

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2015
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NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00175219.</p> <p>Complaint IN 00175219 Substantiated. State deficiencies related to the allegations are cited at R0058, R0217, and R0349.</p> <p>Survey dates: July 15, and 16, 2015</p> <p>Facility number: 011804 Provider number: 011804</p> <p>Census bed type: Residential: 107 Total: 107</p> <p>Census payor type: Other: 107 Total: 107</p> <p>Sample: 4</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
R 0058 Bldg. 00	<p>410 IAC 16.2-5-1.2(bb)(1-9) Residents' Rights - Deficiency (bb) Residents have the right and the facility must provide immediate access to any resident by:</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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	<p>(1) individuals representing state or federal agencies;</p> <p>(2) any authorized representative of the state;</p> <p>(3) the resident ' s individual physician;</p> <p>(4) the state and area long term care ombudsman;</p> <p>(5) the agency responsible for the protection and advocacy system for developmentally disabled individuals;</p> <p>(6) the agency responsible for the protection and advocacy system for mentally ill individuals;</p> <p>(7) immediate family or other relatives of the resident, subject to the resident ' s right to deny or withdraw consent at any time;</p> <p>(8) the resident ' s legal representative or spiritual advisor subject to the resident ' s right to deny or withdraw consent at any time; and</p> <p>(9) others who are visiting with the consent of the resident subject to reasonable restrictions and the resident ' s right to deny or withdraw consent at any time.</p> <p>Based on interview and record review, the facility failed to allow family visitation for 1 of 3 residents reviewed for family visitation in a sample of 4. (Resident #U)</p> <p>Findings include:</p> <p>Resident #U's record was reviewed 7-16-2015 at 9:21 AM. Resident #U's diagnoses included, but were not limited to, Parkinson's disease, dementia, and diabetes.</p> <p>In an interview on 7-16-2015, Resident</p>	R 0058	<p>R 058 Residents' Rights – visitation 1. Thefacility respectfully disagrees with this citation as we did not prevent theresident U from having visitors. Weprovided structured space for visiting, but we did not stop visitors fromseeing resident U. The brother has visited resident U on at least twodocumented occasions.</p> <p>2. All residents have the potential to beaffected by this alleged deficient practice. It is the intent of this facility to ensure that resident visitors haveimmediate access to the resident. .</p> <p>3. Theadministrator and designee</p>	08/14/2015

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	<p>#U had difficulty finding words, but could say he liked his dog, and was able to care for the dog. Resident #U further indicated he would like to visit with his brother, but his niece refused to allow him to visit because she was the POA (Power of Attorney).</p> <p>In a confidential interview on 7-16-2015 at 9:37AM, Employee #1 indicated the POA had indicated certain family members could not visit the resident. Employee #1 further indicated if the POA stated a certain family member could not visit, then the facility was not allowed to let them visit. Employee #1 indicated Resident #U's brother was not allowed to visit without supervision, but she did not know why.</p> <p>A review of Resident #U's record indicated an undated, handwritten note on the inside front cover of the chart. The note indicated the POA was to be notified if any of certain family members asked for contact with Resident #U.</p> <p>In an interview on 7-16-2015 at 9:41 AM, the Administrator indicated the nurses made psychosocial decisions and interventions for the residents because there was no requirement for a Social Services person in Assisted Living.</p>		<p>in-serviced all staff on the guidelines pertaining to the facility's 24 hour visitor rules and resident rights. We emphasized that staff may never restrict someone from visiting a resident, if the resident consents, and this is not a court order or Guardian request to prohibit or limit such visitation. The administrator will also review at next resident council meeting. Copy of facility visitor policy is included with this response. 4. The administrator and/or designee will randomly check with residents & staff, asking them if residents are allowed to have visitors and if they have experienced any problems. Review will be conducted weekly x 3 months, and monthly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. We request an IDR of the citation issued to us under R 058. We contest the citation. We did not at any time prevent the resident U from having visitors including his brother. We believe we were and are honoring the rights of this resident. Our review is as follows: 1. Resident U, upon interview, stated his niece (who is the POA) refused to allow him to visit his brother. She represented to him that this was supported by the facility. He stated that he was never prohibited from visiting his</p>				

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	<p>A review of the POA papers for Resident #U, undated, indicated "Part 1: lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions." The form did not indicate Resident #U had become incapable of making his own decisions, nor did it indicate Resident #U had requested the POA make the decision of who could visit him in the facility.</p> <p>This State Tag relates to Complaint IN00175219.</p>		<p>brother. In face, resident U informed us that his brother hadvisited him a couple of times. 2. Areview of our visitor log showed that the brother signed in on two separate occasionsand reported to us that he was able to see his brother. He visited out the unit in the lobby. This has been verifiedwith family members that have been to visit Resident #U, see attached statement 3. Employee#1, upon interview and review of what was attributed to this employee in 2567report, the employee stated to us that she said the POA had indicated to Herthat certain family members could not visit the resident. No one in facilitymanagement told her that the resident could not be visited by his brother. See attached statement. 4. Employee#1 said visitors were allowed to visit resident #U and at no time was she toldby a facility manager not to allow resident U to have visitors. 5. Employee#1 recalls the brother visiting resident #U. 6. Recordreview found an undated, handwritten note indicating the POA was to be notifiedif any of certain family members asked for contact with Resident #U. This notedid NOT indicate that these individuals were not allowed to visit residentU. The facility honored the POA'srequest to limit information given related to confidentiality of residentinformation., but did not</p>				

