

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2015
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NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
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(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
F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 16, 17, 18, 19, 20, 23, 2015</p> <p>Facility number: 011596 Provider number: 155769 AIM number: 200901690</p> <p>Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Toni Maley, BSW Tina Smith-Staats, RN</p> <p>Census bed type: SNF: 46 SNF/NF: 9 Residential: 31 Total: 86</p> <p>Census payor type: Medicare: 26 Medicaid: 6 Other: 54 Total: 86</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on March 23,, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F 226 SS=D Bldg. 00	<p>Quality review completed on March 25, 2015 by Randy Fry RN.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure an unusual occurrence was reported to required agencies for 1 resident of 4 resident investigations reviewed. (Resident #46).</p> <p>Findings include:</p> <p>Resident #46's treatment to her lower legs was observed on 3/19/15 at 2:59 p.m. During the treatment both LPN #1 and the resident indicated the resident had bumped her leg during a transfer from her wheelchair to her bed and received a laceration requiring stitches.</p> <p>Resident #46's clinical record was reviewed on 3/18/15 at 1:57 p.m. The</p>	F 226	<p>F 226 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The Indiana State Department of Health - Long Term Care Division Surveyors investigated the unusual occurrence for resident #46 during the Recertification and State Licensure Survey on 3/23/2015. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: all residents have the potential to be affected by the same alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Campus Support Nurse will educate the Leadership</p>	04/22/2015

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	<p>resident had a 2/7/15, Admission Minimum Data Set assessment. The assessment indicated the resident had no cognitive impairment.</p> <p>Review of a 2/17/15, 7:45 p.m., Nurse's Note indicated the resident received a 17 centimeter by 5 centimeter laceration to the left lower leg during a transfer. The note indicated the resident's leg caught on the siderail even with a pillow covering the rails.</p> <p>A 2/18/15, 12:15 a.m., Nurse's Note indicated the resident returned from the emergency room with her injury wrapped and sutures would need to be removed in 7 to 10 days.</p> <p>The investigation was provided by the Director of Nursing on 3/20/15 at 8:30 a.m. The investigation lacked evidence of being reported as an unusual occurrence to the Indiana State Department of Health (ISDH).</p> <p>During an interview with the Director of Nursing on 3/20/15 at 9:10 a.m., she indicated the injury was investigated and not reported as abuse or neglect due to the resident being able to tell them what had occurred.</p> <p>An interview was conducted on 3/20/15</p>		<p>Team on the following: Reportable Event Procedural Guidelines How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the ED or designee 1 times per week times 8 weeks, then monthly times 4 months to ensure compliance: The Indiana State Department of Health-Long Term Care Division is notified of all unusual occurrences per their Reportable Incidents Policy and the campus Reportable Event Procedural Guidelines. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>at 1:13 p.m., with the Corporate Nurse and the Director of Nursing. The Corporate Nurse indicated she would expect to be notified of injuries requiring hospital interventions. She indicated she had not been notified of Resident #46's injury and the injury should have been reported to ISDH as an Unusual Occurrence. The Director of Nursing indicated she and the Assistant Director of Nursing had both taken time off work when the incident occurred. The Director of Nursing indicated she had notified the Administrator of the need to report the incident to ISDH after she reviewed the investigation.</p> <p>During a 3/20/15, 2:15 p.m., interview with the Administrator, he indicated he was notified of the occurrence when it happened but did not find out the resident received stitches until the next day. He indicated the Director of Nursing had told him the occurrence needed to be reported when she returned to work. He indicated he did not report it at that time due to it being almost a week later and he thought too much time had passed. He indicated he relied on the Director of Nursing to tell him when he needed to report occurrences and he did not think about calling the Corporate Nurse for guidance when the Director of Nursing was away.</p>			

