

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 07/24/2015
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NAME OF PROVIDER OR SUPPLIER SANDERS GLEN	STREET ADDRESS, CITY, STATE, ZIP CODE 334 S CHERRY ST WESTFIELD, IN 46074
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 23 and 24, 2015</p> <p>Facility number: 005657 Provider number: 005657 AIM number: N/A</p> <p>Residential Census: 102</p> <p>Sample: 7</p> <p>These state findings were cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>This plan of correction constitutes Sanders Glen's written allegation of compliance for the deficiencies cited in the annual survey conducted July 23 through July 24, 2015. Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet state and federal requirements. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements.</p>	
R 0118 Bldg. 00	<p>410 IAC 16.2-5-1.4(c) Personnel - Deficiency</p> <p>(c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.</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>Based on interview and record review, the facility failed to ensure a certified nursing assistant (CNA) had a current certification for 1 of 10 nursing assistants certifications reviewed for recertification. (CNA #1)</p> <p>Findings include:</p> <p>On 7/24/15 at 10 a.m., the review of the employee records was completed. The review of the records indicated CNA #1's "Indiana Online Licensing" information indicated her "Certified Nurse Aide" certification had expired on 7/2/2015.</p> <p>During an interview on 7/24/15 at 12 p.m., the Administrator indicated CNA #1's Nurse Aide certification was expired and she had CNA #1 renew it that day. At that time, she provided an "Indiana Online Licensing" Renewal Receipt dated 7/24/15. She indicated at that time CNA #1 had been on the schedule working providing care for the residents.</p> <p>The current schedule provided by the Administrator on 7/24/15 at 12:10 p.m., indicated the following days were the days CNA #1 worked: 7/4/15--D/F 7/5/15--D 7/6/15--D/F 7/8/15 through 7/10/15--D/F</p>	R 0118	<p>R 0118 Personnel This facility employ's appropriately trained and licensed personnel.</p> <p><u>Corrective action for identified resident(S)</u>: No specific resident has been identified. Immediately, upon identification, identified nurse's aide renewed her license with the Indiana Professional Licensing Agency. <u>Identification and corrective action for other residents with the potential to be affected</u>: All residents have the potential to be affected. All licensed/certified personnel records were reviewed for current active licensure/certification, as determined by the Indiana Professional Licensing Agency. All licensed/certified personnel were determined to have active license/certification status with the IPLA <u>Measures to prevent recurrence</u>: Administrator or designee will review expiration dates of the licenses/certifications of personnel on a monthly basis. A notice will be provided to personnel whose license/certification will be up for renewal, at least 30 days in advance. <u>How will the facility monitor and who is responsible</u>: Administrator or Designee will monitor personnel license/certification status. Any licensed/certified personnel provided a thirty (30) day reminder to renew, will have license/certification monitored weekly until renewed. Failure to renew license/certification prior to</p>	07/24/2015			

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R 0214 Bldg. 00	<p>7/13/15--D/F 7/15/15 and 7/16/15--D/F 7/18/15--D/F 7/19/15--D 7/20/15--D/F 7/23/15 and 7/24/15--D/F</p> <p>During an interview on 7/24/15 at 12:43 p.m., the Administrator indicated a D indicated the 7-3 p.m., shift and the F indicated a float shift, so CNA #1 stayed on that shift until she got her residents she was assigned up and dressed, then she went home. She was at the facility until approximately 10-10:30 a.m., on the days she was scheduled as a float.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to evaluate the individual needs of residents related to significant changes in conditions for 1 of 5 residents reviewed for evaluation of needs assessment. (Residents #110)</p> <p>Findings include:</p>	R 0214	<p>expiration date will result in immediate removal from work schedule. Results will be reported on a monthly basis through the facility Quality Assurance process.</p> <p>R214 Evaluation This facility evaluates residents prior to admission, at least semi-annually and upon a known substantial change. <u>Corrective action for identified resident(S):</u> Immediately, identified resident was re-assessed to determine resident's needs could be met at the facility. Identified needs and services remained consistent with</p>	08/10/2015			

