations will be</p>	

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	<p>following blood sugar readings and insulin administration sites.</p> <p>5/8/16 at 6:00 a.m.-11:00 a.m.-Blood Sugar (BS)=87; Site insulin was administered=abdomen (ABD)</p> <p>5/9/16 at 11:00 a.m.-1:30 p.m.-BS=78; Site=ABD,</p> <p>5/10/16 at 6:00 a.m.-11:00 a.m.-BS=95; Site=RUE (right upper extremity),</p> <p>5/11/16 at 6:00 a.m.-11:00 a.m.-BS=75; Site=ABD,</p> <p>5/14/16 at 11:00 a.m.-1:30 p.m.-BS=98; Site=RA (right arm),</p> <p>5/15/16 at 5:00 p.m.-7:30 p.m.-BS=94; Site rt. arm (right arm) &</p> <p>5/19/16 at 6:00 a.m.-11:00 a.m.-BS=74; Site RA.</p> <p>During an interview with the Director of Nursing (DON), on 5/25/16 at 12:25 p.m., the DON indicated according to the MAR, the insulin was administered on the above days when the the insulin should not have been. The DON indicated she was going to look into why the insulin was administered.</p> <p>At 3:02 p.m., on 5/25/16, the DON indicated she had no further information why the insulin was administered when it should not have been.</p> <p>3.1-48(a)</p>		<p>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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F 0356 SS=A Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and</p>	F 0356	Corrective actions accomplished for those	06/13/2016			

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	<p>record review, the facility failed to ensure daily nurse staffing was posted during 1 of 1 random observations. This had the potential to affect 78 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation, on 5/23/16 (Monday) at 8:54 a.m., the Nurse Staffing Information was posted from 5/20/16 (Friday). At 9:25 a.m., on 5/23/16, the Nurse Staffing Information for Monday 5/23/16 was posted.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 5/23/16 at 3:10 p.m., the ADON indicated staffing should be posted over the weekend.</p> <p>A policy titled, Guidelines for Staff Posting, no date, was received from the Director of Nursing on 5/25/16 at 1:00 p.m. The policy indicated, "Purpose: To ensure compliance with federal regulations requiring posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care. Procedure: At the beginning of the day the number and amount of hours of license nurses (RN and LPN) and the number and hours of unlicensed nursing personnel, per</p>		<p>residents found to be affected by the alleged deficient practice: The nurse staffing information is posted timely.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus leadership team on the following: Guideline for Staff Posting How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit will be conducted by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance: Timely posting of nurse staffing information. 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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F 0514 SS=A Bldg. 00	<p>shift, who provide direct care to residents will be posted...."</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to document the amount of insulin administered using a sliding insulin scale per a physician order for 1 of 5 residents reviewed for unnecessary medications. (Resident #99)</p> <p>The clinical record for Resident #99 was reviewed on 5/23/16 at 12:34 p.m. The diagnosis for Resident #99 included, but was not limited to: diabetes mellitus type II with diabetic polyneuropathy. A physician order dated, 4/14/16,</p>	F 0514	<p>What corrective actions will be accomplished for those residents founds to have been affected by the deficient practice: Insulin orders reviewed for resident #99. Resident insulin orders were updated with the task assigned of entering the blood sugar along with the amount of sliding scale insulin administered.</p> <p>How other residents</p>	06/13/2016			

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	<p>indicated the staff was to administered Novolog (insulin) before meals using the following sliding scale: "if blood sugar is less than 70, call MD (physician) if blood sugar is 150 to 200, give 2 units if blood sugar is 201 to 250, give 4 units if blood sugar is 251 to 300, give 6 units, if blood sugar is 301 to 350, give 8 units, if blood sugar is 351 to 400, give 10 units, if blood sugar is greater than 400, call MD".</p> <p>The staff's task in the facility's computer system used for this physician order was to record blood sugar, the site used to administer the insulin, and the units of insulin given to Resident #99.</p> <p>The Medication Administration Record (MAR) dated, May 2016, indicated the following dates and times the blood sugars were in the parameter of the sliding scale and the amount of insulin administered was not entered: 5/1/16: 5:00 a.m. - 8:00 a.m., blood sugar 173, 11:00 a.m. - 12:30 p.m., blood sugar 193, 3:30 p.m.- 5:30 p.m., blood sugar 253, 5/2/16, 5:00 a.m. - 8:00 a.m., blood sugar 190, 11:00 a.m. -12:30 p.m., blood sugar 283, 3:30 p.m. - 5:30 p.m., blood sugar 163, 5/3/16: 5:00 a.m. - 8:00 a.m., blood sugar 174, 11:00 a.m. - 12:30 p.m., blood sugar</p>		<p>having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents receiving sliding scale insulin have the potential to be affected by this deficient practice. All residents with insulin orders were reviewed. Residents with sliding scale orders were clarified and tasks were assigned to ensure that blood sugar level and insulin units administered are noted on the residents MAR.</p> <p>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-educate the Registered, Licensed Nurses and QMAs on the following campus guidelines: Medication administration insulin administration.</p> <p>How the corrective actions will be monitored</p>	