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F 248 SS=D Bldg. 00	<p>The 11/2010, "Reportable Event Procedural Guidelines" was provided by the Corporate Nurse on 3/20/15 at 12:25 p.m. The purpose of the guidelines was "To provide guidelines to ensure reportable occurrences are recorded and monitored in accordance with state and federal guidelines." The procedure indicated the following: "...Occurrences to report include:...Significant injuries (Contact your Divisional Nurse to discuss injury on an individual basis.)...Unusual or life threatening injury...."</p> <p>3.1-28(e)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review the facility failed to ensure a resident, who could not self initiate activities, received assistance to meet his activities care plan goal and received assistance to ensure leisure times were meaningful for 1 of 3 residents reviewed for activities in a sample of 6 residents who met the criteria (Resident #20).</p>	F 248	<p>F 248</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #20 will be re-assessed by Life Enrichment</p>	04/22/2015	

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	<p>Findings include:</p> <p>1. On 3/16/15 at 2:25 p.m., Resident #20 was seated in the 200 lounge in his wheelchair. He did not appear to be watching the TV. He did not look towards the TV. His eyes did not move with the movement on the screen. He did not smile, laugh or respond in any manner to the program which was playing on the TV. He was not seated in the reclining chair with his feet up as his care plan indicated was his preference. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>On 3/16/15 at 2:54 p.m., Resident #20 was seated in the 200 lounge in his wheelchair. The resident was asleep. He was not seated in the reclining chair with his feet up as his care plan indicated was his preference. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>On 3/17/15 at 9:13 a.m., Resident #20 was seated in the 200 lounge in his</p>		<p>Director (LED) regarding supplies and resources for resident engagement. Supplies and resources based on interests will be made available in the resident's lounge.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Residents who have been identified as unable to initiate engagement in individual leisure pursuits will be reassessed to determine if there are any preferred activities, supplies and resources that we are currently not providing. If they are unable to articulate preferences, LED will contact family. Care plans will be updated and implemented.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Life Enrichment Director/ Designee will provide reeducation to all Nursing, Social Service, Environmental Services and Life Enrichment staff regarding the need to be aware, engage and assist with utilizing provided resources that are meaningful</p>				

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	<p>wheelchair. He did not appear to be watching the TV. He did not look towards the TV. His eyes did not move with the movement on the screen. He did not smile, laugh or respond in any manner to the program which was playing on the TV. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>On 3/17/15 at 10:12 a.m., Resident #20 was seated in the 200 lounge in his wheelchair. The resident was asleep. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>On 3/17/15 at 10:22 a.m., Resident #20 was seated in the 200 lounge in his wheelchair. The resident was asleep. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>On 3/17/15 at 1:07 p.m., Resident #20 was seated in the 200 lounge in his wheelchair. He did not appear to be</p>		<p>and stimulating to the resident. As well as how to document resident engagement in care tracker</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the LED or designee 2 times per week times 4 weeks, then monthly times 5 months to ensure compliance: Life Enrichment Director will observe residents who can not self initiate activities to ensure assistance is provided to meeting his/her activity care plan goal and receives assistance to ensure leisure times are meaningful.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>watching the TV. He did not look towards the TV. His eyes did not move with the movement on the screen. He did not smile, laugh or respond in any manner to the program which was playing on the TV. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>On 3/20/15 at 9:25 a.m. Resident #20 was seated in the 200 lounge in his wheelchair. He did not appear to be watching the TV. He did not look towards the TV. His eyes did not move with the movement on the screen. He did not smile, laugh or respond in any manner to the program which was playing on the TV. The TV sound was not turned on. The 200 lounge did not contain any manipulative diversionary materials such as books, puzzles, games or sensory stimulating items. Resident #20 did not have any form of diversionary device.</p> <p>2. Resident #20's clinical record was reviewed on 03/20/2015 at 9:41 a.m. Resident #20's current diagnoses included, but were not limited to, Alzheimer's disease, macular degeneration and depression.</p>						

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	<p>Resident #20 had a current, 12/6/14, quarterly, Minimum Data Set assessment (MDS) which indicated the resident was severely cognitively impaired and rarely or never made decisions and required staff assistance for mobility both on and off of the unit.</p> <p>Resident #20 had a 12/10/14 "Activities Progress Note", which indicated the resident had a recent hospital stay and continued to be at risk for social isolation due to dementia.</p> <p>Resident #20 had a current, 2/27/15, "Life Enrichment Assessment", which was completed with the assistance of Resident #20's family, and indicated the following:</p> <p>a. Resident #20 enjoyed (either currently or in the past) cards, reading, exercise, dining out, gardening, walking, socializing (happy hour), sports, shopping, movies, art, TV and watching sports.</p> <p>b. Resident #20's favorite activities were music activities, exercise, socials, humor on TV and being outdoors.</p> <p>c. Resident #20 would enjoy and desired opportunities for exercise, socials,</p>			

