STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE COMMONS ASSISTED LIVING	7525 ROSEGATE DRIVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 7, 8, 11, and 12, 2015 Facility number: 012936 Provider number: 012936 AIM number: N/A Census bed type: Residential: 80 Total: 80 Sample: 9 These state findings are cited in accordance with 410 IAC 16.2-5.	R 000		
R 090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to inform the division within twenty-four (24) hours of an unusual occurrence directly threatening	R 090	**It is the common practice of this facility to ensure that theadministrator informs the division within 24 hours of becoming aware of anunusual**	05/28/2015

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	the welfare and safety of a resident in that an ambulatory resident with a diagnosis of dementia was found wandering outside of the facility on 2 separate occasions. (Resident #43) Findings include: The clinical record review for Resident #43, completed on 5/7/15 at 1:30 p.m., indicated the resident had diagnoses including, but not limited to, Alzheimer's dementia. The resident was readmitted to the facility on 4/2/15, following a hospitalization and rehabilitation stay of 9 weeks. A history and physical dated 3/31/15, indicated the resident had a BIMS (Brief Interview for Mental Status) of 3 out of 15, indicating severe cognitive impairment. A re-admission Resident Data Collection form dated 4/2/15, indicated the resident was independently ambulatory, transferred independently, was alert, disoriented to time and place, and wandered mentally. A 72 hour follow up note dated 4/5/15, for the 2:00 p.m. to 10:00 p.m. shift, indicated the resident had spit out medications, was confused and		**occurrence that directly threatens the welfare and safety or health ofa resident.** **(TAG 090)** 1. Resident number #43-Immediately reviewed the policy and procedure for reporting unusualoccurrences. Staff interviews were conducted to determine other residents thatmay potentially be at risk. None havebeen identified at this time. Re-educated all community personnel onreporting unusual occurrences. Incident has been reported to ISDH per state regulation and facility policy. 2. Staff re-educated tocontact General Manager and Clinical Director immediately of any unusualoccurrences. General Manager will assumefull responsibility to ensure all unusual occurrences have been reported toISDH within the 24 hour time period. Allresidents have the potential to be affected. 3. Licensed registered nursesand general manager in-serviced all by May 27, 2015. Created binder to include, all reportingdocumentation, supporting investigation, and copy of follow-up. General manager and/or clinical director willbe responsible to ensure any	

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	wandering around the halls, and was not acclimating to the room. A 72 hour follow up note dated 4/7/15, for the 2:00 p.m. to 10:00 p.m. shift, indicated the resident chewed and spit out medications, had attempted to exit the building, and had to be redirected several times. 1. A nurse's note dated 4/21/15 at 4:00 p.m., indicated the resident was found at another facility and was unable to recall reason for leaving or destination. The resident was escorted back to the facility by a staff member and was placed on hourly checks. During an interview with the General Manager (GM) on 5/12/15 at 2:20 p.m., the GM indicated the management team was not made aware of the resident being found at another facility on 4/21/15, and the occurrence had not been reported to the State agency. 2. A nurse's note dated 5/2/15 at 6:00 p.m., indicated the resident was found by a staff member outside of the building near the smoking area. The smoking area was located across the parking lot and behind another facility. During an interview with Licensed		unusual occurrences are reported within 24hours. General manager or designeewill during daily managers meeting determine if any unusual occurrences havehappened, review the 24 hour report, manager on duty during weekends willmonitor 24 hour report and verbally verify with nursing any circumstances thatmay warrant unusual occurrences and report these immediately to general managerand clinical director. 4. A CQI tool titled ***Reportablesto ISDH within 24 hours*** will be implemented to ensure all potentialreportable are investigated, resolved and reported to the ISDH within 24 hoursof the actual occurrence. This tool will be monitored weekly X1 month, thenmonthly X2 months. The Director ofAssisted Living Clinical Services and or designee will complete this CQImonitoring.	

