

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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F0000	<p>This visit was for the Recertification and State License Survey.</p> <p>Survey dates: March 12, 13, 14, and 15, 2012</p> <p>Facility number: 000150 Provider number: 155246 AIM number: 100267000</p> <p>Survey team: Sheila Sizemore, RN, TC Kelly Sizemore, RN Regina Sanders, RN Marcia Mital, RN</p> <p>Census bed type: SNF/NF: 87 Total: 87</p> <p>Census payor type: Medicare: 12 Medicaid: 69 Other: 06 Total: 87</p> <p>Sample: 18 Supplemental Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this plan of correction and statement of compliance does not constitute an admission by The Waters of Duneland, LLC (the "facility") that the allegations contained in the survey report are true or accurate portrayals of the nursing care and services provided by the facility. The facility recognizes its obligation to provide legally and medically required care and services to its residents in an economic and efficient fashion. The facility hereby maintains that it is in substantial compliance with the Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. As a result, this Plan of Correction constitutes an allegation of compliance.</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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	Quality review 3/22/12 by Suzanne Williams, RN			

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F0280 SS=E	<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, record review, and interview, the facility failed to ensure residents' care plans were developed and updated, related to, medications, seizures, pain, feeding techniques, and oxygen for 5 of 18 residents reviewed for care plans in a total sample of 18. (Residents #6, #8, #39, #48, and #79)</p> <p>Findings include:</p> <p>1. Resident #48's record was reviewed on 03/13/12 at 9:30 a.m. The resident's diagnoses included, but were not limited to, seizures, insomnia, and peripheral vascular disease.</p>	F0280	<p>It is the intent of this facility to develop and update all necessary care plans including and related to: medications, seizures, pain, feeding techniques and oxygen. The actions taken by the facility are as follows: Regarding Resident 48, the care plan was updated to include the diagnoses of insomnia, pain and seizures. Regarding Resident 8, the specialized feeding instructions were dc'd on 3/15/12 due to the cognition of the resident. Oxygen care plan was discontinued from the care plan. Regarding Resident 6, the care plan was updated with antipsychotic care plan being discontinued. Regarding Resident 79, the care</p>	03/19/2012			

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	<p>The resident's pain assessment, dated 02/03/12, indicated the resident had pain occasionally, which was rated as moderate.</p> <p>The resident's Quarterly Minimum Data Set (MDS) assessment, dated 02/04/12, indicated the resident had received as needed pain medication, pain was present occasionally and the pain was rated as moderate.</p> <p>The resident's physician's recapitulation orders, dated 03/12, indicated the resident had orders for Ambien (sleeping medication) 2.5 mg (milligrams) at bedtime for insomnia, originally dated 09/12/11 and Keppra (seizure medication) 500 mg twice daily for seizures originally dated for 09/15/10.</p> <p>The resident's care plan, reviewed on 02/16/12 by the facility, lacked documentation to indicate the resident had a care plan for insomnia, seizures, and pain.</p> <p>During an interview on 03/13/12 at 11:05 a.m., the MDS Coordinator indicated there was no care plan for insomnia, seizures, and pain.</p> <p>2. Resident #8's record was reviewed on 3/14/12 at 11:10 a.m. Resident #8's</p>		<p>plan was updated with a diabetes care plan reflecting the type of diabetic medication being utilized. Regarding Resident 39, the care plan was updated to reflect palliative care. II. The facility's actions taken to identify other residents are as follows: 100% audits were completed by the IDT to review and revise all care plans to the resident's current status. No further issues identified. III. The measures put into place by the facility are as follows: Licensed nursing staff were re-inserviced on revising/updating care plans with the appropriate interventions as resident status/desires changed. The IDT will audit all residents upon admission, quarterly and as needed to ensure residents with the diagnosis of insomnia, pain, seizure and specialized feeding is reflected on the care plans. This will be an on-going process. IV. The facility will monitor actions as follows: D.O.N. and/or designee will review the audits in the weekly QA meeting. Administrator and/or designee will review audits with the QA committee in the monthly QA meeting, and in the quarterly QA meeting with the Medical Director. VII. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

