

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/30/2016
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NAME OF PROVIDER OR SUPPLIER  PROVIDENCE ANDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN 46011
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00203128.</p> <p>Complaint IN00203128 - Substantiated. Federal/State deficiencies related to allegations are cited at F309 and F514.</p> <p>Survey dates: June 29 and 30, 2016</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Census bed type: SNF/NF: 118 SNF: 15 Total: 133</p> <p>Census payor type: Medicare: 15 Medicaid: 99 Other: 19 Total: 133</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on July 5, 2016.</p>	F 0000	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. We would like to request a desk review for acceptable compliance with our plan of correction.</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 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 record review and interview, the facility failed to ensure bowel monitoring and administration of physician ordered interventions were completed for 1 of 5 residents reviewed for bowel monitoring. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 6/29/2016 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, end stage Alzheimer's, diabetes type 2, major depressive disorder, coronary artery disease and cardiac defibrillator.</p> <p>Review of the Physician orders for May, 2016 indicated Resident C had an order for Milk of Magnesia 30 ml every three days as needed for constipation.</p> <p>Review of the May, 2016 Medication Administration Record lacked any</p>	F 0309	<p>F 309 D Care and Services</p> <p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p><u>Resident C</u>- no longer resides at the facility</p> <p><b>How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken;</b></p> <p>A chart review was completed to identify other residentshaving the potential to be affected by the same deficient practice. Auditincluded residents identified with a change in condition. Change in conditionmay include but is not limited to signs and symptoms of lack of BM x 3 days orgreater.</p> <p>The Unit Manger or designee completed a review of allresidents that have triggered for no bowel</p>	07/30/2016			

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	<p>documentation of Milk of Magnesia being administered to Resident C.</p> <p>Review of the Activities of Daily Living Sheet for bowel monitoring for May, 2016 indicated Resident C had no bowel movement documentation for 5/4/2016 through 5/10/2016 (a 7 day period), 5/12/2016 through 5/15/2016 (a 4 day period) and 5/22/2016 through 5/30/2016 (a 9 day period).</p> <p>Review of the nursing notes, dated 5/4/2016 through 5/30/2016, indicated the nursing notes lacked any documentation of constipation or interventions for constipation for Resident C.</p> <p>During an interview on 6/30/2016 at 8:30 a.m., the Director of Nursing provided a care path titled "Gastrointestinal (GI) Symptoms dated 2011. The Director of Nursing indicated each nursing station had a copy of the care path and the nurses were educated on how to use them. The care path indicated residents who have not had a bowel movement in 3 days should receive medication per the physician orders for constipation and the physician or nurse practitioner should be notified.</p> <p>The Director of Nursing also indicated the bowel monitoring was documented</p>		<p>movement in 3 days and to ensure there is documentation of clinical assessment, interventions and notification if appropriate.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>RN/LPN staff will be educated on the guidelines for monitoring for acute change in condition related to bowel status monitoring to include pertinent documentation of assessment, interventions and physician notification when appropriate.</p> <p>The Unit Manager or designee will complete audit of the Bowel Movement Alerts 5 x a week to ensure there is documentation of clinical assessment, interventions and notification if appropriate. Findings will be presented weekly to the QAA committee for review. QAA will review findings and determine need for further monitoring and education per the QAA process.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4</p>				

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	<p>on the ADL (Activity of Daily Living) sheets which are kept in a book at each nursing station.</p> <p>During an interview on 6/30/2016 at 9:19 a.m., LPN #6 stated "My aides will tell me when they haven't gone and I will check the ADL book. If they haven't gone in 3 days, they get treatment. It's always been that way since I've been here - 9 years."</p> <p>During an interview on 6/30/2016 at 9:33 a.m., LPN #5 indicated the care paths were kept at the nursing station and confirmed resident's with no bowel movement in 3 days would receive whatever medication for constipation the physician had ordered.</p> <p>During an interview on 6/30/2016 at 9:56 a.m., LPN #4 indicated residents with no bowel movement for three days would receive an abdominal assessment and medication for constipation as ordered by the physician.</p> <p>This Federal tag relates to Complaint IN00203128.</p> <p>3.1-37(a)</p>		<p>weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process</p> <p><b>By what date the systemic changes will be completed?</b> July 30th 2016</p>		