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	<p>intergenerational events and pets.</p> <p>d. Resident #20 liked to "sit in the lounge chair in the afternoon [with] my feet up."</p> <p>Resident #20 had a 2/26/15 Care Conference. Notes from the Care Conference indicated: the resident had generalized weakness, required extensive assistance for all activities of daily living, and desired to attend happy hour, sensory, exercise and music.</p> <p>Resident #20 had a current, 3/16/15, care plan problem/need regarding having dementia and requiring assistance to participate in activities. The goal for this care plan problem was "I am at risk for social isolation- I will participate in 2-3 activities weekly- 30 min [minutes] cues as needed." Approaches to this problem included, but were not limited to, assistance to and from events and "I enjoy attending exercise, music groups, happy hour and intergenerational activities."</p> <p>Review of the facility's current March 2015 activity calendar (3/1/15 to 3/18/15), which was provided on 3/20/15 at 2:25 p.m., by the Activities Director, indicated the following:</p>			

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	<p>a. "Sports and News Round Up" had been offered 3 times during this 18 day period.</p> <p>b. "Happy Hour" had been offered 5 times during this 18 day period.</p> <p>c. "Fun at the Pub" [like Happy Hour] had been offered 2 times during this 18 day period.</p> <p>d. Exercise events such as "Motion Madness", "Move to Music" and "Wellness Moving Forward" were offered 21 times during this 18 day period.</p> <p>f. Music related events such as "Gospel Music with [name]", "Sing along with [name]", "Music with [name]", "Piano Music with [name]" were offered 6 times during this 18 day period.</p> <p>g. Pet Therapy had been offered 1 time during this 18 day period</p> <p>Review of Resident #20's March 2015 activity attendance record indicated the resident attended 5 events during this 18 day period. The attendance record indicated Resident #20:</p> <p>a. attended 1 of the 7 opportunities for "Happy Hour" or "Fun in the Pub",</p>			

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	<p>b. attended none of the 6 music events,</p> <p>c. did not participate in Pet Therapy,</p> <p>d. participated in exercise 3 of 21 opportunities.</p> <p>The record did not contain information regarding invitations and refusals.</p> <p>3. During a 3/19/15, 9:55 a.m., interview, CNA#8 indicated Resident #20 liked balloon games, ball activities and crafts. She indicated he had been sleeping a lot.</p> <p>During a 3/19/15, 10:00 a.m., interview, CNA #9 indicated Resident #20 likes balloon bop and music activities.</p> <p>During a 3/20/15 interview at 2:19 PM, the Activity Director indicated she was unsure how to read the attendance record printed out by the computer. She indicated Resident #20 had been hospitalized in the recent past and had declined after his hospitalization. She indicated Resident #20 could not self initiate activities. She indicated Resident #20's wife had recently provided videos that he should enjoy. The videos had not yet been taken to the unit. The Activity Director indicated Resident #20 seemed</p>			

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F 309 SS=D Bldg. 00	<p>more fatigued since he was taking therapy. The Activity Director indicated Resident #20's care plan should have been updated to reflect his change. The Activities Director indicated the facility used to have sensory materials and diversionary materials in the lounge areas for the staff to assist residents in leisure pursuits. She indicated the items were no longer in the lounges. She indicated residents needed to be supervised with some of the items and that had lead to them being removed. She indicated the activities department and nursing department needed to work together to encourage meaningful leisure time pursuits for dependent residents.</p> <p>3.1-33(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure hospice interventions were implemented related to contractures for 1 of 1 resident reviewed for hospice services. (Resident</p>	F 309	F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: A. The bilateral hand splints for resident #69 have been	04/22/2015