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	Practical Nurse (LPN) #1 on 5/8/15 at 3:45 p.m., LPN #1 indicated the resident frequently went out the front door to sit on the front porch and was able to find the way back into the building without assistance. LPN #1 indicated on the evening of 5/2/15, the resident went out a side door and was found by another staff member. LPN #1 indicated the incident was not considered an elopement because the resident frequently went outside to the front porch. LPN #1 indicated the resident was placed on every 2 hour checks after the incident as a precautionary measure. During an interview with the General Manager (GM) and the Clinical Director (CD) on 5/8/15 at 4:00 p.m., the CD indicated the management staff had not been made aware of the resident being found outside of the building on 5/2/15, until the morning of 5/4/15, as the nurse on duty at the time of the incident left a note with the information under the door of the CD's office. The CD and the GM indicated the resident being found outside of the building on 5/2/15, was not considered as an elopement incident because the resident frequently went outside to sit on the front porch. The CD indicated the incident on 5/2/15, was reported on 5/5/15, after the resident			

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	had been located in the back parking lot of the facility and was wandering around until escorted back into the building by a staff person. The CD indicated the incidents were reported together as the same resident was involved and the incidents involved the resident being found outside of the building. The CD indicated the incident from 5/2/15, was reported to the State agency approximately 72 hours after the incident had occurred. On 5/8/15 at 9:15 a.m., the GM provided the policy Unusual Occurrences for Residents - Residential Care dated 1/2015, and indicated the policy was the one currently used by the facility. The policy indicated, "...All reportable incidents which occur against a resident will be reported to ISDH [Indiana State Department of Health] and if applicable to local law enforcement per CMS [Centers for Medicare and Medicaid Services] and ISDH guidelines...7. RESIDENT ELOPEMENT A. A cognitively impaired resident who was found outside the Community and whose whereabouts had been unknown B. Any circumstance of elopement which required police notification...."			

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R 216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. A. Based on interview and record review, the facility failed to assess 3 of 3 residents who were independently ambulatory with a diagnosis of dementia for the risk of elopement (leaving a facility unsupervised or unnoticed). The three residents were found outside of the facility and were unable to return to the facility without assistance. (Resident #59, Resident #60, and Resident #43) B. Based on interview and record review, the facility failed to assess 2 residents who were administering medications for the ability to self administer the medications for 2 of 9 residents reviewed for medication administration. (Resident #34 and	R 216	**It is the common practice of this facility to ensure that allresidents needs are evaluated and assessed for the purpose of safety. (TAG216) A. Resident 59, 60 and 43 B. Resident 34 and 8 1A. Residents affected have had anelopement risk assessment and mini mental evaluation completed and the facilityinitiated changes to the service plan and werereviewed with family. It was determinedan outside care agency provide one on one care while residents remained infacility. Residents continued with oneon one care until all three were discharged to a facility which offered ahigher**	05/28/2015

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	Resident #8) Findings include: A. 1. The clinical record for Resident #59 was reviewed on 05/8/2015 at 09:00 a.m. Diagnoses for Resident #59 included, but were not limited to, mild to moderate dementia. A review of a Mini-Mental State Examination dated 06/17/2014, assessed Resident #59's score as 14 out of 30, indicating moderate dementia (a decline in higher-level brain functions, such as memory, reasoning and personality). A review of the Service Plan for Residential Care dated 12/17/2014, indicated Resident #59 was alert to self only. A review of the Examination for Housebound Status or Permanent Need for Regular Aid and Attendance dated 03/26/2015, indicated "...32. ...Pt [patient] is a high risk for getting lost if he leaves assisted living... 33...would only recommend leaving premises with adult supervision...." A review of the Physician's Face-to-Face Encounter for Patient Receiving Home Care dated 05/07/2015, indicated		**level of care. 1B. Completed the selfmedication administration assessment for each of the residents affected. Ensuredresident's fully capable of administering medications, ensured medication waslabeled appropriately and locked in secured cabinet. Clinical director or designee will ensure allnew M.D. orders are reviewed daily. 2A Licensed nursing staff has completedan elopement risk assessment on all current residents in facility. Assessmentswill be maintained in clinical chart. Ifdetermined a resident is at risk, safety measures will be initiated. Licensed nursingstaff will complete upon admission an elopement risk assessment as well asmental status evaluation with those affected by a disease that impactscognition. Elopement risk assessment as well as a mental status evaluation forthose identified with a diagnosis of mental status alteration will be completedevery six months or upon change of condition along with service planupdate. All residents have the potentialto be affected. 2B All resident's medicalrecords have been audited to identify any residents who may be in need of aself medication**	

