

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/09/2014
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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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R000000	<p>This visit was for the Investigation of Complaint IN00150605.</p> <p>Complaint IN 00150605 Substantiated. State deficiencies related to the allegations are cited at R0036, R0214, R0217, R0241, R0297, and R0349.</p> <p>Survey dates: July 7, 8, and 9, 2014</p> <p>Facility number: 011804 Provider number: 011804 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: Residential: 119 Total: 119</p> <p>Census payor type: Other: 119 Total: 119</p> <p>Sample: 16</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July</p>	R000000		
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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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R000036	<p>11, 2014 by Randy Fry RN.</p> <p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on interview and record review, the facility failed to notify the physician of skin tears and medications not given for 2 of 6 residents reviewed for physician notification in a sample of 16. (Resident #F and Resident #R)</p> <p>Findings include:</p> <p>1. Resident # F's record was reviewed on</p>	R000036	The statements made in this Plan of Correction are not an admission to, nor constitute an agreement nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following plan of correction. All deficiencies cited have been or are to be corrected by the date or dates	08/22/2014

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	<p>7-9-2014 at 9:36 AM. Resident #F's diagnoses included but were not limited to depression and high blood pressure.</p> <p>Nurse's notes dated 4-28-2014 at 9:00 AM indicated Resident #F sustained a 2.4 centimeter (cm) skin tear to his right hand. Additionally, the note indicated 3 steri strips had been applied to the skin tear. There was no indication in the note the physician had been notified of the skin tear or of the extent of the first aid rendered.</p> <p>A review of Resident #F's physician's orders for the dates of 4-28 through 5-1 did not indicate an order had been given to treat the area.</p> <p>A review of Resident #F's Treatment Administration Record (TAR) dated April 2014 indicated a treatment had been initiated on 4-28-2014. The TAR indicated to apply telfa and kling to right hand skin tear daily until healed.</p> <p>In an interview on 7-9-2014 at 10:24 Am, the Director of Nursing (DON) indicated physician notification should have been completed when the initial assessment was completed and physician orders should have been written on the physician order sheet at the time they were obtained.</p>		<p>indicated.</p> <p>R036: Failure to notify the physician about skin tears and medications not given for 2 of 6 residents</p> <ol style="list-style-type: none"> <li>Resident #F physician was notified on July 24, 2014 of skin issue from April 28, 2014. The skin tear was treated and area is healed. Resident #R physician notified on July 24, 2014 that Lovenox was not administered from June 11-19, 2014.</li> <li>All residents have the potential to be affected by this alleged deficient practice. Director of Nursing and/or designee will review incident reports for the last 60 days to insure physician notification. Director of Nursing or designee will review current months Medication Administration Records to make sure resident is receiving medication as ordered.</li> <li>Facility will ensure compliance by having Director of Nursing be notified by phone of any skin tear or skin issue. Nurse will measure initially and properly document skin issue. First aid to the area will be fulfilled and treatment orders obtained when notifying the physician. The Director of Nursing and/or designee will review resident record on next business day to verify physician notification, treatment</li> </ol>	

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	<p>2. Resident #R's record was reviewed 7-9-2014 at 1:31 PM. Resident #R's diagnoses included but were not limited to osteoporosis, depression, and stroke.</p> <p>A physician's order dated 5-27-2014 indicated Resident #R was to receive Lovenox (an anticoagulant) 40 milligrams (mg) daily.</p> <p>A further review of physician's orders indicated on 6-19-2014 to discontinue the Lovenox use.</p> <p>A review of Resident #R's Medication Administration Record dated June 2014 indicated the Lovenox had been given as ordered on June 1st through the 10th. The MAR further indicated the doses on the dates of June 11th through the 19th had been circled. A review of the back of the MAR did not indicate why the medication had not been given.</p> <p>A review of Nurse's notes dated 6-11 through 6-19-2014 did not indicate why the medication Lovenox had not been given.</p> <p>A review of physician progress notes did not indicate why the Lovenox had not been given.</p>		<p>order obtained and skin issue is properly documented. If there is a medication discrepancy, the physician will be notified. Pharmacy will be notified if medication is unavailable for administration so needed medication is delivered to the facility. Staff will follow facility policy when obtaining medications. If unable to obtain medication, nursing staff will report to Director of Nursing and/ or designee by placing it on the 24 hour report for appropriate follow up.</p> <p>4. Wellness Director and/or designee will in-service QMA's, LPN's and RN's on Incident reporting, physician notification and documentation of first aid, obtaining physician orders for skin issues, medication administration, documentation of refused or missed medications. Director of Nursing and/or designee will review Incident reports with proper notification, resident record documentation, physician orders and Medication Administration Records weekly for 6 weeks, then bi-monthly for 6 weeks, and monthly for 3 months. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. These systematic changes will be completed by August 15, 2014.</p>	

