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 08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE WOODS	2335 N MADISON AVE ANDERSON, IN 46011

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R000000	This visit was for a State Licensure Survey. Survey Dates: August 13 and 14, 2013 Facility Number: 010409 Provider Number: 010409 AIM Number: N/A Survey Team: Tina Smith-Staats, RN-TC Ginger McNamee, RN Karen Lewis, RN Jason Mench, RN (August 13, 2013) Census Bed Type: Residential: 60 Total: 60 Census Payor Type: Medicaid: 33 Other: 27 Total: 60 Sample: 7 These State findings are in accordance with 410 IAC 16.2.	R000000		

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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R000192	410 IAC 16.2-5-1.6(p) Physical Plant Standards - Nonconformance (p) The facility shall have a janitor's closet conveniently located on each resident occupied floor of the facility. The janitor's closet shall contain a sink or floor receptacle and storage for cleaning supplies. The door to the janitor's closet shall be equipped with a lock and shall be locked when hazardous materials are stored in the closet. Based on observation, interview and record review the facility failed to ensure chemicals were maintained safely in a locked maintenance room for 1 of 1 maintenance rooms observed. Findings include: During the initial facility tour on 8/13/13 at 8:37 a.m., the door to the maintenance room was unlocked. Inside the maintenance office the following items were located on open shelves and the floor: Three aerosol cans of "Hot Shot Fogger" spray. The label on the container indicated the substance was highly flammable and harmful if absorbed through the skin. One bottle of "Kaylin Phenolic Disinfectant". The label on the bottle indicated "Inhalation may irritate mouth, nose and throat leading to sleep and stupor. Ingestion: harmful	R000192	What corrective action(s) will be accomplished for these residents found to have been affected by deficient practice- n/a - no residents affected How the facility will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken-n/a no residents identified What measures will be out into place or what systemic changes the facility will make to ensure that the deficient practice does not occur-Maintenance personnel have been instructed to keep the room(s) where chemicals are stored in locked at all times. All chemicals in the maintenance office were removed on August 14th and have been placed in the secured maintenance shed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place-Random checks will be conducted by the administrator five times a week. If there is a negative finding then immediate coaching with the maintenance employee will be	08/14/2013

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	or fatal depending on amount consumed." One can of "Spectracide Wasp and Hornet Killer". The label on the can indicated "Avoid contact with skin and clothing. Avoid breathing vapors." One container of "Gojo Pumice Hand Cleaner". The label on the container indicated "Keep out of reach of small children. Eye contact: may cause eye irritation. Ingestion: may cause upset stomach, nausea. Do not induce vomiting. Contact a physician or Poison Control Center." Two bottles of "Liquid-Plumr". The label on the bottle indicated "Keep out of reach of children. Can cause burns on contact. Harmful if swallowed. Ingestion may cause nausea, vomiting, and burning sensation of the mouth and throat. Exposure to vapor or mist may irritate eyes, nose, throat and lungs." One bottle of clog remover gel. The label on the bottle indicated "DANGER (Corrosive) CAUSES EYE AND SKIN BURNS. If irritation occurs see a doctor immediately. Keep out of reach of children and pets."		conducted. This employee and the Administrator are the only two employees with keys to the secured maintenance shed. The random checks will be done until 100% compliance for 90 consecutive days is met. Findings from the random checks will be reviewed at the quarterly QA meeting.	

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	During an interview with the Administrator on 8/13/13 at 8:37 a.m., she indicated the maintenance room door should be kept locked. On 8/13/13 at 2:30 p.m., Material Data Safety Sheets (MSDS) were requested for the chemicals observed in the maintenance room. On 8/13/13 at 4:40 p.m., the MSDS sheets were provided.			