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	"...**5.**...Leaving home is dangerous for patient...." During a review of the Fax Incident Reporting Form dated 05/04/2015, the resident was found at a local hardware store 0.6 miles from the facility, and "...appeared lost & [and] had been wandering in store...." The employees at the hardware store contacted IMPD (Indianapolis Metropolitan Police Department). An IMPD officer returned Resident #59 to the facility on 05/04/2015 at 6:20 p.m. During an interview on 05/08/2015 at 4:00 p.m., the Clinical Director (CD) indicated no elopement risk assessment was completed prior to or upon admission for residents. The CD indicated residents were not considered an elopement risk until the resident eloped a second time, and then an elopement risk assessment would be completed. The CD indicated no risk assessment had been completed for Resident #59 as this incident was the first elopement for the resident. The CD indicated the facility did not have a policy regarding completion of an Elopement Risk Assessment. The policy and procedure for "Unusual Occurrences for Residents - Residential		**administration assessment. Those residents affected by thispractice have been identified andreceived assessment to ensure resident safety, MD order obtained if applicable, and service plan has been updated. Self medication administration assessmentwill be maintained in the clinical chart. Self medication administrationassessment will be re-evaluated every six months or upon a change of condition.All residents have the potential to be affected. 3A Policy updated to reflect safetymeasures to be taken upon resident being located. Licensed nursing staff hascompleted an elopement risk assessment on all current residents in facility.Assessments will be maintained in clinical chart. Licensed nursing staff will complete upon newadmissions an elopement risk assessment. Elopement risk assessment will becompleted every six months or upon change of condition along with service planupdate. General manager and clinicaldirector held mandatory staff in-service to ensure all staff understood thedefinition of elopement and the changes to the policy that have been made. Cognitive**	

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	Care" was provided by the Administrator on 05/08/2015 at 9:15 a.m. The policy indicated, "...7. RESIDENT ELOPEMENT A. A cognitively impaired resident who was found outside the Community and whose whereabouts had been unknown B. Any circumstance of elopement which required police notification...." 2. The clinical record for Resident #60 was reviewed on 05/7/2015 at 2:00 p.m. Diagnoses for Resident #60 included, but were not limited to, Alzheimer's dementia. A review of the Service Plan for Residential Care dated 12/17/2014, indicated Resident #60 was alert to self only. A review of a Mini-Mental State Examination dated 06/17/2014, assessed Resident #60's score as 21 out of 30, indicating mild dementia. The policy and procedure for "Unusual Occurrences for Residents - Residential Care" was provided by the Administrator on 05/08/2015 at 9:15 a.m. The policy indicated, "...7. RESIDENT ELOPEMENT A. A cognitively impaired resident who was found outside the Community and whose whereabouts had		**screening will be initiated andmaintained with semi-annual assessments and/or change of conditions for thoseaffected with a memory loss or related diagnosis. 3B Licensed nursesin-serviced that the clinicaldirector must be given a copy of any M.D. order indicating self-medadministration and/or resident may keep medication at bedside. During the newadmission process, resident/family is made aware that no medication of any kindcan be at bedside without proper MD orders and assessment. Self medication assessments will be completed semi-annuallyand/or with a significant change to ensure safety with self administrationmedication. 4A Clinical director or licensed nurse will complete elopement risk assessment upon admission, with every six month service plan update, and with any change in condition when applicable. General manager or designee will audit chart within 72 hours to ensure assessment has been completed and maintained in clinical record. General manager or designee will initial and date theelopement risk assessment upon review to ensure assessment is correct**	

