

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155813	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/09/2014
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NAME OF PROVIDER OR SUPPLIER  VILLAGES AT HISTORIC SILVERCREST THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1809 OLD VINCENNES ROAD NEW ALBANY, IN 47150
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: December 1, 2, 3, 4, 5, &amp;, 9, 2014</p> <p>Facility Number: 012619 Provider Number: 155813 AIM Number: 201238590</p> <p>Survey Team Gwen Pumphrey, RN -TC Gloria Reisert, MSW Trudy Lytle, RN Jenny Sartell, RN</p> <p>Census Bed Type SNF: 46 SNF/NF: 1 Residential: 25 Total: 72</p> <p>Census Payor Type Medicare: 34 Private: 38 Total: 72</p> <p>Residential Sample: 9</p> <p>Supplemental sample: 14</p> <p>This deficiency reflects state findings</p>	F000000		

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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F000514 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 12, 2014 by Randy Fry RN.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review the facility failed to ensure pre and post assessments for residents receiving dialysis services were accurately documented. This deficient practice had the potential to affect 1 of 1 residents reviewed for dialysis (Resident #128).</p> <p>Findings include:</p> <p>On 12/1/14 at 11:15 a.m., the administrator indicated Resident #128 received dialysis services outside of the</p>	F000514	<p>1. An order was obtained for pre and post assessments and were initiated for Resident #128 and documented on the MAR. 2. There are no other residents receiving dialysis at the time of survey or currently. 3. The Guideline for Dialysis was updated to reflect the need for pre and post assessment for residents receiving dialysis services to include obtaining an order and noting the assessment on the MAR. All nurses will be in-serviced by the Director of Health Services regarding this addendum to the guideline.</p>	01/08/2015

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	<p>facility.</p> <p>On 12/03/14 at 9:30 a.m. Resident #128's clinical record was reviewed. The resident had diagnoses including but not limited to stroke, heart failure, high blood pressure and end stage renal disease.</p> <p>A physician order dated 10/01/14 indicated, "Monitor R[right] tunnel cath [catheter] every shift for s/s [signs and symptoms] of infection".</p> <p>A physician order dated 10/2/14 indicated, "Have resident ready for [named transportation company] p/u [pick up] tues [Tuesday], thurs [Thursday], Sat [Saturday] dialysis days at [named dialysis center]</p> <p>The Treatment Administration Record was reviewed for October 2014, November 2014, and December 2014. The record had documentation of the right tunnel catheter monitored daily. There was no documentation of the pre or post assessments on the Tuesday, Thursday, or Saturdays when the resident received dialysis treatment.</p> <p>LPN #1 was interviewed on 12/03/14 at 9:45 a.m. She indicated Resident #128 had not missed any dialysis treatments. She indicated the resident is assessed</p>		<p>4. Monitoring of this change will take place through the Daily CQI process. All residents receiving dialysis will be monitored to ensure they have orders for pre and post assessment and noted on the MAR. The MAR will be checked when other MARs are checked (through Daily CQi) to confirm orders are transcribed correctly. This will occur a minimum of daily for one month, 3 times per week for one month then weekly for one month. Results of these audits will be reviewed by the QA Committee. If 100% compliance isn't reached, then then the weekly audits will continue until 3 months of 100% compliance is attained.</p>	

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	<p>before treatment including vital signs and the documentation is sent to the dialysis center. She indicated when the resident returns from dialysis the center does not return the documentation and instead sends documentation of the dialysis treatment. She indicated the resident is assessed after returning to the facility the nurse assesses the resident and monitors for complications. LPN #1 indicated the resident did not have any complications related to the dialysis treatments. LPN #1 was not able to provide any documentation of the residents assessments on dialysis days.</p> <p>Resident #128 was interviewed on 12/03/14 9:55 a.m. The resident indicated she had been receiving dialysis treatments for about 6 months. She indicated on dialysis days she has diarrhea, cramps and often feels tired.</p> <p>The Director of Nursing (DON) was interviewed on 12/03/14 at 10:28 a.m. She indicated, "We document once a day. If we notice there are problems we would notify the physician and dialysis center; We look at the paperwork they [the dialysis center] sends back. We will also chart vitals on the medicare charting. These vitals are usually in the morning. What we send to the dialysis center is over and above what is required from our</p>			