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R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure sliding scale insulin coverage was given as ordered for 1 of 3 residents reviewed for sliding scale insulin coverage in a sample of 7. (Resident #55) Findings include: The clinical record for Resident #55 was reviewed on 8/13/13 at 10:21 a.m. Diagnoses for the resident included, but were not limited to, back pain, renal insufficiency, and diabetes mellitus. Current physician's orders, signed July 19, 2013, for Resident #55 included, but were not limited to, the following orders: a. Monitor blood sugar results 4 times daily at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The original	R000241	What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #55's diabetic protocol was reviewed by the physician and each licensed nurse from the facility to ensure all professionals were familiar with the sliding scale coverage parameters. The DON compared the diabetic protocol for Resident #55 to the MARS & Diabetic Testing log to ensure accuracy of physician orders on all documents on August 14, 2013. Resident #55 did not display an adverse reaction from the insulin dose errors. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;The remaining residents with diabetic protocols were reviewed by their respective physicians and each licensed nurse from the facility to ensure all professionals were familiar with the parameters ordered by August 14, 2013. The DON compared the diabetic protocols to the MARS & Diabetic	08/26/2013

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	date of this order was 3/23/12. b. If blood sugar is less than 60 mg/dl (milligrams per deciliter), give orange juice and recheck blood sugar in 1 hour. The original date of this order was 1/26/12. c. Humalog sliding scale [insulin coverage] 175 - 199 = 7 units 200 - 224 = 10 units 225 - 249 = 12 units 250 - 274 = 15 units 275 - 350 = 18 units 351 - 400 = 20 units call physician if greater than 400 and symptomatic The original date of this order was 5/23/13. Review of the June and July 2013, "Keystone Woods Diabetic Testing Log" and the June and July 2013, Medication Administration Records (MAR) for Resident #55 indicated the incorrect dose of insulin was documented as having been given on the following dates and times, June 5, 4:00 p.m., the blood sugar result was 246 and 10 units of Humalog was documented as having been given. The resident should		Testing logs to ensure accuracy of physician orders on all documents on August 26, 2013. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;All licensed staff were in-serviced on medication administration and documentation policy, sliding scales, and diabetic protocol policy on August 22, 2013 by Joyce Harris, DON. Audits were performed on August 22 and August 26, 2013 by Becky Vandenhoven, RN. To establish a best practice for checking administration of sliding scale coverage, the licensed nurse will have a 2nd person verify the amount of insulin to be given before each dose is administered. The best practice will be documented on the Diabetic Testing Log by both staff persons. 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; and by what date the systemic changes will be completed.The DON will review the Diabetic Testing Logs daily to ensure the diabetic protocol parameters were followed. The DON will address any errors found with the licensed nurse and provide education as appropriate to prevent further errors. The resident's respective physician will be notified if any error	

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	have received 12 units of Humalog insulin. June 21, 4:00 p.m., the blood sugar result was 200 and no insulin was documented as having been given. The resident should have received 10 units of Humalog insulin. July 12, 4:00 p.m., the blood sugar result was 128 and 7 units of Humalog was documented as having been given. The resident should not have received any Humalog insulin. July 16, 4:00 p.m., the blood sugar result was 172 and 7 units of Humalog was documented as having been given. The resident should not have received any Humalog insulin. During an interview with the Director of Nursing and the Administrator on 8/14/13 at 9:20 a.m., additional information was requested related to the incorrect amount of sliding scale insulin coverage having been given. During an interview the Administrator on 8/14/13 at 1:07 p.m., she indicated she had no additional information to provide regarding the sliding scale insulin coverage for Resident #55.		occurs. The diabetic protocol will be updated yearly or as needed, when a change in the orders is received. The charge nurse will notify the DON of a change in the diabetic protocol and the DON will send the revised Diabetic Protocol to the physician for signature and ensure each licensed nurse has reviewed the revised Diabetic Protocol. The DON will compare the revised Diabetic Protocol with MARS & Diabetic Testing Log to ensure accuracy. The DON will review the findings from the daily audits at the quarterly QA meeting.Completion of diabetic protocols reviewed date – August 26, 2013	