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	<p>Resident #110's record was reviewed on 7/23/15 at 12:43 p.m. Diagnoses included, but were not limited to Chronic Obstructive Pulmonary Disease (COPD) exacerbation, diabetes, hypoxic respiratory failure, end stage (COPD), and right upper lobe pneumonia.</p> <p>A "Nurse's Note" dated 7/2/15 at 1:30 p.m., indicated the resident was admitted to the hospital with a new diagnosis of End Stage COPD.</p> <p>A "Nurse's Note" dated 7/4/15 at 7:30 p.m., indicated the resident returned to her apartment at the facility from the hospital.</p> <p>The resident's current "Level of Service Assessment/Evaluation" was dated 2/5/15. The resident's "Level of Service Assessment/Evaluation" lacked updated information for a substantial change in condition based on her last hospitalization or for her self administration of medication of her nebulizer treatments. The assessment dated 2/5/15, indicated the resident continued to receive nebulizer treatments from the staff, while she administered the nebulizer treatments to herself.</p> <p>During an interview on 7/23/15 at 2:38 p.m., LPN #2 indicated the resident was</p>		<p>needs and services prior to hospitalization. An admission health assessment was completed on identified resident on 7/4/2015. (Document A) <u>Identification and corrective action for other residents with the potential to be affected:</u> All residents have the potential to be affected. All resident charts were reviewed to ensure all residents re-assessments were completed in accordance with Indiana State Department of Health residential care regulations. No other residents were identified.</p> <p><u>Measures to prevent recurrence:</u> Director of Nursing or Designees will monitor 24 Hour reports for identification of residents with a significant change in condition. All identified residents will be re-assessed and have service plans updated to ensure resident's needs are met. In addition, Director of Nursing or Designee will maintain a master schedule identifying when each resident's semi-annual assessment is due, allowing for updating based on re-assessments due to a significant change in condition.</p> <p><u>How will the facility monitor and who is responsible:</u> Director of Nursing or Designee will monitor assessment master schedule every two weeks for 6 weeks, then monthly, following up by reviewing charts of residents who trigger for a re-assessment to assure assessment and service</p>	

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	<p>self administering her nebulizer treatments.</p> <p>During an interview on 7/24/15 at 11 a.m., LPN #2 indicated the resident's evaluation was not updated for a substantial change in condition or for self medication administration.</p> <p>During an interview on 7/24/15 at 12 p.m., LPN #2 indicated she completed the evaluation assessments semi-annually, for a change in condition, if the resident went to rehabilitation or the hospital, but she usually waited two weeks for the CNA's to check for changes in the resident's status and she just got back after a week off and was still catching up on things, so it was not completed yet.</p> <p>A current policy titled "Resident Assessment" provided by the Administrator on 7/23/15 at 11 a.m., indicated "Policy: Assessments will be performed by the Director of Nursing and/or licensed nurse designee. Data obtained during assessment is used to determine that resident's needs for care, treatment and or develop a plan of care. Assessment is also used to determine resident's needs can be met by this Residential Care facility. Resident Assessments will be completed</p>		<p>plan are completed in accordance with Indiana State Department of Health residential care regulations.</p>	

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R 0216 Bldg. 00	<p>semi-annually thereafter or upon an identified significant change. Suggested Guidelines: ... When the resident's condition changes significantly, When the resident's diagnosis changes ... Procedure: ... The assessment is updated and revised, as frequently as the resident's condition warrants due to a major decline or improvement in the resident's health status and/or every six months...."</p> <p>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. Based on interview and record, the facility failed to ensure all self medication administration assessments were up to date for 1 of 2 self administration assessments reviewed. (Resident # 110)</p>	R 0216	<p><u>R216 Evaluation</u></p> <p>This facility evaluates residents prior to admission, at least semi-annually and upon a known substantial change.</p>	08/10/2015

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	<p>Findings include:</p> <p>Resident #110's record was reviewed on 7/23/15 at 12:43 p.m. Diagnoses included, but were not limited to Chronic Obstructive Pulmonary Disease (COPD) exacerbation, diabetes, hypoxic respiratory failure, end stage (COPD), and right upper lobe pneumonia.</p> <p>Resident #110's "Medication Self-Administration Evaluation" was dated 2/27/14.</p> <p>The resident had a Physician Order Recapitulation dated July 2015, which included, but was not limited to the following orders: 7/5/15--Resident may self administer nebulizer treatments.</p> <p>During an interview on 7/23/15 at 2:38 p.m., LPN #2 indicated Resident #110 was administering her nebulizer treatments herself. She indicated at that time there was no updated "Medication Self-Administration Evaluation" for this resident.</p> <p>During an interview on 7/23/15 at 4:24 p.m., the Administrator indicated Resident #110 would not have needed an updated "Medication Self-Administration</p>		<p><u>Corrective action for identified resident(S):</u></p> <p>Identified resident was immediately re-evaluated to determine appropriateness of medication self-administration. Resident was found to remain competent to administer her nebulizer treatments. Appropriate documentation has been reviewed by Director of Nursing and Administrator and is in place.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>All records of residents identified to self-administer medication were reviewed to ensure a current Medication Self-Administration Evaluation was in place upon admission, semi-annually or upon a known significant change in condition. One (1) other resident was identified and a Medication Self-Administration Evaluation was completed and is in place.</p> <p>-</p> <p><u>Measures to prevent recurrence:</u></p> <p>Self-administering medication reviews will be conducted simultaneously with Level of Service Assessment upon admission, semi-annually or upon a known</p>	