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	been unknown B. Any circumstance of elopement which required police notification...." During a review of the Fax Incident Reporting Form dated 05/04/2015, the resident was found at a local hardware store 0.6 miles from the facility, and "...appeared lost & [and] had been wandering in store...." The employees at the hardware store contacted IMPD (Indianapolis Metropolitan Police Department). An IMPD officer returned Resident #60 to the facility on 05/04/2015 at 6:20 p.m. During an interview on 05/08/2015 at 4:00 p.m., the Clinical Director (CD) indicated no elopement risk assessment was completed prior to or upon admission for residents. The CD indicated residents were not considered an elopement risk until the resident eloped a second time, and then an elopement risk assessment would be completed. The CD indicated no risk assessment had been completed for Resident #60 as this incident was the first elopement for the resident. The CD indicated the facility did not have a policy regarding completion of an Elopement Risk Assessment. 3. The clinical record review for Resident #43, completed on 5/7/15 at		**and inclinical chart. Consultant to complete a CQI audit titled *Elopement Risk Assessment* to be done weekly times fourweeks and monthly times two. 4B Clinical director or designee will audit clinical record of all new admissions to ensure that the medication administration assessment is completed, MD order obtained, and indicated on MAR within 72 hours of admission,with every six month service plan update, and with any change in condition when applicable. Clinical director must be given a copy of any M.D. order indicating self-med administration and/or resident may keepmedication at bedside. Consultant to complete CQI audit titled *Medication Administration Assessment* to be done weekly times four weeks andmonthly times two.**	

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	1:30 p.m., indicated the resident had diagnoses including, but not limited to, Alzheimer's dementia. The resident was readmitted to the facility on 4/2/15, following a hospitalization and rehabilitation stay of 9 weeks. A history and physical dated 3/31/15, indicated the resident had a BIMS (Brief Interview for Mental Status) of 3 out of 15, indicating severe cognitive impairment. A re-admission Resident Data Collection form dated 4/2/15, indicated the resident was independently ambulatory, transferred independently, was alert, disoriented to time and place, and wandered mentally. A 72 hour follow up note dated 4/5/15, for the 2:00 p.m. to 10:00 p.m. shift, indicated the resident had spit out medications, was confused and wandering around the halls, and was not acclimating to the room. A 72 hour follow up note dated 4/7/15, for the 2:00 p.m. to 10:00 p.m. shift, indicated the resident chewed and spit out medications, had attempted to exit the building, and had to be redirected several times.			

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	A nurse's note dated 4/21/15 at 4:00 p.m., indicated the resident was found at another facility and was unable to recall reason for leaving or destination. The resident was escorted back to the facility by a staff member, and was placed on hourly checks. A nurse's note dated 5/1/15 at 11:22 a.m., indicated the resident's responsible party was contacted regarding the resident's cognitive abilities getting progressively worse. The note indicated the resident was not processing verbal directions and required constant re-directing, escorting to and from meals, once returned to the room the resident would come into the hallway looking for someone or something, and needed a higher level of care. A nurse's note dated 5/2/15 at 6:00 p.m., indicated the resident was found by a staff member outside of the building near the smoking area. The smoking area was located across the parking lot and behind another facility. A nurse's note dated 5/5/15 at 12:15 p.m., indicated the resident was found in the back parking lot of the facility "roaming around" and was brought back into the facility by a staff member.			