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	<p>diagnoses included, but were not limited to, Alzheimer's disease, stroke, and dysphagia.</p> <p>The resident's physician order recapitulation, dated 3/12, indicated pureed diet with nectar thick liquids, double swallow and chin tuck.</p> <p>A physician's order, dated 1/16/12, indicated to discontinue oxygen orders.</p> <p>The resident's care plans, dated 1/17/12 and updated 2/4/12, indicated a lack of documentation of a care plan for any specialized feeding techniques for resident #8.</p> <p>CNA #5 was observed assisting resident #8 with his noon meal on 3/14/12 at 12:15 p.m. CNA. #5 was observed to give the resident bites of food without cueing the resident to double swallow or tuck his chin.</p> <p>During an interview at the above date and time, CNA #5 indicated she did not have any specific feeding instructions for the resident.</p> <p>A care plan, dated 1/17/12, indicated "Pot (Potential) for impaired gas exchange R/T (related to) oxygen use..."</p> <p>During an interview on 3/14/12 at 2:23</p>			

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	<p>p.m., the ADoN (Assistant Director of Nurses) indicated the resident's care plans lacked any specialized feeding instructions and the care plan for oxygen should have been discontinued.</p> <p>3. Resident #6's record was reviewed on 3/14/12 at 12 p.m. Resident #6's diagnoses included, but were not limited to, dementia, hypertension, and anemia.</p> <p>A care plan, dated 12/20/11, indicated "Resident receives antipsychotic medication...."</p> <p>The resident's physician's order recapitulation, dated 3/12, lacked documentation of an order for an antipsychotic medication.</p> <p>During an interview on 3/14/12 at 2:56 p.m., the Social Service Director indicated the resident was not on an antipsychotic medication and the care plan needed to be discontinued.</p> <p>4. Resident #79's record was reviewed on 3/13/12 at 10:10 a.m. Resident #79's diagnoses included, but were not limited to, diabetes mellitus, seizures, and hypomagnesium.</p> <p>A physician's order, dated 2/25/12, indicated "decrease (indicated by an</p>			

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	<p>arrow) Lantus (insulin) to 20 units SQ (subcutaneous) Q/hs (every hour of sleep). New Novolog (insulin) sliding scale use w/ (with) meals only..."</p> <p>The physician order recapitulation, dated 2/12, lacked documentation of any oral diabetes mellitus medications.</p> <p>The resident's care plans, dated 3/23/09 and updated 2/16/12, indicated "Potential for glycemic reactions r/t oral antidiabetic medications..."</p> <p>The resident's care plans, dated 3/23/09 and updated 2/16/12, lacked documentation of a care plan for seizures.</p> <p>During an interview on 3/13/12 at 11:20 a.m., the ADoN indicated there was no care plan for the resident's seizures. She indicated there should have been a care plan for the seizures. She indicated the resident was receiving insulin and was not on an oral diabetes mellitus medication. She indicated the resident's care plans needed updated.</p> <p>5. Resident #39's record was reviewed on 3/12/12 at 11:50 a.m. Resident #39's diagnoses included, but were not limited to, diabetes, hypertension, and Alzheimer's disease.</p> <p>Physician recapitulation orders for March</p>			