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F 0514 SS=D Bldg. 00	<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 record review and interview, the facility failed to ensure resident records were complete and accurate in regard for 5 of 5 residents reviewed for complete and accurate records. (Resident B, Resident C, Resident D, Resident E and Resident F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 6/29/2016 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, paranoid schizophrenia, inflammatory polyneuropathies, obesity, transient paralysis, major depressive disorder and lumbar-sacral spondylosis.</p>	F 0514	<p>F 514 D Records Complete and Accurate</p> <p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p><u>Resident B</u>- Medical record was reviewed and currentlyreflects documentation that resident is receiving medications per physicianorders <u>Resident C</u>- no longer resides at the facility <u>Resident D</u>- Medical record was reviewed and currentlyreflects documentation that resident is receiving medications per physicianorders <u>Resident E</u>- Medical record was</p>	07/30/2016

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	<p>Review of the Physician orders, for June 2016, indicated the following: Cal-Gest 500 mg tablet. Take 1 tablet by mouth twice daily. Furosemide 20 mg tablet. Take 1 tablet by mouth twice daily. Gabapentin 300 mg capsule. Take 1 capsule by mouth three times daily. Benzotropine MES 1 mg tablet. Take one by mouth three times daily.</p> <p>Review of the Medication Administration Record, for June 2016, indicated the following:</p> <p>June 11 at 4:00 p.m., the clinical record lacked documentation of Cal Quest.</p> <p>June 11 at 4:00 p.m., the clinical record lacked documentation of Furosemide.</p> <p>June 11 at 9:00 p.m., the clinical record lacked documentation of Gabapentin.</p> <p>2. The clinical record for Resident C was reviewed on 6/29/2016 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, end stage Alzheimer's, diabetes type 2, major depressive disorder, coronary artery disease and cardiac defibrillator.</p> <p>Review of the Physician orders, for May 2016, indicated the following: 2 guard apply to neck each shift due to redness.</p>		<p>reviewed and currently reflects documentation that resident is receiving medications per physician orders <u>Resident F</u>- No longer resides at the facility</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;</b></p> <p>A chart review completed to identify other residents having the potential to be affected by the same deficient practice. Residents that receive medications have the potential to be affected by this same practice.</p> <p>The Unit Manager or designee will complete a medication pass observation on each of the shifts to ensure proper technique and follow up is in place for a total of 15 observations a week.</p> <p>The Unit Manager or designee will conduct an audit of Medication Administration Record and Treatment Administration Record Daily 5 times a week.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;</b></p> <p>RN/LPN will be educated on the Medication Administration guidelines</p>		

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	<p>Lexapro 10 mg one tablet by mouth once daily.</p> <p>Review of the Medication Administration Record, for May 2016, indicated the following:</p> <p>May 2, 3, 4, 10, and 31 on the 2p to 10p shift, the clinical record lacked documentation of 2 guard.</p> <p>May 7, 11 and 17 on the 6a to 2 p shift, the clinical record lacked documentation of 2 guard.</p> <p>May 30 and 31 on the 10p to 6a shift, the clinical record lacked documentation of 2 guard.</p> <p>May 6 and 22 at 8a, the clinical record lacked documentation of Lexapro.</p> <p>3. The clinical record for Resident D was reviewed on 6/29/2016 at 4:19 p.m. Diagnoses for the resident included, but were not limited to, vascular dementia, major depressive disorder, cerebral infarction, left sided hemiplegia and hemiparesis, cerebrovascular disease and hypertension.</p> <p>Review of the Physician orders, for May and June 2016, indicated the following: Atorvastatin 40 mg tablet. Take one by</p>		<p>to include ensuring residents receive the medication as ordered and any pertinent documentation is completed at the time of the medication administration.</p> <p>The Unit Manager or designee will complete six Medication Administration observations a week times four weeks with findings presented weekly to the QAA committee for review. QAA will review findings and determine need for further monitoring and education per the QAA process.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;</b></p> <p>Audit findings will be presented to the QA&amp;A Committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of 6 months. The QA&amp;A Committee will review findings and determine the need for further monitoring and/or education per the QA&amp;A process</p> <p><b>By what date the systemic changes will be completed?</b> July 30th 2016</p>				