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	<p>Evaluation" according to the facility's policy because it indicated "A Medication Self-Administration Evaluation shall be completed for each resident or designee prior to admission, and will be repeated as deemed necessary, or upon request by the resident."</p> <p>A current policy titled "Medication Self Administration Evaluation" by the Administrator on 7/23/15 at 4:24 p.m., indicated "Policy: The resident's desire to self-administer medications will be determined during the admission process and will be repeated as deemed necessary, or upon request by the resident. If the resident desires to self-administer medications, the resident's ability to self-administer medications shall be determined through an evaluation by Facility's Director of Nursing and/or designee (licensed nurse). Procedure: 1. A Medication Self-Administration Evaluation shall be completed for each resident or designee prior to admission, and will be repeated as deemed necessary, or upon request of by resident. Refer to Medication Self-Administration Evaluation Form ... 3. If the resident indicates a desire to self-administer medications, this will be indicated in the Service Level Assessment. The Director of Nursing or</p>		<p>significant change in condition. 24 Hour report will be monitored daily by Director of Nursing or designee to ensure all residents with a significant change in condition are re-assessed for Level of Care and their ability to self-administer medication. Resident service plans will be updated accordingly. Director of Nursing or Designee will maintain a master schedule identifying when each resident's semi-annual assessment is due, allowing for updating based on re-assessments due to a significant change in condition.</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Director of Nursing or Designee will review all new admissions, semi-annual assessments and changes of condition to ensure all assessments are in accordance with the designated timeframes determined by the Indiana State Department of Health residential care regulations. Findings will be reported through the ongoing quality assurance process.</p>	

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R 0217 Bldg. 00	<p>designee will proceed to observe and interview the resident or designee to complete four components of medication self-administration evaluation, and document the results. Facility will obtain a physician's order for resident to self-administer medication....."</p> <p>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 both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p>			

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	<p>Based on interview and record review, the facility failed to update service plans for services to be provided for significant changes for 2 of 5 residents being reviewed for service plans. (Residents #42 and #112)</p> <p>Findings include:</p> <p>1. Resident #42's record was reviewed 7/23/15 at 1:22 p.m. Diagnoses included hypertension, atrial fibrillation and wounds on the first and fourth toes.</p> <p>The resident's "Service Plan For Residential Care" dated 7/6/15, lacked updated information regarding the resident receiving hospice services or that hospice was changing the dressings to her left foot.</p> <p>A "Facsimile Phase I" report dated 7/7/15, indicated the resident was starting Hospice Care. Her record lacked an order or information indicating, the dates the Home Health Care company was discontinued and the Hospice company was started.</p> <p>A "Hospice Team Sign in" log provided by the Administrator on 7/23/15 at 4:55 p.m., indicated the Hospice RN had visited the resident on 7/13/15, 7/16/15, 7/20/15 and 7/23/15. The Hospice</p>	R 0217	<p><u>R217 Evaluation</u></p> <p>This facility maintains and updates individual service plans upon admission, semi-annually and upon known significant changes in condition.</p> <p><u>Corrective action for identified resident(S):</u></p> <p>Immediately, identified resident's service plans were updated to reflect identification of contracted services provided. Additionally, identifying significant changes which resulted in the need for contracted services.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>All residents have the potential to be affected. All resident records have been reviewed to ensure all residents with significant changes to conditions have been updated, in particular, those contracted with outside agencies. All agency services are reflected on the resident Service Plans.</p> <p><u>Measures to prevent recurrence:</u></p> <p>Director of Nursing or Designee will monitor 24 Hour report for residents identified with a significant change in condition to ensure evaluations</p>	08/10/2015