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	During an interview with Licensed Practical Nurse (LPN) #1 on 5/8/15 at 3:45 p.m., LPN #1 indicated the resident had not been considered an elopement risk as the resident frequently went out the front door to sit on the front porch and was able to find the way back into the building without assistance. LPN #1 indicated on the evening of 5/2/15, the resident went out a side door and was found by another staff member. LPN #1 indicated the resident was placed on every 2 hour checks after the incident as a precautionary measure. During an interview with the General Manager (GM) and the Clinical Director (CD) on 5/8/15 at 4:00 p.m., the CD indicated the management staff had not been made aware of the resident being found outside of the building on 5/2/15, until the morning of 5/4/15, as the nurse on duty at the time of the incident left a note with the information under the door of the CD office. The CD and the GM indicated the resident being found outside of the building on 5/2/15, was not considered as an elopement incident because the resident frequently went outside to sit on the front porch. The GM and the CD indicated an elopement risk assessment was not completed for residents who had eloped from the facility only one time, but would be			

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	completed when a resident had eloped from the facility 2 or more times. The GM and the CD indicated Resident #43 did not have an elopement risk assessment currently in place. B. 1. The clinical record review for Resident #34, completed on 5/11/15 at 9:15 a.m., indicated the resident had diagnoses including, but not limited to, osteoporosis and arthritis. Osteoporosis is a condition in which the bones become weak and brittle. A review of the Evaluation Agreement for Residential Healthcare Services dated 3/17/15, indicated the resident needed coordination of pharmacy services and required assistance with medication administration 1-2 times a day. The recapitulation of physician's orders dated 5/1/15 - 5/31/15, indicated the resident had a current order for alendronate 70 mg (milligrams) 1 tablet every week on Sunday. The original start date for the order was 3/20/14, and the order indicated, "per self on Sunday." During an interview with Licensed Practical Nurse (LPN) #2 on 5/11/15 at 9:45 a.m., LPN #2 indicated the medication was not timed to be administered during the day shift (6:00			

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	a.m. to 2:00 p.m.), and LPN #2 was not sure if the resident self administered the medication. During an interview with the Director of Assisted Living Clinical Services (DALCS) on 5/12/15 at 11:30 a.m., the DALCS indicated the resident self administered the alendronate and a self administration assessment had not completed until 5/11/15. During an interview with Resident #34 on 5/12/15 at 12:55 p.m., the resident indicated the medication was indicated for the treatment of osteoporosis and was taken once a week. Hand written on the label of the medication was "on Wed (Wednesday)." Resident #34 indicated the day of administration was changed due to the resident forgetting to take the medication on the day prescribed and so it was taken the next day and so now it was taken on Wednesdays. On 5/12/15 at 1:50 p.m., the General Manager (GM) provided the policy dated 1/2008, Self Administration of Medications and indicated the policy was the one currently used by the facility. The policy indicated, "...3. The nurse at the Community must also evaluate each resident who self administers his or her medication by completing the 'Self			

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	Administration of Medication Assessment' form...." 2. The clinical record review of Resident #8, completed on 5/7/15 at 3:30 p.m., indicated the resident had diagnoses including, but not limited to, hypertension (high blood pressure) and a recent nose bleed requiring emergency room treatment. A review of the Evaluation Agreement for Residential Healthcare Services dated 4/9/15, indicated the resident needed assistance with medication administration 1-2 times a day. A recapitulation of physician's orders dated 5/1/15 - 5/31/15, indicated the resident had a current order dated 4/23/15, for Saline Nasal Spray to be kept at the bedside. During an interview with the Clinical Director (CD) on 5/8/15 at 9:50 a.m., the CD indicated the nurse practitioner had written the order for the resident to keep the saline nasal spray at the bedside on 4/23/15, and a self administration assessment had not been completed for the resident. On 5/12/15 at 1:50 p.m., the General Manager (GM) provided the policy dated			

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	1/2008, Self Administration of Medications and indicated the policy was the one currently used by the facility. The policy indicated, "...3. The nurse at the Community must also evaluate each resident who self administers his or her medication by completing the 'Self Administration of Medication Assessment' form...."			
R 217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or			