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	<p>mouth once daily. Plavix 75 mg tablet. Take one by mouth once daily. Aricept 10 mg tablet. Take one tablet by mouth at bedtime. Famotidine 20 mg tablet. Take one tablet by mouth twice daily.</p> <p>Review of the Medication Administration Record, for May and June 2016, indicated the following:</p> <p>May 8 at 8p, the clinical record lacked documentation of Atrovastatin.</p> <p>June 21 at 8p, the clinical record lacked documentation of Plavix.</p> <p>June 21 at 8p, the clinical record lacked documentation of Aricept.</p> <p>June 21 at 4p, the clinical record lacked documentation of Famotidine.</p> <p>4. The clinical record for Resident E was reviewed on 6/29/2016 at 10:05 a.m. Diagnoses for the resident included, but were not limited to, bipolar disorder, anxiety disorder, major depressive disorder, diabetes type 2 and hypertension.</p> <p>Review of the Physician orders, for May and June 2016, indicated the following: Atrovastatin 40 mg tablet- take one by mouth at bedtime. Levothyroxine 0.5 mg</p>			

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	<p>tablet-take one tablet by mouth once daily. Metoprolol Succ ER 25 mg tablet-take 1/2 tablet (12.5 mg) by mouth once daily. Senexon-S tablet-take 2 tablets by mouth twice daily. Trileptal 150 mg tablet-one by mouth every morning. Accu check before meals and at bedtime. Humalog 100 units/ml-inject 5 units sub q before lunch and dinner. Lantus Solostar 100 units/ml-inject 14 units sub q at bedtime. Norco 5mg/25mg-one tablet every four hours.</p> <p>Review of the Medication Administration Record, for May and June 2016, indicated the following:</p> <p>May 4 at 6a, the clinical record lacked documentation of Levothyroxine.</p> <p>May 14 at 4p, the clinical record lacked documentation of Senexon-S.</p> <p>May 27 at 8a, the clinical record lacked documentation of Trileptal.</p> <p>May 1, 8 at 11a, May 8 and 20 at 8p, the clinical record lacked documentation of blood sugars.</p> <p>May 8 at 11a, the clinical record lacked documentation of Humalog.</p> <p>May 23 at 5p, the clinical record lacked</p>			

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	<p>documentation of Humalog.</p> <p>May 10 and 23 at 8p, the clinical record lacked documentation of Lantus.</p> <p>May 23 at 12p, the clinical record lacked documentation of Norco 5mg/325mg.</p> <p>June 2, 22, 25 and 29 at 8p, the clinical record lacked documentation of Atrovastatin.</p> <p>June 21 and 22 at 6a, the clinical record lacked documentation of Levothyroxine.</p> <p>June 8 at 8a, the clinical record lacked documentation of Metoprolol.</p> <p>5. The clinical record for Resident F was reviewed on 6/29/2016 at 9:12 a.m. Diagnoses for the resident included, but were not limited to, cerebrovascular disease, spastic hemiplegia, muscular contracture, major depressive disorder and atherosclerotic heart disease.</p> <p>Review of the Physician orders, for May and June 2016, indicated the following: Tizandine HCL 4 mg tablet-take one tablet by mouth 3 times daily. Atrovastatin 80 mg-take one tablet by mouth at bedtime. Tamsulosin HCL 0.4 mg capsule-take one capsule by mouth once daily.</p>			

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	<p>Review of the Medication Administration Record, for May and June 2016, indicated the following:</p> <p>May 26 and 27 at 9p, the clinical record lacked documentation for Tizandine HCL.</p> <p>June 6 at 5p, the clinical record lacked documentation for Tamsulosin HCL.</p> <p>During an interview on 6/30/2016 at 8:30 a.m., the DON (Director of Nursing) indicated the missing documentation on the Medical Administration Records could not be located. The DON indicated all medications and treatments were to be documented on the Medication and Treatment Administration Records.</p> <p>This Federal tag relates to Complaint IN00203128.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			