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	<p>"24-Hour Patient Care Profile" indicated on the above dates the resident's left foot dressing was changed on these dates.</p> <p>During an interview on 7/23/15 at 1:10 p.m., LPN #4 indicated the resident was on Hospice services now and Hospice changed her dressings to her left foot.</p> <p>During an interview on 7/23/15 at 4:28 p.m., the Administrator indicated she did not know if Hospice or Home Health Care was providing the dressing change care to the resident's left foot. At that time, LPN #2 indicated Hospice services were not found on Resident #42's Service Plan.</p> <p>2. Resident #112's record was reviewed on 7/23/15 at 12:13 p.m. Diagnoses included, dementia, chronic kidney disease, and hypertension.</p> <p>The resident's "Nurses's Notes" were reviewed, which indicated the following: 4/10/15 at 2 p.m.--A CNA reported the resident had complained of right arm weakness and pain. She had been having difficulty getting up from the sitting position due to she was unable to push herself up with her right arm. The doctor was notified. 4/22/15 at 2:40 p.m.--A new order was requested from MD for</p>		<p>and service plans are updated appropriately. Director of Nursing or Designee will maintain a master list identifying residents on contracted services to ensure services provided by outside agencies are reflected on the resident's service plans.</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Director of Nursing or Designee will monitor master list weekly, of those receiving contracted services and ensure service plans reflect contracted services and specific services provided by the agencies.</p>	

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	<p>Physical/Occupational (PT/OT) therapy for the resident's right shoulder pain and stiffness. The doctor was notified.</p> <p>4/23/15--The physician ordered Prednisone 5 mg decreasing dose over several days.</p> <p>5/2/15 at 10 a.m.--The resident continued to have pain in her right shoulder. A message was left for the physician.</p> <p>5/4/15 at 9:00 a.m.--New order for Prednisone tapered dose and PT on right shoulder.</p> <p>5/18/15 at 11 a.m.--New order for tapering dose of Prednisone.</p> <p>5/28/15--New order for Biofreeze in the notes.</p> <p>7/1/15--The resident was needing Tylenol at bedside for the right shoulder pain.</p> <p>7/10/15--The resident had a new order for Voltaren Gel for the pain in the right shoulder.</p> <p>7/13/15 at 11:25 a.m.--The daughter requested routine Tylenol and Voltaren Gel for the right shoulder pain.</p> <p>The resident's "Service Plan For Residential Care" dated 7/2/14, lacked information regarding the resident had started therapy or she had right shoulder pain since 4/10/15.</p> <p>During an interview on 7/23/15 at 2:30 p.m., LPN #2 indicated the resident's Service Plan lacked information</p>			

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 07/24/2015
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NAME OF PROVIDER OR SUPPLIER SANDERS GLEN	STREET ADDRESS, CITY, STATE, ZIP CODE 334 S CHERRY ST WESTFIELD, IN 46074
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R 0354 Bldg. 00	<p>indicating she was receiving therapy services or she was having right shoulder pain.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review, the facility failed to ensure transfer information was documented for 1 of 1 resident reviewed for transfer information. (Residents #120)</p> <p>Findings include:</p> <p>Resident #120's record was reviewed on 7/23/15 at 11:38 p.m. Diagnoses included, but were not limited to, venous stasis with ulcers to the right lower extremity, lung mass and iron deficiency</p>	R 0354	<p><u>R354 Clinical Records</u></p> <p>This facility provides accurate interfacility transfer records to ensure continuity of care for residents.</p> <p><u>Corrective action for identified resident(S):</u></p> <p>Identified resident had already been discharged from the facility.</p> <p><u>Identification and corrective action for other residents with the potential</u></p>	08/10/2015

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	<p>anemia.</p> <p>The resident's "Nurse's Notes" indicated he was sent to (name of hospital) on 5/26/15, for complaints of chest pain.</p> <p>Resident #120's record lacked a transfer form or a record of transfer documentation, which included the Resident's identification data, Name of the transferring institution, Name of the receiving institution and date of the transfer, the resident's personal property disposition when transferred to an acute care facility, Nurses' notes relating to the resident's: functional abilities and physical limitations, nursing care prior to the transfer, medications, treatments and current diet and condition of the resident on transfer to the acute care facility, Diagnosis, Date of chest x-ray and skin test for tuberculosis.</p> <p>During an interview on 7/23/15 at 2:55 p.m., LPN #2 indicated there was no transfer form found in Resident #120's record. At that time, the Administrator indicated the facility did not keep copies in the residents chart of any of the records the facility sent to the hospital with the resident.</p>		<p><u>to be affected:</u></p> <p>-</p> <p>All residents have the potential to be affected.</p> <p><u>Measures to prevent recurrence:</u></p> <p>To ensure continuity of care, a Transfer/Discharge Form (Document B) has been implemented for use when a resident goes to an acute facility or another facility for purposes of relocation. Implemented form will be included with record packet which is currently being sent with residents when transferring to the hospital for evaluation.</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Director of Nursing or Designee will review 24 Hour report and monitor through daily meetings residents condition and placement of transfer form within resident chart. Discrepancy of practice will be reported through our Quality Assurance process.</p>	