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	<p>2012 indicated an order for palliative (sic) care.</p> <p>The resident's record lacked a care plan for palliative care.</p> <p>During an interview with the MDS Coordinator on 3/13/12 at 10:25 a.m., she indicated the resident did not have a care plan for palliative care. She indicated they received the care plans last week from corporate. She indicated it still should have been added to the care plans.</p> <p>3.1-35(c)(1) 3.1-35(d)(2)(B)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed related to blood sugar checks for 1 of 7 residents with blood sugar checks in a total sample of 18. (Resident #79)</p> <p>Findings include:</p> <p>Resident #79's record was reviewed on 3/13/12 at 10:10 a.m. Resident #79's diagnoses included, but were not limited to, diabetes mellitus, seizures, and hypomagnesium.</p> <p>A physician's order, dated 2/25/12, indicated "decrease (indicated by an arrow) Lantus (insulin) to 20 units SQ (subcutaneous) Q/hs (every hour of sleep). New Novolog (insulin) sliding scale use w/(with) meals only..."</p> <p>The physician order recapitulation, dated 2/12, indicated accu checks (blood sugar testing) before meals and at bedtime.</p> <p>The resident's MAR (medication administration record), dated 2/12,</p>	F0282	<p>It is the intent of this facility to ensure physician's orders are followed for Blood Sugar checks.</p> <p>I. The action taken by the facility are as follows: Regarding Resident 79 a clarification order was received from the physician in regards to appropriate times for blood sugar checks. II. The facility's actions taken to identify other residents are as follows: 100% audits were completed to ensure all blood sugar accuchecks were being obtained per physician orders. No others were identified. III. The measures put into place by the facility are as follows: Licensed nursing staff were re-inserviced on complete and accurate medication orders, auditing re-writes and proper recording of blood sugar accuchecks. IV. The facility will monitor actions as follows: D.O.N. and/or designee will review all physician orders daily for accuracy of completion. This will be on-going. D.O.N. and/or designee will review audit in the weekly QA meeting. Administrator and/or designee will review audits with the QA committee in the monthly QA meeting and in the Quarterly QA meeting with the Medical Director.</p>	03/19/2012

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	<p>indicated the 9 p.m. blood sugar check had been discontinued on 2/25/12. The 9 p.m. blood sugar checks were not documented as done from 2/25/12 through 2/29/12.</p> <p>During an interview on 3/13/12 at 11:35 a.m., the ADoN indicated the blood sugar checks should not have been discontinued. She indicated the only the sliding scale had been changed, not the accu checks.</p> <p>3.1-35(g)(2)</p>		VII. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

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F0309 SS=D	<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 observation, record review, and interview, the facility failed to ensure specialized eating instructions were followed for 1 of 2 residents with specialized eating instructions in a total sample of 18 residents. (Resident #8)</p> <p>Findings include:</p> <p>Resident #8's record was reviewed on 3/14/12 at 11:10 a.m. Resident #8's diagnoses included, but were not limited to, Alzheimer's disease, stroke, and dysphagia.</p> <p>The resident's physician order recapitulation, dated 3/12, indicated pureed diet with nectar thick liquids, double swallow and chin tuck.</p> <p>The resident's care plans, dated 1/17/12 and updated 2/4/12, indicated a lack of documentation of a care plan for any specialized feeding techniques for resident #8.</p>	F0309	<p>It is the intent of this facility for all staff to be educated/instructed in regards to any resident with a specialized feeding instructions and that the specialized feeding instructions will be care planned.</p> <p>I. The actions taken by the facility are as follows: Regarding Resident 8, the physician was contacted and the order was discontinued on 3/15/12 due to cognition. II. The facility's actions taken to identify other residents are as follows: 100% audit completed. No further residents with specialized feedings were identified. III. The measures put into place by the facility are as follows: All nursing staff was re-inserviced on following orders for specialized feedings. Licensed nursing staff was re-inserviced on care plan revision. D.O.N. and/or designee will inform all nursing staff of any resident admitted with new orders for specialized feeding per 24 hour report board and C.N.A. pocket worksheet and updated care plan. IV. The facility will monitor actions as follows: D.O.N. and/or designee will</p>	03/19/2012			

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	<p>CNA #5 was observed assisting resident #8 with his noon meal on 3/14/12 at 12:15 p.m. CNA. #5 was observed to give the resident bites of food without cueing the resident to double swallow or tuck his chin.</p> <p>During an interview at the above date and time, CNA #5 indicated the resident did not have any specific feeding instructions.</p> <p>CNA #5 was observed to continue to feed resident #8 on 3/14/12 at 12:25 p.m., without instructing the resident to double swallow or tuck his chin.</p> <p>During an interview on 3/14/12 at 2:23 p.m., the ADoN (Assistant Director of Nurses) indicated the resident's care plans lacked any specialized eating instructions. She indicated the CNA feeding the resident should have been aware of the feeding instructions.</p> <p>3.1-37(a)</p>		<p>review all physcian orders for specialized feeding and ensure the new orders are carried over to the 24 hour report board, pocket worksheets and care planed as needed. This will be on-going. D.O.N. and/or designee will review audits in the weekly QA meeting. Administrator and/or designee will review audits with the QA committee in the monthly QA meeting and in the Quarterly QA meeting with the Medical Director. VII. This plan of correction constitutes our credible allegation of compliance with all regulatory requirement.</p>		