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	both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to administer sliding scale insulin as indicated by the sliding scale dose for 1 of 1 residents reviewed for insulin administration. (Resident #10) Findings include: The clinical record review for Resident #10, completed on 5/12/15 at 9:30 a.m., indicated the resident had diagnoses including, but not limited to, diabetes. A review of the Evaluation Agreement for Residential Healthcare Services dated 3/17/15, indicated the resident needed coordination of pharmacy services and required assistance with medication administration 1-2 times a day. The recapitulation of physician's orders dated 5/1/15 - 5/31/15, indicated the resident had a current order for Humalog (a short acting insulin) 15 units with breakfast, 14 units with lunch, 16 units with supper, with additional doses as needed on a sliding scale with meals. During an observation of medication administration on 5/8/15 at 11:25 a.m.,	R 217	**It is the common practice of this facility to ensure that allnursing staff administer sliding scale insulin as indicated by the slidingscale ordered dose. (TAG 217) 1. The licensed nursing staffimmediately (#2) made contact with the physician and family to ensure that theywere aware of the medication error. Clinical director and general manager provided a disciplinary action to(LPN #2) and reeducated of the importance of validating the order, dose, andfrequency of insulin to be administered. 2. All residents have thepotential to be affected. Licensednursing staff completed insulin audits on all residents with scheduled insulinand sliding scale orders. ClinicalDirector and Director of Assisted Living Clinical Services Reeducatelicensed nursing staff on following physicians orders, slow down, check orderand ensure proper dose is given. Check medication (3) times beforeadministering. 3. Reeducate licensed nursing staff onfollowing physicians orders, slow down, check order and ensure proper dose isgiven. Check medication (3)**	05/28/2015

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	Licensed Practical Nurse (LPN) #2 was observed checking the blood sugar of Resident #10 . LPN #2 indicated the blood sugar was 173. LPN #2 consulted the Medication Administration Record (MAR) and indicated the resident should receive a total dose of 17 units of Humalog. LPN #2 dialed the dosage on the insulin pen and administered the insulin. During a reconciliation of the current physician's order for the dosage prescribed and the dosage administered as documented on the MAR, LPN #2 indicated an incorrect dose of Humalog insulin was administered to the resident. The sliding scale indicated the resident should have received 2 units of insulin for a blood sugar result of 170 - 200 for a total dose of 16 units (14 units scheduled with lunch plus 2 sliding scale units), and the resident received 3 units of insulin for a total dose of 17 units.		**times before administering. Pharmacy to complete overthe next three months at random, observing insulin administration. Pharmacy will provide follow-up report. 4. Clinical director willensure that the Pharmacy completes over the next three months at random, observing insulin administration. Pharmacy will provide follow-up report of compliance. For all scheduled and sliding scale insulin, two licensed nurses will initial proper dose administered on the MAR. The Director of Assisted Living Clinical Services willcomplete a CQI titled *Insulin / Sliding Scale Administration*,monitoring licensed nurses administering insulin/sliding scale to ensure theaccurate dose is being administered. This CQI tool will be monitoring licensed nurses at least 1X weekly, then1X monthly X2 months.**	
R 349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as			

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	follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to accurately document the hourly monitoring services provided by the facility for 2 of 3 residents reviewed for hourly monitoring. (Resident #59 and Resident #60) Findings Include: 1. The clinical record for Resident #59 was reviewed on 05/8/2015 at 09:00 a.m. Diagnoses for Resident #59 included, but were not limited to, mild to moderate dementia. A review of the current Service Plan for Residential Care for Resident #59 dated 12/17/2014, indicated the service plan was not updated to include the hourly nursing safety checks implemented on 05/04/2015. During a review of the Fax Incident Reporting Form dated 05/04/2015, the resident was found at a local hardware store 0.6 miles from the facility, and "...appeared lost & [and] had been wandering in store...." The employees at the hardware store contacted IMPD (Indianapolis Metropolitan Police	R 349	**It is the common practice of this facility to ensure that accurateclinical records are maintained for each resident. (TAG 349) 1. Immediate actions forresidents #59 and #60 include a care plan meeting to discuss the facilitiesrecommendation for a one on one caregiver for safety due to most recentelopements. 72 hour reporting, every 15minute checks were implemented and in place until one on one caregiver assignedto residents #59 and #60. Various labsordered, per physician and placement for a secured memory care unitinitiated. On 5/20/15 residents #59 and#60 discharged and moved to a secured memory care unit. 2. Licensed nursing staffreviewed and completed an at risk elopement assessment for all currentresidents residing within the facility. Any residents that were deemed to be at risk for elopement were reviewedby clinical director and general manager to ensure safety measures were inplace and service plans updated accordingly. Clinical director was re-educatedto the**	05/28/2015