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R000214	<p>In an interview on 7-9-2014 at 2:10 PM, the DON indicated there was no reason to her knowledge the Lovenox had not been given. The DON further indicated the physician should have been notified if the medication was unable to be given more than 3 days in a row.</p> <p>A current policy titled Missed medication reporting dated 12-31-2013 provided by the Corporate Nurse on 7-9-2014 at 10:23 AM indicated " DON/ Designee will notify the physician of any repeated and/or consistently missed/ refused medications. "</p> <p>This State tag relates to Complaint IN00150605.</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>	R000214	R214: Evaluation	08/22/2014

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	<p>Based on interview and record review, the facility failed to evaluate the nursing needs of 2 of 3 residents with skin conditions. (Resident #F and Resident #O). The facility further failed to update the service plan for 1 of 5 residents reviewed for service plan updates in a sample of 16 ( Resident #I).</p> <p>Findings include:</p> <p>1. Resident # F's record was reviewed on 7-9-2014 at 9:36 AM. Resident #F's diagnoses included but were not limited to depression and high blood pressure.</p> <p>Nursing notes dated 5-3-2014 at 7:30 PM indicated Resident #F sustained a skin tear to his left forearm while in the shower. The note indicated first aid was given by dressing the area with bacitracin and telfa. the note did not indicate the size or characteristics of the skin tear.</p> <p>Nursing notes dated 6-3-2014 at 8 PM indicated Resident #F sustained a skin tear to his left upper extremity. The notes indicated first aid was given by applying steristrips and a dressing. There was no indication of the size of the skin tear or the characteristics of it.</p> <p>In an interview on 7-9-2014 at 10:21 AM, the Director of Nursing (DON) indicated</p>		<p><b>Please note that Resident #O had documentation from 6/2/14 -6/22/14 with the exception of 6/17/ which is noted on the 2567 and was on leave of absence with family during 6/22/14 – 6/27/14 and notes were provided to state surveyor and reviewed during the survey.</b></p> <p>1. Resident #F on July 24, 2014 the physician was notified of skin tear and treatment. Area healed as of June 24, 2014. Resident #O wound has significantly improved and continues to go weekly to wound healing center for treatment, service plan updated on July 24, 2014. Res # I was updated on July 24, 2014.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. Director of Nursing and/or designee will audit incident reports for the last 60 days for notification of physician and proper documentation. Director of Nursing and/or designee will audit resident records for updated service plans and update those out of compliance.</p> <p>3. Updated service plans will be entered into Assisted Living Intelligent Solutions system for tracking. The Director of Nursing and/or designee will print list of service plans to be completed each</p>				