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents maintained acceptable parameters of nutrition and follow up on the Registered Dietician's (RD) recommendations to prevent weight loss for 2 of 3 residents with significant weight loss (Residents #28 and #69) reviewed in a total sample of 18.</p> <p>Findings include:</p> <p>1. During an observation of the noon meal on 3/12/12 at 12:05 p.m., Resident #28 was observed sitting up in her wheelchair in the rehab dining room. The resident's meal tray was observed not to have eight ounces of whole milk included in the meal. The resident's daily menu card lacked documentation of the eight ounces of whole milk.</p> <p>Resident #28 was observed on 3/13/12 at</p>			F0325	<p>It is the intent of this facility for all residents to maintain acceptable parameters of nutrition and to follow up on the Registered Dietician's recommendations to prevent weight loss. I. The Actions taken by the facility are as follows: Regarding Resident 28 the dietary card was updated to include 8 ounces of whole milk at each meal. Care plan was updated. Regarding Resident 69 the dietary meal card was updated to reflect RD's recommended intervention. The care plan was updated. II. The facility's actions taken to identify other residents are as follows: RD reviewed weight losses and recommended interventions on 3/16/12. No further issues were identified. 100% audit of RD recommendations were completed. No further issues were identified. III. The measures put into place by the facility are as follows: Dietary Manager was re-inserviced on weight loss and dietary</p>		03/19/2012

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	<p>5:40 p.m., lying in her bed with the head of the bed up. The resident was being fed by CNA #7. The resident's meal did not include the eight ounces of whole milk. CNA #7 indicated the resident did not receive eight ounces of whole milk. The daily menu card on the resident's meal tray lacked documentation of the eight ounces of whole milk.</p> <p>Resident's #28's record was reviewed on 3/12/12 at 11:40 a.m. Resident #28's diagnoses included, but were not limited to, diabetes mellitus, and anemia.</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 2/20/12, indicated the resident had short and long term memory problems and impaired decision making skills. The quarterly MDS assessment indicated the resident required total assist of one staff for eating and had weight loss of five percent or more in the last month and/or ten percent in the last six months.</p> <p>A care plan for nutrition, dated 09/20/10, indicated "whole milk all meals."</p> <p>A care plan for nutrition, dated 11/28/11, indicated " Palliative care... 4. provide power foods at all meals."</p> <p>A quarterly nutritional evaluation, dated 2/20/12, indicated the resident was on</p>		<p>recommendations on 3/16/2012. Dietary staff was re-inserviced on updating/following dietary recommendations. RD will attach all RD recommendations notes to the Dietary Consult Report for review of recommendations to be followed by the DM to ensure accuracy of recommendations. IV. The facility will monitor actions as follows: Dietary Manager will perform an audit of all residents who receive recommendations per visits and any new physician orders to ensure that any recommendation is included on the diet card and care planned accordingly. This will be on-going. Dietary Manager and/or designee will monitor diet cards and orders daily x 1 month, then 3 x week x 1 month and then as needed. This will be on-going. Dietary Manager and/or designee will review audits in the weekly QA meeting. Administrator and/or designee will review audits with the QA team in the monthly QA Meeting and in the Quarterly QA meetin with the Medical Director. VII. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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	<p>palliative care and had a 15.8% weight loss in six months.</p> <p>A nutritional progress note, dated 2/29/12, indicated "...Diet is supplemented c/ (with) power foods q/ (every) meal and 8 oz (ounces) whole milk q/ meal."</p> <p>Review of the resident monthly weight record indicated: October 2011: 165.4 pounds November 2011: 162.8 pounds December 2011: 155 pounds January 2012: 151.8 February 2012: 147.8 January 2012: 137.6</p> <p>This is a 27.8 pound weight loss in six months.</p> <p>During an interview on 3/14/12 at 10:15 a.m., the Dietary Manager indicated the eight ounces of whole milk was not on the daily menu card, and the dietary staff would not know to serve the whole milk.</p> <p>2. Resident #69's record was reviewed on 3/12/12 at 11:40 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's disease, and anemia.</p> <p>The resident's weight record indicated the following weights:</p>			