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	<p>302, 3:30 p.m. - 5:30 p.m., blood sugar 198, 5/4/16: 5:00 a.m. - 8:00 a.m., blood sugar 196, 11:00 a.m. - 12:30 p.m., blood sugar 247, 3:30 p.m. - 5:30 p.m., blood sugar 387, 5/5/16: 3:30 p.m. - 5:30 p.m., blood sugar 389, 5/6/16: 5:00 a.m. - 8:00 a.m., blood sugar 152, 3:30 p.m. - 5:30 p.m., blood sugar 288, 5/7/16: 11:00 a.m. - 12:30 p.m., blood sugar 241, 3:30 p.m. - 5:30 p.m., blood sugar 172, 5/8/16: 11:00 a.m. - 12:30 p.m., blood sugar 230, 5/9/16: 5:00 a.m. - 8:00 a.m., blood sugar 156, 3:30 p.m. - 5:30 p.m., blood sugar 173, 5/10/16: 5:00 a.m. - 8:00 a.m., blood sugar 168, 11:00 a.m. - 12:30 p.m., blood sugar 193, 3:30 p.m. - 5:30 p.m., blood sugar 381, 5/11/16: 5:00 a.m. - 8:00 a.m., blood sugar 172, 11:00 a.m. - 12:30 p.m., blood sugar 159</p> <p>An interview was conducted with the Assistant Director of Wellness on 5/24/16 at 11:09 a.m. She indicated the amount of insulin administered to Resident #99 should have been entered by the created task in the computer system. She was unable to locate documentation the amounts of insulin</p>		<p>to ensure the deficient practice will not recur: The following audits for 5 residents will be conducted by the DHS or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance with medication administration specifically amount of insulin administered. 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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R 0000 Bldg. 00	administered to Resident #99 was documented. A "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES" was provided by the Director of Wellness on 5/25/16 at 12:59 p.m. It indicated "...Policy To administer medications in a safe and effective manner. Procedures...M. Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. N. After administration,..document administration in the MAR or TAR (treatment administration record)." 3.1-50(a)(2)	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal		
	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.				

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R 0033 Bldg. 00	<p>410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to provide government</p>	R 0033	<p>and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification State Licensure Survey (ID DWGK11) on May 25, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p>Corrective actions accomplished for those</p>	06/13/2016	

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	<p>agency posting in an accessible location observed during an environment tour. This had a potential to effect 14 or 14 residents living in the assisted living.</p> <p>An environmental tour was conducted in the assisted living on 5/25/16 at 2:00 p.m. There were no observations of the government agency posting in the assisted living or main entrance of the facility.</p> <p>An observation was made with the Assistant Director of Wellness on 5/25/16 at 2:10 p.m. The government agency posting was located on the right side of the wall at the end of a hallway walking toward the certified nursing unit. This location was passed the main front entrance, a common area, a dining room and a beauty shop.</p> <p>An interview was conducted with the Administrator on 5/25/16 at 2:15 p.m. She indicated that was the only public posting of the government agency information.</p> <p>An interview was conducted with the Administrator on 5/25/16 at 3:15 p.m. She indicated the facility follows the regulation of the state agency regarding the posting of the contact information of the government agency's.</p>		<p>residents found to be affected by the alleged deficient practice: The facility will post government agency posting in an accessible location in the assisted living area.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All assisted living residents have the potential to be affected by this alleged deficient practice</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Executive Director or designee will re-educate the campus leadership team on the following: Guidelines for posting governmental agency information in the assisted living area.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice</p>	

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			does not recur: The facility will post the government agency posting in an accessible location in the assisted living area.		