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	<p>staff should document the characteristics and sizes of skin wounds assessed. The DON indicated she was unsure if the staff had assessed the area.</p> <p>2. Resident #O's record was reviewed 7-9-2014 at 11:46 AM. Resident #O's diagnoses included but were not limited to high blood pressure, dementia, and arthritis.</p> <p>A Nurse's note dated 6-9-2014 at 8:30 PM indicated there were bruises on the right outer knee the resident was unable to give origin for.</p> <p>Nurse's notes dated 6-12-2014 at 9 PM indicated the hematoma had no drainage, but there was no other description of the area.</p> <p>Nurse's notes on 6-16-2014 indicated the area was boggy and the area did not appear to be healing. The physician was contacted and an order was received to send Resident #O to the Wound Clinic.</p> <p>There were no Nursing notes to review on 6-17-2014.</p> <p>There were no Nurse's notes to review between 6-2-2014 and 6-27 2014.</p> <p>On 6-27-2014, at 1:30 PM, the Nurse's</p>		<p>month and give to Executive Director. Director of Nursing and/or designee will complete updated service plan for residents due each month. The Regional Director of Clinical Service will in-service the Director of Nursing and/or designee on requirements to be included in service plan including signatures and tracking system to ensure service plans are completed prior to admission, and quarterly thereafter. The Director of Nursing and/or designee will review resident record on the next business day to verify physician notification, treatment order obtained and skin issue is properly documented.</p> <p>4. The Executive Director will audit updated service plans by signing after all requirements are fulfilled, and placed in resident record. Director of Nursing and/or designee will review Incident reports with proper notification, resident record documentation weekly for 6 weeks, then bi-monthly for 6 weeks, and monthly for 3 months. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. The systemic changes will be completed by August 15, 2014.</p>				

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	<p>notes indicated the hematoma was still bleeding.</p> <p>On 6-30-2014, a new order was received from the wound clinic to leave an UNA boot ( a hard protective boot) and wrap on the left leg.</p> <p>In an interview on 7-8-2014 at 2:23 PM, LPN #2 indicated bruising should have been assessed daily after the area opened and became unstable.</p> <p>3. Resident #I's record was reviewed 7-9-2014 at 10:32 AM. Resident #I's diagnoses included, but were not limited to, stroke, high blood pressure, and anemia.</p> <p>Resident #I's Service Plan available on the chart was dated 10-14-2013. There was no recent Service plan available on the chart.</p> <p>In an interview on 7-9-2014 at 11:24 AM, the DON indicated she was unable to locate an updated service plan for Resident #I.</p> <p>This State tag relates to Complaint IN00150605.</p>			

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R000217	<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> <p>Based on interview and record review,</p>	R000217	R217: Evaluation	08/22/2014			

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	<p>the facility failed to ensure the service plans were completed, reviewed and signed by the resident representative for 2 of 13 residents reviewed for evaluation completion in a sample of 16. (Resident #D, and Resident #H)</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 7-8-2014 at 12:52 PM. Resident #D's diagnoses included, but were not limited to, depression, anxiety, and Parkinson's disease.</p> <p>A preadmit assessment dated 3-20-2014 indicated Resident #D had behavior concerns, but there were no interventions listed regarding care after admission.</p> <p>A Care Package dated 3-20-2014 indicated Resident #D required level 4 interventions. There was no indication of behavior interventions on the care package and the care package had not been signed by Resident #D or the responsible party.</p> <p>In an interview on 7-8-2014 at 1:10 PM, the Director of Nursing (DON) indicated the care packages are the service plan, and the expectation was the plan was to be completed, discussed with the resident if alert and oriented, or the resident</p>		<p>1. Resident #D Resident record audited and updated and signed by family by August 22, 2014. Resident # H Resident record audited and updated and signed by family by August 22, 2014.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. Updated service plans will be entered into Assisted Living Intelligent Solutions system for tracking. The Director of Nursing and/or designee</p> <p>3. Updated service plans will be entered into Assisted Living Intelligent Solutions system for tracking. The Director of Nursing and/or designee will print list of service plans to be completed</p> <p>each month and give to Executive Director. Director of Nursing and/or designee will complete updated service plan for residents due each month. The Regional Director of Clinical Service will in-service the Director of Nursing and/or designee on requirements to be included in service plan including signatures and tracking system to ensure service plans are completed prior to admission, and quarterly thereafter. The Director of Nursing and/or designee will review resident record on next business day to verify physician notification, treatment order obtained and skin issue is</p>				