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	<p>#69)</p> <p>B. Based on record review and interview, the facility failed to administer sliding scale insulin as ordered by the physician for 1 of 5 residents reviewed for diabetic monitoring. (Resident #124)</p> <p>Findings include:</p> <p>A. During an observation on 3/17/15 at 8:59 a.m., Resident #69 was sitting in the 100 hall lounge without bilateral hand splints in place.</p> <p>During an observation on 3/17/15 at 1:02 p.m., Resident #69 was sitting in the 100 hall lounge without bilateral hand splints in place.</p> <p>During an observation on 3/17/15 at 1:37 p.m., Resident #69 was sitting in the 100 hall lounge without bilateral hand splints in place.</p> <p>During an observation on 3/17/15 at 2:08 p.m., Resident #69 was in bed without bilateral hand splints in place.</p> <p>During an observation on 3/17/15 at 2:42 p.m., Resident #69 was sitting in the 100 hall lounge without bilateral hand splints in place.</p>		<p>implemented per therapy and hospice recommendation. B. Resident #124 has been discharged Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents for the following: A. Ensure hospice interventions have been implemented as recommended related to contractures. B. Sliding scale insulin administered as ordered and documented Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: A. Contracture Prevention and Management Program and Coordination of Care with Hospice to ensure a plan of care is developed and communicated B. Blood Sugar Monitoring. The Hospice nurse will provide a written summary of recommendations to the DHS after each visit. This will be utilized for follow up to ensure the recommendations have a order received (if applicable) and are implemented. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the</p>		

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	<p>During an observation on 3/18/15 at 9:58 a.m., Resident #69 was sitting in the 100 hall lounge without bilateral hand splints in place.</p> <p>During an interview with LPN #2 on 3/17/15 at 12:34 p.m., she indicated the Resident #69 had contractures in her both of her hands. She indicated the family of Resident #69 did not want range of motion or splints for the resident's contractures.</p> <p>The clinical record for Resident #69 was reviewed on 3/19/15 at 7:17 a.m. Diagnoses for Resident #69 included, but were not limited to, End-Stage Alzheimer's disease, arthritis, and weakness. The clinical record did not contain an order for bilateral hand splints.</p> <p>During an interview with the Hospice RN on 3/19/15 at 8:51 a.m., she indicated hospice had ordered hand splints for Resident #69 to be worn daily. The Hospice RN went to Resident #69's room and retrieved two hand splints from the bedside table. The Hospice RN indicated the hand splints had been ordered from occupational therapy.</p> <p>During an interview with LPN #5 on 3/19/15 at 8:57 a.m., she indicated there was not an order for hand splints in the</p>		<p>DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: A. Ensure hospice interventions have been implemented as recommended related to contractures. B. Sliding scale insulin administered as ordered and documented The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>medication administration record or in the treatment administration record for Resident #69.</p> <p>During an interview with Physical Therapy Assistant #6 on 3/19/15 at 9:05 a.m., she indicated the hand splints for Resident #69 had been ordered on 8/29/14.</p> <p>During an interview with Resident #69's spouse on 3/19/15 at 1:28 p.m., he indicated he had no objections to interventions used for his wife that did not cause discomfort to his wife.</p> <p>During an interview with the Corporate Nurse on 3/19/15 at 2:44 p.m., she indicated the facility was unaware Resident #69 had hand splints in her room. She indicated Resident #69 did not have a physician's order for bilateral hand splints.</p> <p>Review of the current, October 2007, facility policy, titled "Contracture Prevention and Management Program", provided by LPN #7 on 3/19/15 at 3:13 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To prevent or reduce contractures and deformity... ...7. Evaluate the need for</p>			

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	<p>splint/brace/prosthetic device use and assistance and refer to therapy as indicated..."</p> <p>Review of the current, signed hospice contract, provided by the Administrator on 3/20/15 at 3:01 p.m., included, but was not limited to, the following:</p> <p>"...In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice patient.... ...Hospice is responsible for providing those services that are reasonable and necessary for the palliation and management of a Hospice patient's terminal illness and are specified in a Hospice patient's Plan of Care, including nursing care and services by or under the supervision of a registered nurse;... and use of medical appliances..."</p> <p>B. The clinical record for Resident #124 was reviewed on 3/18/15 at 7:21 a.m. Diagnoses for Resident #124 included, but were not limited to, diabetes, hypertension, and depression.</p> <p>Current signed physician's orders for Resident #124 included, but were not limited to, the following orders:</p>			