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R000000	<p>policy so they [the dialysis center] will have an idea of what the resident was like before we send them. On the TAR [Treatment Administration Record] we are assessing the shunt each shift. When I looked to the policy it did not say that the resident needed to be assessed with vitals before and after-its really vague and doesn't speak to vital signs."</p> <p>The DON then provided a copy of the communication form to the dialysis center dated 12/2/14.</p> <p>The policy titled "Guidelines for Monitoring Shunt was provided by the DON on 12/03/14 at 10:27 a.m. This policy indicated..., "Document assessment finding in resident medical record nursing notes and or in a designated area on treatment administration record." The policy did not indicate proper monitoring for a resident receiving dialysis with a tunneled catheter.</p> <p>3.1-50(a)1 3.1-50(a)2</p>			

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R000356	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to keep a complete emergency information file on 3 of 9 residents in a sample of 9, and 14 of 14 residents in a supplemental sample of 14. (Residents 3,6,7,8-21)</p> <p>Findings include:  A review of the emergency information</p>	R000000		
		R000356	<p>1. Residents 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21 face sheets have been reviewed and all missing information has been obtained and the forms updated. These face sheets have been placed in the emergency binder. 2. All other resident face sheets in the emergency binder were reviewed and updated as needed. 3. Nursing administration,</p>	01/08/2015

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	<p>files, presented on 12/05/14, at 1:22 p.m., by the Administrator, indicated the following residents with incomplete emergency files:</p> <ul style="list-style-type: none"> <li>-Resident #3: Admitted on 11/29/14. Hospital preference, allergies, and physician not listed.</li> <li>-Resident #6: Admitted on 9/24/14. Hospital preference and allergies not listed.</li> <li>-For Resident #7: Admitted on 09/03/14. Hospital preference and allergies not listed.</li> <li>-Resident #8: Admitted on 9/10/14. Hospital preference and allergies not listed.</li> <li>-Resident #9: Admitted on 6/06/14. Hospital preference and allergies not listed.</li> <li>-Resident #10: Admitted on 10/01/14. Hospital preference, and allergies not listed.</li> <li>-Resident #11: Admitted on 06/10/14. Hospital preference and allergies not listed.</li> <li>-Resident #12: Admitted on 05/14/14. Hospital preference and allergies not listed.</li> <li>-Resident #13: Admitted on 06/26/14. Hospital preference and allergies not listed.</li> <li>-Resident #14: Admitted on 05/13/14. Hospital preference and allergies not</li> </ul>		<p>Admissions, and Business Office staff have been in-serviced by the Executive Director to ensure they obtain all required information on admission on the face sheet according to facility policy and state regulation. The Medical Records Coordinator will check the face sheet for completion before placing in the emergency binder. This double-check has been added to the Admission Checklist. 4. Every new admission will be audited by the Medical Records Coordinator to ensure all data that is required by regulation and policy is present in the emergency binder for the next 3 months. Results will be reviewed monthly by the QA Committee. If 100% compliance isn't obtained for 3 consecutive months, then audits will continue until 3 months of compliance is attained at 100%.</p>				

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	<p>listed.</p> <p>-Resident #15: Admitted on 06/28/14. Hospital preference and allergies not listed.</p> <p>-Resident #16: Admitted on 09/06/14. Hospital preference and allergies not listed.</p> <p>-Resident #17: Admitted on 09/15/14. Hospital preference and allergies not listed.</p> <p>-Resident #18: Admitted on 4/12/14. Hospital preference and allergies not listed.</p> <p>-Resident #19: Admitted on 11/12/14. Hospital preference and allergies not listed.</p> <p>-Resident #20: Admitted on 10/01/14. Hospital preference and allergies not listed.</p> <p>-Resident #21: Admitted on 11/29/14. Hospital preference and allergies not listed.</p> <p>During an interview on 12/09/14 at 8:35 a.m., the administrator indicated the medical records clerk was responsible for ensuring the emergency files were up to date.</p> <p>On 12/09/14 at 8:45 a.m., the Medical Records Clerk indicated the emergency files are completed during the admission process to the facility. She indicated if the residents don't have a hospital</p>			

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	<p>preference the file should reflect the hospital closest to the facility. She also indicated any other updates would be addressed by the nursing staff during care plan meetings.</p> <p>A copy of a policy updated December 2010 titled, "Assisted Living Guidelines Emergency Information File" was provided by the Medical Records Clerk on 12/9/14 at 9:25 a.m. The policy indicated,..."2. The file shall contain the following information: b. The resident's hospital preference... d. The name and phone number of the resident's physician of record...f. Listing of any known allergies..."</p>				