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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE				STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304			
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	<p>10/11 163.4 pounds 11/11 163 pounds 12/11 148.2 pounds 1/12 148.4 pounds 2/12 144.8 pounds 3/12 140.8 pounds This was a 22.6 weight loss in 6 months.</p> <p>A RD (Registered Dietician) note, dated 2/29/12, indicated "...sig (significant) wt (weight) loss 18.2 # (pounds) /11.2% x (times) 3 months and 18#/ 11.1% x 6 months...Recommend...increase Med Pass 2.0 to 90 ml (milliliters) TID (three times a day)...continue c (with) power foods and whole milk q (every) meals..." (sic)</p> <p>A care plan, dated 6/30/11 and updated 3/2/12, indicated "Potential for weight loss...Significant wt (weight) loss past 6 mo's (months)...Approaches...Power foods at B/D (breakfast and dinner)..."</p> <p>Resident #69 was observed during the noon meal on 3/12/12 at 12:15 p.m., being assisted to eat by the MDS (minimum data set) Coordinator. The resident had received ground Salisbury steak, potatoes, green beans, bread and butter, a glass of milk and water. The resident had not received any power foods with the meal.</p> <p>During an interview on 3/13/12 at 12:02</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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	<p>p.m., LPN #9 indicated the resident should receive power foods with meals.</p> <p>During an interview on 3/14/12 at 10:15 a.m., the Dietary Manager indicated she thought the power pudding at lunch had been added recently. She indicated the resident should have received the power pudding at lunch.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>			

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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE				STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304			
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F0425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview, the facility failed to administer medications as ordered by the residents' physicians, for 2 of 18 residents reviewed for physician's orders out of a total sample of 18. (Residents #39 and #79)</p> <p>Findings include:</p> <p>1. Resident #39's record was reviewed on 3/12/12 at 11:50 a.m. Resident #39's diagnoses included, but were not limited to, diabetes, hypertension, and Alzheimer's disease.</p>	F0425	<p>It is the intent of this facility to administe all medications as ordered by the physician. I. The actions taken by the facility are as follows: Regarding Resident 39 the physician was contacted on 3/16/2012. No new orders were received. Regarding Resident 79 the physician was called on 3/13/2012. New order was received. II. The facility's actions taken to identify other residents are as follows: 100% audit was completed on all residents who receive liquid Magnesium. No further residents were identified to be on liquid Magnesium. 100% audit of all residents who receive sliding scale insulin. No further</p>	03/19/2012			

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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE			STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304		
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	<p>Physician's orders, dated 8/14/07, indicated blood glucose monitoring check and record three times daily.</p> <p>Physician's orders, dated 9/15/11, indicated Novolog (insulin) inject subcutaneous per sliding scale (amount of insulin given based on blood sugar results) three times daily. The sliding scale was as follows:</p> <p><100 (less than 100)= 0 units 101-150= 3 units 151-200= 6 units 201-250= 8 units 251-300= 10 units 301-350= 14 units 351-400= 16 units</p> <p>A Medication Administration Record (MAR) for March 2012 indicated the following:</p> <p>3/2 at 11 a.m., blood sugar result was 165 and 3 units of insulin was given 3/9 at 11 a.m., blood sugar result was 109 and no insulin was given 3/10 at 5 p.m., blood sugar result was 198 and 8 units of insulin was given</p> <p>During an interview with RN #6 on 3/12/12 at 1:25 p.m., she indicated the insulin was not given as ordered. She indicated the resident should have been</p>		<p>issues identified. III. The measures put into place by the facility are as follows: Licensed nursing staff was re-inserviced on proper measurement of the Magnesium liquid form medication.. Licensed nursing staff was re-inserviced on correct administration of sliding scale insulin's IV. The facility will monitor actions as follows: D.O.N. and/or designee will audit all sliding scale insulin for correct administration daily x 1 month, then 3 times a week. Any issues found will be corrected immediately. This will be on-going. Administrator and/or designee will review audits with the QA committee in the monthly QA Meeting and in the Quarterly QA meeting with the Medical Director. VII. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.ADDENDUM: APRIL 6, 2012 D.O.N. and /or designee will monitor any resident who is receiving liquid magnesium for proper dosage administration upon receiving the physician order and weekly. This will be on-going until a determination has been made by the QA committee to discontinue.</p>		