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R000349	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 follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurate in regards to blood glucose monitoring for 2 of 7 resident reviewed for complete and accurate clinical records in a sample of 7. (Resident #'s 55 and 54) Findings include: 1.) The clinical record for Resident #55 was reviewed on 8/13/13 at 10:21 a.m. Diagnoses for the resident included, but were not limited to, back pain, renal insufficiency, and diabetes mellitus. Current physician's orders, signed July 19, 2013, for Resident #55 included, but were not limited to, the following orders:	R000349	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The residents did not display an adverse reaction from the lack of documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;The DON reviewed all of the remaining residents with accucheck orders for missing accucheck results. The DON will determine if the accucheck result was due to the resident being LOA or not. There were no adverse reactions noted for any of the remaining residents. What measures will be put into place or what systemic changes teh facility will make to ensure that the deficient practice does not recur;The DON, or designee will review the Diabetic Testing Log daily to ensure the accuchecks are documented accordingly. The DON will investigate any missing accucheck result and	08/21/2013

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	a. Monitor blood sugar results 4 times daily at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The original date of this order was 3/23/12. b. If blood sugar is less than 60 mg/dl (milligrams per deciliter), give orange juice and recheck blood sugar in 1 hour. The original date of this order was 1/26/12. c. Humalog sliding scale [insulin coverage] 175 - 199 = 7 units 200 - 224 = 10 units 225 - 249 = 12 units 250 - 274 = 15 units 275 - 350 = 18 units 351 - 400 = 20 units call physician if greater than 400 and symptomatic The original date of this order was 5/23/13. Review of the June and July 2013, "Keystone Woods Diabetic Testing Log" and the June and July 2013 Medication Administration Records (MAR) for Resident #55 lacked a blood sugar result having been completed on the following dates and times: June 14, 4:00 p.m., no blood sugar		document findings. The DON will provide education with the licensed nurse responsible for the missing accucheck result. All staff were informed of reminding residents and family members to sign the LOA book when leaving the building to ensure the staff are aware when a resident is LOA. The licensed staff were in-serviced on the protocol for documenting a refusal and/or LOA unable to administer of a medications and/or treatment on August 21, 2013 by Joyce Harris, DON. 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, and by what date the systemic changes will be completed.The DON will review the findings of the Diabetic Testing Log audits at the quarterly QA meeting.Completion date- August 21, 2013	

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	result documented. June 14, 8:00 p.m., no blood sugar result documented. July 13, 8:00 p.m., no blood sugar result documented. July 22, 8:00 p.m., no blood sugar result documented. July 31, 8:00 p.m., no blood sugar result documented. During an interview with the Director of Nursing and the Administrator, on 8/14/13 at 9:20 a.m., additional information was requested related to the missing blood sugar results. During an interview with the Director of Nursing and the Administrator in 8/14/13 at 12:17 p.m., the Director of Nursing indicated the blood sugar results are to be documented on the "Keystone Woods Diabetic Testing Log". 2.) The clinical record for Resident #54 was reviewed on 8/13/13 at 10:44 a.m. Diagnoses for the resident included, but not limited to, hypertension, type II diabetes, constipation, coronary artery disease, esophageal reflux and hyperlipidemia. Current physician's orders, signed January 3, 2013, for Resident #54			

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	included, but were not limited to, the following orders: a. Glucometer checks to be done three times daily at 6:00 a.m., 2:30 p.m. and 7:30 p.m. The original date of this order was dated 1/24/12. b. If blood sugar is less than 60 mg/dl (milligrams per deciliter) or greater than 400 mg/dl, call the medical doctor. The original date of this order was dated 4/14/12. Review of the June and July 2013, "Keystone Woods Diabetic Testing Log" and the June and July 2013, Medication Administration Records (MAR) for Resident #54 lacked a blood sugar result having been completed on the following dates and times: June 14, 2013 at 2:30 p.m., no blood sugar documented. July 3, 2013 at 9:00 p.m., no blood sugar result documented. July 11, 2013 at 2:30 p.m., no blood sugar documented. During an interview with the Director of Nursing and the Administrator on 8/14/13 at 9:20 a.m., additional information was requested related to the missing blood sugar results.			

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	During an interview with the Director of Nursing and the Administrator on 8/14/13 at 12:17 p.m., the Director of Nursing indicated the blood sugar results are to be documented on the "Keystone Woods Diabetic Testing Log". During an interview with the Administrator on 8/14/13 at 1:07 p.m., the Administrator indicated she had no further information to provide regarding the missing glucometer results.			