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R 0217 Bldg. 00	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(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:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure the resident or responsible party signed the service plan</p>	R 0217	<p>restrict visitation. We do not believe we violated the rights of Resident U to have visitors. We respectfully ask for reconsideration and removal of citation tag R 058.</p> <p>R 217 Evaluation – signed service plans 1. Resident's U, V and W were</p>	08/14/2015

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	<p>when updated for 3 of 4 residents reviewed for service plan signatures in a sample of 4. (Resident #U, Resident #V, and Resident #W)</p> <p>Findings include:</p> <p>1. Resident #U's record was reviewed 7-16-2015 at 9:21 AM. Resident #U's diagnoses included, but were not limited to, Parkinson's disease, dementia, and diabetes.</p> <p>A review of Resident #U's service plan, dated 5-19-2015, indicated the plan had been signed by the Wellness Director, but did not have the signature of the Responsible party on the document.</p> <p>In an interview on 7-16-2015 at 10:10 AM, the Wellness Director indicated none of the Service Plans were signed by the responsible party's or the resident.</p> <p>2. Resident #V's record was reviewed 7-16-2015 at 10:10 AM. Resident #V's diagnoses included, but were not limited to, dementia, lung cancer, and osteoporosis.</p> <p>A review of Resident #V's service plan, dated 6-2-2015, indicated the plan had been signed by the Wellness Director, but did not have the signature of the</p>		<p>contacted by nursing staff and all now have signed servicesplans in their medical record.</p> <p>2. All residents have the potential to beaffected by this alleged deficient practice. The Wellness Directors audited each current medical record to ensurethat the resident's service plan is signed. Any unsigned services plans have been removed from the resident'smedical record and signature is being obtained.</p> <p>3. Resident/representativesignat ures will be obtained for all initial service plans and any subsequentevaluations indicating a need for a change in services, in accordance withstate guidelines. For residents/familiesthat choose to attend a care plan meeting the service plan will be signed atthat time. For those who can't attend,the service plan will be reviewed by telephone or email and then mailed to themfor signature. A copy of the serviceplan will remain in the medical record chart noting the telephone consent until a signed copy is received back to the facility. Copy will be replaced with signed service plan when received. Facility will allow two weeks for signaturereturn, then re-send request again. The regionaloperations manager has in-serviced the administrator, wellness directors andbusiness office manager on this process.</p>	

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R 0349 Bldg. 00	<p>Responsible party on the document.</p> <p>3. Resident #W's record was reviewed 7-16-2015 at 10:44 AM. Resident #W's diagnoses included, but were not limited to, depression, dementia, and high blood pressure.</p> <p>A review of Resident #W's service plan, dated 2-10-2015, indicated the plan had been signed by the Wellness Director, but did not have the signature of the Responsible party on the document.</p> <p>This State Tag is related to Complaint IN00175219.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure Medical records were complete for 2 of 3 residents reviewed for Medical record completion in a sample of 4. (Resident #U, and Resident #V)</p>	R 0349	<p>4. WellnessDirector/designee will audit 10% of the medical records for residents' receiving services to ensure appropriate service plan signatures have beenobtained. Audit will be conducted twotimes a week x 2 weeks, weekly x 4 weeks, and monthly thereafter. Results of these audits will be reviewed bythe QA Committee, who will establish the threshold of compliance and makefurther recommendations accordingly.</p> <p>R 349 Clinical Records 1. Noadverse effects were identified or noted due to this alleged deficientpractice. Residents #U's record wasreviewed and a new updated Short Portable Mental Status</p>	08/14/2015

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	<p>Findings include:</p> <p>1. Resident #U's record was reviewed 7-16-2015 at 9:21 AM. Resident #U's diagnoses included, but were not limited to, Parkinson's disease, dementia, and diabetes.</p> <p>A review of Resident #U's Short Portable Mental Status Questionnaire, dated 5-20-2015, indicated there were 5-7 errors on the form. This indicated Resident #U had moderate Cognitive Impairment. The column with responses to the questions was completed, but the column with incorrect responses was blank. There was no way to validate if the response column entries were correct or incorrect, thereby potentially affecting the cognitive level score.</p> <p>2. Resident #V's record was reviewed 7-16-2015 at 10:10 AM. Resident #V's diagnoses included, but were not limited to, dementia, lung cancer, and osteoporosis.</p> <p>A review of Resident #V's service plan, dated 6-2-2015, indicated Resident #V's "judgement and memory are not always good. Requires Keepsake Village." There was no documentation in the medical record to indicate the results for this</p>		<p>Questionnaire completed.</p> <p>Resident V's clinical record was reviewed and a new assessment completed.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. Wellness Directors/designee will audit resident clinical records to ensure that the medical record is complete. Any concerns will be resolved promptly.</p> <p>3. The regional Director of Clinical Service conducted a series of in-services for licensed nurses on resident assessments, including ensuring that all documentation is completed in full and based in part upon observation and interview with the resident. Their service included a review of the facility's generally used nursing forms.</p> <p>4. The Wellness Director/designee will audit 10% of the current residents' medical records to ensure assessments are completed correctly. Any concerns will be resolved promptly. Audit will be conducted two times a week x 2 weeks, weekly x 4 weeks, and monthly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

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	<p>assessment were based on observation or interview of the resident.</p> <p>In an interview on 7-16-2015 at 10:34 AM, the Wellness Director indicated memory and judgement observations were documented on Admission only, then observations were completed to validate the assessment. The Wellness Director further indicated she did not document her observations in the medical record.</p> <p>This State Tag is related to Complaint IN00175219.</p>				