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	<p>given 6 units on 3/2, 3 units on 3/9, and 6 units on 3/10.</p> <p>2. Resident #79's record was reviewed on 3/13/12 at 10:10 a.m. Resident #79's diagnoses included, but were not limited, hypomagnesium, hypertension, and diabetes.</p> <p>A physician's order, dated 1/21/11, indicated Magonate (magnesium supplement) liquid 1000/5 ml (milliliters) give 22.3 ml by mouth twice daily.</p> <p>A MAR (Medication Administration Record) for February 2012 indicated the resident was receiving Magonate 22.3 ml twice daily.</p> <p>During an interview with LPN #8 on 3/13/12 at 11:30 a.m., she indicated she gives 20 ml then measures 2.5 ml on the cup and pours it right below the line. She indicated she couldn't measure the correct dose without a syringe. She indicated she was calling the pharmacy to clarify the dose.</p> <p>During an interview with the ADoN (Assistant Director of Nursing) on 3/13/12 at 11:35 a.m., she indicated the dose "doesn't make sense for 22.3 ml."</p> <p>3.1-25(b)</p>			

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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, record review and interview, the facility failed to follow</p>	F0441	It is the intent of this facility to follow Standard Precautions	03/19/2012	

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	<p>standard precautions during the performance of routine testing of blood glucose levels, related to disinfecting blood glucose monitors (checks blood sugars) before and between obtaining residents' blood sugars during three observations of blood sugar monitoring, resulting in a risk of transmission of blood borne pathogens, for 3 of 3 residents observed for blood glucose testing in a supplemental sample of 7 (Residents #7, #54 and #59) . In addition, the facility failed to ensure 3 of 7 nurses (LPN #1, LPN #2, and LPN #3) in the facility were knowledgeable of the facility's policy and procedure for disinfecting the blood glucose monitors to prevent the transmission of blood borne pathogens. This had the potential to affect 26 residents who received blood glucose monitoring out of a total population of 87 in the facility.</p> <p>B. Based on observation, record review, and interview, the facility failed to ensure a dressing change was completed to prevent the potential for cross contamination of the areas, related to cleansing the wounds, handwashing, and glove changes for 1 of 2 dressing changes observed for 1 of 2 residents with dressing changes in a total sample of 18. (Resident #11 and LPN #3)</p>		<p>during the performance of routine testing of blood glucose levels related to disinfecting blood glucose monitors before and between obtaining residents' blood sugar and for all staff to be knowledgeable of the facility's policy/procedures for disinfecting the blood glucose monitors to prevent the transmission of blood borne pathogens. It is the intent of this facility to ensure all dressing changes are completed using Standard Precautions to prevent the potential for cross contamination of the areas related to cleansing the wounds, hand washing and glove changes. I. The actions taken by the facility are as follows: All Nurses' were re-inserviced/educated on the use of Standard Precautions and the policy/procedure for the performance of routine testing of blood glucose levels related to disinfecting blood glucose monitors before and between residents' blood sugar testing to prevent the transmission of blood borne pathogens. All Nurses' were re-inserviced/educated on performing dressing changes per the facility policy/procedure and Standard Precautions to prevent the potential cross contamination of the areas being treated, related to cleansing the wounds, hand washing and glove changes. In regards to Resident 11, the wounds were cleansed using the proper technique, washing hands,</p>				