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	<p>a. Lantus (insulin) inject 50 units subcutaneous every bedtime. This order originated on 2/24/15.</p> <p>b. Humalog kwikpen (insulin) inject 10 units subcutaneous 3 times daily with meals. This order originated 2/24/15.</p> <p>c. Check blood sugar before meals and at bedtime. This order originated 2/24/15.</p> <p>c. Administer Humalog sliding scale insulin according to blood sugar results as listed below,</p> <p>200-250 = 2 units 251-300 = 4 units 301-350 = 6 units 351-400 = 8 units 401-450 = 10 units 451-500 = 12 units</p> <p>1/2 (one half) dose of sliding scale dose after 8:00 p.m. Call physician if blood sugar is equal or less than 60 or equal or greater than 500. This order originated 2/24/15.</p> <p>A health care plan, dated 3/4/15, indicated Resident #124 had diabetes mellitus. Interventions for this care area were to check Resident #124's blood sugar and administer insulin/medication as ordered by the physician, and observe</p>			

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	<p>the resident for signs and symptoms of hypo/hyperglycemia.</p> <p>Review of the March 2015 Medication Administration Record for Resident #124 on 3/19/15 at 2:07 p.m., with LPN #11 indicated the following:</p> <p>March 1, at bedtime, the blood sugar result was 305, 6 units of insulin was documented as having been given, the resident should have received 3 units;</p> <p>March 4, at bedtime, the blood sugar result was 289, no insulin was documented as having been given, the resident should have received 2 units;</p> <p>March 5, at dinner, the blood sugar result was 317, 8 units of insulin was documented as having been given, the resident should have received 6 units;</p> <p>March 6, at dinner, no blood sugar result was documented;</p> <p>March 6, at bedtime, the blood sugar result was 360, 8 units of insulin was documented as having been given, the resident should have received 4 units;</p> <p>March 8, at breakfast, no blood sugar documented;</p>			

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	<p>March 10, at breakfast, the blood sugar result was documented as 204, no coverage was given and the resident should have received 2 units of insulin;</p> <p>March 12, at lunch, no blood sugar result was documented;</p> <p>March 12, at bedtime, the blood sugar result was 342, 6 units of insulin was documented as having been given, the resident should have received 3 units;</p> <p>March 13, at bedtime, the blood sugar result was 376, 8 units of insulin was documented as having been given, the resident should have received 4 units:</p> <p>March 14, at lunch, the blood sugar result was 271, 2 units of insulin was documented as having been given, the resident should have received 4 units;</p> <p>March 14 at bedtime, the blood sugar result was 418, 10 units of insulin was documented as having been given, the resident should have received 5 units;</p> <p>March 15, at breakfast, the blood sugar result was 263, 2 units of insulin was documented as having been given, the resident should have received 4 units;</p> <p>March 15, at breakfast, the blood sugar</p>			

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	<p>result was 262, no insulin was documented as having been given, the resident should have received 4 units;</p> <p>And March 17, at bedtime, no blood sugar result was documented.</p> <p>During this interview on 3/19/15 at 2:07 PM, LPN #11 indicated there were missing blood sugar results and incorrect insulin coverage documented for Resident #124. She indicated Resident #124 was to have 1/2 (one half) dose of insulin at bedtime based on blood sugar result. LPN#11 indicated the blood sugar result and amount of insulin should be documented on the medication administration record.</p> <p>Review of the current, 2012, facility policy, titled "Blood Sugar Monitoring", provided by the Director of Nursing on 3/23/15 at 9:46 a.m., included, but was not limited to, the following:</p> <p>"DOCUMENTATION GUIDELINES... ...Date, time, blood glucose level.... ...If insulin is ordered based on a sliding scale document the type and amount of insulin administered and the site of injection...."</p> <p>3.1-37(a)</p>			