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	Department). An IMPD officer returned Resident #59 to the facility on 05/04/2015 at 6:20 p.m. The Fax Incident Reporting Form indicated, "...**Immediate Action/Interventions**...Residents placed on hourly checks for 24 hours...." A review of the Nursing Safety Checks form for Resident #59 was completed on 05/08/2015 at 10:15 a.m. The Nursing Safety Checks dated 05/04/2015, indicated the checks were completed every 2 hours instead of hourly between the hours of 6:00 a.m. and 2:00 p.m. The Nursing Safety Checks form lacked documentation between 2:00 p.m. and 7:00 p.m. The form indicated safety checks were completed every two hours between 7:00 p.m. on 05/04/2015, and 5:00 a.m. on 05/05/2015. The Nursing Safety Checks form lacked documentation between 5:00 a.m. and 2:30 p.m. on 05/05/2015. During an interview on 05/12/2015 at 12:15 p.m., the Director of Assisted Living Clinical Services indicated the hourly checks should be documented on the Nursing Safety Checks form every hour. The Director of Assisted Living Clinical Services indicated the facility does not have a policy and procedure in place for hourly monitoring of residents.		**requirements for updating service plans if needed with any changes inresident's condition or care. Clinical director was provided copy of serviceplan policy for residents** **3. Policy for elopement (risk and missing resident) updated to include measures to be taken once a resident has been found and safely returned to the facility if elopement has occurred. General Manage and clinical director will review all elopement required documentation, safety measures, and nursing documentation to ensure accuracy within the clinical record. A mandatory in-service with all facility staff was held to review new changes toelopement policy. Clinical director andgeneral manager to ensure the elopement risk assessment is completed with allnew residents and repeated with any service plan update if identified as beingat risk or with any cognitive diagnosis. The general manager and/or designeewill review the clinical record of all new residents to ensure that the at riskelopement assessment has been completed as a base line upon move-in within 72hours. Effective immediately at each at risk meeting held once a month,clinical director and/or**	

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	2. The clinical record for Resident # 60 was reviewed on 05/7/2015 at 2:00 p.m. Diagnoses for Resident #60 included, but were not limited to, Alzheimer's dementia. A review of the current Service Plan for Residential Care for Resident #60 dated 12/17/2014, indicated the service plan was not updated to include the hourly nursing safety checks implemented on 05/04/2015. During a review of the Fax Incident Reporting Form dated 05/04/2015, the resident was found at a local hardware store 0.6 miles from the facility, and "...appeared lost & [and] had been wandering in store...." The employees at the hardware store contacted IMPD (Indianapolis Metropolitan Police Department). An IMPD officer returned Resident #60 to the facility on 05/04/2015 at 6:20 p.m. The Fax Incident Reporting Form indicated, "...**Immediate Action/Interventions**...Residents placed on hourly checks for 24 hours...." A review of the Nursing Safety Checks form for Resident #60 was completed on 05/08/2015 at 10:30 a.m. The form indicated nursing safety checks were		**designee will review all residents potentially at riskfor elopement. Clinical director and or licensed nurse will complete an updated at risk elopement assessment and make the determination if service plan requires an update to ensure all safetymeasures are in place. 4. A CQI tool titled *Elopement Follow Up*will be implemented to ensure that the elopement (risk and missing resident) is being followed and that safety measures are in place, and accurate nursing documentation is within clinical record until resolution is obtained. The Director of AssistedLiving Clinical Services and/or designee will complete this CQI tool X1 weeklythen X1 monthly X2 months.**	