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	<p>Findings include:</p> <p>A1. During an observation on 03/13/12 at 4:28 p.m., on the 300 unit, LPN #1 obtained a glucometer, lancet, and alcohol prep pad from the medication cart, and entered resident #54's room to perform a glucometer test. LPN #1 performed the test, which included obtaining a drop of blood from the resident's finger, and placing the blood on the test strip on the glucometer. LPN #1 then exited the resident's room and returned to the medication cart. LPN #1 then used an alcohol prep pad and wiped the glucometer off, placed the glucometer in the medication cart drawer, and prepared and administered resident #54's insulin injection.</p> <p>During an interview right after the insulin injection observation, LPN #1 indicated she uses the alcohol pad to clean the glucometer most of the time. She indicated sometimes she uses the disinfectant clothes, but they make the glucometer go, "wacky." She indicated the facility policy says to clean the glucometer, so she uses the alcohol prep pads. She indicated, "as long as it (the glucometer) is clean."</p> <p>LPN #1 then indicated she had not been sure if the glucometer had been</p>		<p>and changing gloves as necessary during the tretments, and a new dressing was applied. II. The facility's actions taken to identify other residents are as follows: This concern would have the potential to affect all residents with blood glucose monitoring being performed; and any resident with a wound being treated. III. The measures put into place by the facility are as follows: All Nurses' were re-inserviced/educated on the use of Standard Precautions and the policy/procedure for the performance of routine testing of blood glucose levels related to disinfecting blood glucose monitors before and between residents' blood sugar testing to prevent the transmission of blood borne pathogens. A demonstration will be performed by each nurse during the obtaining of blood glucose levels to ensure compliance with facility policy/procedure and standar precautions. All Nurses' were inserviced/educated on performing dressing changes per the facility policy/procedure and Standard Precautions to prevent the potential cross contamination of the areas being treated, related to cleansing the wounds, hand washing, and glove changes. Each nurse will prform a dressing change under observation to ensure compliance with facility policy/procedure and Standard Precautions. IV. The</p>		

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NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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	<p>disinfected prior to performing the glucometer test on Resident #54. LPN #1 indicated she had used a alcohol prep pad to clean the glucometer prior to performing the glucometer test on Resident #54. LPN #1 indicated she was not sure what the policy says about cleaning the glucometer.</p> <p>LPN #1 then retrieved the glucometer from the medication cart drawer and obtained supplies to perform a glucometer test on Resident #59. LPN #1 then walked down the hall to Resident #59's room and was stopped at the door and shown the glucometer manufacturer's instructions. LPN #1 then indicated she had not been disinfecting the glucometer between residents. LPN #1 then approached the medication cart with the glucometer, used a disinfectant wipe and wiped the glucometer for less than 30 seconds. LPN #1 then walked down the hall toward resident #59's room. LPN #1 was stopped before she reached the room. LPN #1 indicated she had not used the disinfectant wipe for one minute. LPN #1 stated, "I never read the bottle (container for the disinfectant wipes)." LPN #1 then wiped down and wrapped the glucometer with the disinfectant cloth and timed it at one minute.</p> <p>2. During an observation of glucometer testing on 3/13/12 at 4:00 p.m., with LPN</p>		<p>facility will monitor actions as follows: D.O.N./designee will audit each nurse during a performance of obtaining a blood glucose level to ensure facility policy/procedure and standard precautins are followed. A nurse will not perform obtaining blood glucose levels unsupervised until he/she has performed the proficiency without error. This proficiency will be repeated quarterly x 1 year and then annually thereafter.</p> <p>D.O.N./designee will do an observation of each nurse during a dressing change/treatment to ensure facility policy/procedure and standard precautions are followed. A nurse will not perform a dressing change/treatment unsupervised until he/she has performed a dressing change/treatment without error. This proficiency will be repeated quarterly x 1 year and then annually thereafter. The Administrator/designee will review all audits as completed in the weekly QA meeting, in the monthly QA meeting and in the Quarter;u QA meeting with the Medical Director. VII. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.ADDENDUM: April 6, 2012Blood Glucose monitoring machines will be disinfected after each use of the machine.</p>	

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	<p>#2 on the 100 unit, the LPN was observed to remove a glucometer from the drawer of the medication cart. LPN #2 was observed to wipe the glucometer for less than 30 seconds with a disinfectant wipe. LPN #2 was stopped from using the glucometer to test Resident #7's blood sugar. At this time, LPN #2 indicated he did not know if the glucometer had been disinfected after use on the last resident. LPN #2 indicated he did not wipe the glucometer long enough. LPN #2 indicated he had been "inserviced a long time ago."</p> <p>During an interview on 3/13/12 at 4:45 p.m., the DON indicated the "new company" had changed the brand of wipes in November of 2011.</p> <p>3. During an interview on 03/14/12 at 9:11 p.m., LPN #3 indicated he did not know about disinfecting the glucometers correctly until after the inservice this morning.</p> <p>The employee roster, received from Human Resources on 03/13/12, indicated LPN #3 was hired at the facility in 2006.</p> <p>A facility policy, dated 07/11, received as current from the DoN, titled, "Glucometer Cleaning," indicated, "...Complete sanitization of glucometers by wiping</p>			