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R 000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 16, 17, 18, 19, 20, 23, 2015</p> <p>Facility number: 011596 Provider number: 155769 AIM number: 200901690</p> <p>Survey team: Ginger McNamee, RN, TC Karen Lewis, RN Toni Maley, BSW Tina Smith-Staats, RN</p> <p>Census bed type: SNF: 46 SNF/NF: 9 Residential: 31 Total: 86</p> <p>Census payor type: Medicare: 26 Medicaid: 6 Other: 54 Total: 86</p> <p>Residential sample: 8</p>	R 000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on March 23,, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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R 304 Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on March 25, 2015 by Randy Fry RN.</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication cart was locked when not in use for 1 of 2 residential medication carts observed (the Assisted Living medication cart). This deficient practice failed to provide secured limited access for 21 residents. (Residents #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, #R9, #R10, #R11, #R12, #R13, #R14, #R15, #R16, #R17, #R18, #R19, #R20, and #R21)</p> <p>This deficient practice also allowed narcotics and drugs at risk for abuse to not be double locked for Residents R#1, R#4, R#5, R#6, R#7, R#10, R#14, R#15, R#17, R#19, R#20, and R#21.</p>	R 304	<p>R 304 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The Assisted Living medication cart was locked immediately when noted to be unlocked during the survey.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All Assisted Living Residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient</p>	04/22/2015

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	<p>Findings include:</p> <p>During an observation on 3/23/15 at 7:11 a.m., the Assisted Living medication cart was observed unlocked and unattended. The medication cart was in the lounge next to the Assisted Living dining room. Resident R#15 was seated at a table in the corner of the Assisted Living dining room. LPN #12 entered the Assisted Living dining room from the kitchen door and approached the medication cart. She indicated she thought she had locked the cart before walking away.</p> <p>A list of residents with medications stored on the Assisted Living medication cart was provided by LPN #12 on 3/23/15 at 9:54 a.m. The list indicated Residents #R1, #R2, #R3, #R4, #R5, #R6, #R7, #R8, #R9, #R10, #R11, #R12, #R13, #R14, #R15, #R16, #R17, #R18, #R19, #R20, and #R21 all had medications on the Assisted Living medication cart when it was observed unlocked. Twelve of the residents with medications stored on the Assisted Living medication cart had Schedule II drugs and other drugs subject to abuse stored. These medications were to be double locked:</p> <p>Resident R#1 had 34 tablets of</p>		<p>practice does not recur: DHS or designee will re-educate the Assisted Living Licensed Nurses / QMAs on the following guideline: Medication Storage in the Facility How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observation of Assisted Living medication cart to ensure it is locked. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>alprazolam (anti anxiety medication) 0.25 (milligram) mg;</p> <p>Resident R#4 had 23 tablets of hydrocodone (pain medication) 5-325 mg;</p> <p>Resident R#5 had 16 tablets of hydrocodone (pain medication) 5-325 mg;</p> <p>Resident R#6 had 37 tablets of hydrocodone (pain medication) 5-325 mg;</p> <p>Resident R#7 had 16 tablets of hydrocodone (pain medication) 5-325 mg;</p> <p>Resident R#10 had 59 tablets of hydrocodone (pain medication) 10-300 mg;</p> <p>Resident R#14 had 15 tablets of tramadol (pain medication) 50 mg;</p> <p>Resident R#15 had 21 tablets of hydrocodone (pain medication) 5-325 mg;</p> <p>Resident R#17 had 50 tablets of hydrocodone (pain medication) 5-300 mg;</p>			

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	<p>Resident R#19 had 18 tablets of Norco (pain medication) 5-300 mg and 47 tablets of Lyrica (pain medication) 75 mg;</p> <p>Resident R#20 had 82 tablets of tramadol (pain medication) 50 mg;</p> <p>and Resident R#21 had 31 tablets of lorazepam (anti anxiety medication) 5-325 mg.</p> <p>During an interview with the Director of Nursing on 3/23/15 at 7:51 a.m., she indicated the medication carts are to be locked anytime they are unattended.</p> <p>Review of the current facility policy, dated 9/1/13, titled "MEDICATION STORAGE IN THE FACILITY", provided by the Director of Nursing on 3/23/15 at 9:46 a.m., included, but was not limited to, the following:</p> <p>"...B. Only licensed nurse, pharmacy personnel, and those lawfully authorized to administer medications [such as medication aides] are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access...."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2015

FORM APPROVED

OMB NO. 0938-0391

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