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	completed every 2 hours instead of hourly on 05/04/2015 between 9:00 p.m. and 5:00 a.m. The Nursing Safety Checks form lacked documentation of hourly checks on 05/05/2015 between 5:00 a.m. and 2:30 p.m. During an interview on 05/12/2015 at 12:15 p.m., the Director of Assisted Living Clinical Services indicated the hourly checks should be documented on the Nursing Safety Checks form every hour. The Director of Assisted Living Clinical Services indicated the facility does not have a policy and procedure in place for hourly monitoring of residents.			
R 412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility administered a tuberculin skin test 3 times to a resident with a	R 412	**It is the common practice of this facility to only administer atuberculin skin test upon admission if there is no**	05/28/2015

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	documented history of tuberculosis (TB) and treatment and failed to perform a risk assessment for the development of symptoms suggestive of TB for 1 of 9 residents reviewed for tuberculosis screening. (Resident #34) Findings include: The clinical record review for Resident #34, completed on 5/11/15 at 9:15 a.m., indicated the resident had diagnoses including, but not limited to, pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and heart) and congestive heart failure. An admission chest x-ray dated 12/29/13, indicated, "...IMPRESSION: 1. Extensive chronic changes...Tuberculosis would be a consideration...." A history and physical dated 3/6/14, indicated the resident had TB around 1952 - 1958, and a tuberculin skin test was not applicable for the resident. A hospital admission history and physical dated 4/6/15, indicated the resident had a past medical history of TB in 1957-1958, and had been treated with medications. A review of the Resident Immunization		**indication of a history ofTB or a history of any type of reaction to a previous tuberculin skin test.** **(TAG 412)** 1. Licensed nursing staffimmediately communicated with physician and family to ensure that they wereaware of the error made with administering a tuberculin skin test threetimes. Licensed nursing staff completedthe TB questionnaire and is now maintained within the clinical record. Facility received a clarification order fromphysician for the completion of the annual TB questionnaire. 2. Licensed nursing staffreviewed all residents clinical records to ensure annual tuberculin skin testwere performed appropriately and that TB questionnaires were completed asordered by the physician. If tuberculin skin test is not to be administered,nursing staff in-serviced to obtainan MD order stating do not administer PPD, resident must have yearly TBquestionnaire, MD order must state reason why resident cannot have and it mustshow on MAR. History of TB should beadded to diagnosis list. On the immunization record clinical director or nurseto document do not administer PPD yearly	

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	and Health History Form indicated Resident #34 received a TB skin test on 3/21/14, 4/3/14, and 4/18/15. A risk assessment for TB was not present in the clinical record. The recapitulation of physician's orders dated 5/1/15 - 5/31/15, indicated the resident had a current order for aplisol (a solution injected just under the skin to detect tuberculosis infections) annually in March. The original start date for the order was 7/9/14. During an interview with the Director of Assisted Living Clinical Services (DALCS) on 5/12/15 at 11:30 a.m., the DALCS indicated Resident #34 had a documented history of TB, had been administered a TB skin test on 3 occasions, and a TB risk assessment had not been completed until 5/11/15, after the staff had been made aware of the history of TB.		questionnaire done only. 3. The clinical director wasre-educated to the admission requirements all new and readmissions are assessedto determine physician orders for admission tuberculin skin test, TBquestionnaire, and chest x-ray. Clinicaldirector was provided a copy of the Tuberculosis – Resident Screening policy asit relates to tuberculin skin tests.The general manager and/or designee and clinical director and/or designee willreview the clinical record of all new residents to ensure that thetuberculosis/resident screening has been completed upon move-in. 4. A CQI tool will be implemented toensure that the tuberculin skin test is not administered to any resident thathas a history of TB or is indicated to have been a reactor. The CQI tool will include a review of the MARto ensure that the order is clear. TheCQI will be completed by the Director of Assisted Living Clinical Services forall new move-ins 1X weekly X1 month, then monthly X2 months.	