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	<p>with approved disposable wipes between resident use...There should be 2 glucometers per medication cart--one in use and one cleaned and drying..."</p> <p>During an interview on 03/13/12 at 4:25 p.m., the DoN indicated the medication carts have two glucometers but they just use one (glucometer).</p> <p>The glucometer manufacturer's cleaning instructions, non-dated, and received from the DoN on 03/13/12 at 4:25 p.m., indicated, "...Procedure: Consult the manufacturer's instructions for additional information regarding the use of disinfecting wipes...2. To clean the meter, take an alcohol pad or wipe and wipe down the body of the meter...3. To disinfect the meter, refer to the product label of the disinfectant wipes to determine how long the liquid from the wipes needs to be on the body of the meter for full disinfecting (also known as 'contact time')...."</p> <p>The container for the disinfectant wipes, found on the medication cart, indicated for viruses (HIV and Hepatitis A, B, and C) (blood borne pathogens), contact time is one minute.</p> <p>B1. During a dressing change observation on 03/13/12 at 10:10 a.m.,</p>						

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	<p>LPN #3 and CNA #4 entered Resident #11's room so LPN #3 could perform wound care for the resident. LPN #3 and CNA #4 washed their hands and then applied gloves. CNA #4 then turned the resident to his right side and supported the resident during the wound care. LPN #3 then removed the dressing from the resident's coccyx area. LPN #3 indicated there was light green/beige drainage on the soiled dressing. LPN #3 then used a normal saline soaked gauze and washed the sacral wound. LPN #3 indicated there was slough (dead tissue) hanging from the wound, which was a deep wound. LPN #3 then used the same gauze to wash the resident's three sacral wounds, which were a stage II (partial thickness of skin missing). LPN #3 then used a dry gauze and blotted the sacral wounds dry then used the same gauze to blot the coccyx wound.</p> <p>LPN #3 then opened the tube of Medihoney (ointment), touched the applicator with his gloves (same gloves he touched soiled dressing and cleaned wounds with), and placed the applicator inside the deep wound of the coccyx and applied the ointment, touching the side of the wound while the applicator was in the wound. LPN #3 then laid the tube of ointment on the bedside table on a towel and placed a dressing over the coccyx</p>			

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	<p>wound. LPN #3 then put cream on the resident's sacral wounds with his gloved hand (gloves still have not been changed). LPN #3 then assisted the CNA #4 with applying the resident's brief. LPN #3 then started to place the cap on the Medihoney and dropped the cap on the floor, picked up the cap and placed the cap on the applicator. LPN #3 then removed his gloves and washed his hands.</p> <p>LPN #3 had not removed his gloves nor washed his hands since he began the treatment for the resident's wounds.</p> <p>During an interview on 03/13/12 at 10:25 a.m., LPN #3 indicated he only needed to wash his hands and put gloves on before and after the treatment. He indicated he was unaware he needed to change his gloves and wash his hands during the treatment.</p> <p>Resident #11's record was reviewed on 03/12/12 at 11:40 a.m. The resident's diagnoses included, but were not limited to, stroke and malnutrition.</p> <p>The resident's pressure ulcer monitoring sheet, dated 03/06/12, indicated the wound on the coccyx was 2.5 cm (centimeters) by 2 cm with yellow slough with yellow drainage. The form indicated the area was unstageable due to the</p>			

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	<p>slough.</p> <p>A facility policy, dated 07/11, received from the DoN as current, titled, "Standard Precautions", indicated, "...A. Handwashing...It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites...B...Put on clean gloves just before touching mucous membranes and nonintact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces..."</p> <p>3.1-18(j) 3.1-18(l)</p>			