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	<p>representative, and signed. She further indicated she was unsure if the plan had been discussed with the family as there was no signature on the form.</p> <p>2. Resident #H's record was reviewed on 7-8-2014 at 11:39 AM. Resident #H's diagnoses included but were not limited to anxiety, dementia, and high blood pressure.</p> <p>An Admission Evaluation form with the designation for Resident #H had no information under narrative description, nurse signature, or date.</p> <p>A Care Package form dated 5-22-2014 indicated the resident required level 5 care, but had no signature from the resident or responsible party.</p> <p>A current policy titled Assistance/Service Plan dated 9-27-2011 provided by the Corporate Nurse on 7-9-2014 at 10:23 AM indicated "...4. All components of the Assistance/ service plan form must be completed. "</p> <p>This State tag relates to Complaint IN00150605.</p>		<p>properly documented.</p> <p>4. Wellness Director will monitor for the above stated concerns weekly for 6 weeks, then bi-monthly for 6 weeks, and monthly for 3 months. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. Systemic changes will be completed by August 22, 2014.</p>				

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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to provide medications and treatments as ordered by the physician for 2 of 5 residents reviewed for medications in a sample of 16. (Resident #R and Resident #F)</p> <p>Findings include:</p> <p>1. Resident #R's record was reviewed 7-9-2014 at 1:31 PM. Resident #R's diagnoses included but were not limited to osteoporosis, depression, and stroke.</p> <p>A physician's order dated 5-27-2014 indicated Resident #R was to receive Lovenox (an anticoagulant) 40 milligrams (mg) daily.</p> <p>A further review of physician's orders indicated on 6-19-2014 to discontinue the Lovenox use.</p> <p>A review of Resident #R's Medication</p>	R000241	<p>R241: Administration of medications and failure to notify physician of treatment</p> <p>1. Resident #F on July 24, 2014 physician notified of skin and treatment. Area healed as of June 24, 2014. Resident #R on July 25, 2014 the physician as notified that Levenox June 11-19, 2014 with no documentation on the back of the MAR.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. Director of Nursing and/or designee will review incident reports for the last 60 days to ensure physician notification. Director of Nursing and/or designee will review current months Medication Administration Records to make sure resident is receiving medication as ordered.</p> <p>3. Facility will ensure compliance by having Director of Nursing be notified by phone of any</p>	08/22/2014

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	<p>Administration Record dated June 2014 indicated the Lovenox had been given as ordered on June 1st through the 10th. The MAR further indicated the doses on the dates of June 11th through the 19th had been circled. A review of the back of the MAR did not indicate why the medication had not been given.</p> <p>A review of Nurse's notes dated 6-11 through 6-19-2104 did not indicated why the medication Lovenox had not been given.</p> <p>A review of physician progress notes did not indicate why the Lovenox had not been given.</p> <p>In an interview on 7-9-2014 at 2:10 PM, the DON indicated there was no reason to her knowledge the Lovenox had not been given. The DON further indicated the physician should have been notified if the medication was unable to be given more than 3 days in a row.</p> <p>A current policy titled Missed medication reporting dated 12-31-2013 provided by the Corporate Nurse on 7-9-2014 at 10:23 AM indicated " DON/ Designee will notify the physician of any repeated and/or consistently missed/ refused medications. "</p>		<p>skin tear or skin issue. The Nurse will measure initially and properly document skin issue. First aid to the area will be fulfilled and treatment orders obtained when notifying the physician. The Director of Nursing and/or designee will review resident record on next business day to verify physician notification, treatment order obtained and skin issue is properly documented. If there is a medication discrepancy, the physician will be notified. Pharmacy will be notified if medication is unavailable for administration so needed medication is delivered to the facility. Staff will follow facility policy when obtaining medications. If unable to obtain medication, nursing staff will report to Director of Nursing or designee by placing it on the 24 hour report for appropriate follow up.</p> <p>4. Wellness Director will monitor for the above stated weekly for 6 weeks, then bi-monthly for 6 weeks, and monthly for 3 months. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. Systemic changes will be completed by August 22, 2014.</p>	

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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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	<p>2. Resident # F's record was reviewed on 7-9-2014 at 9:36 AM. Resident #F's diagnoses included but were not limited to depression and high blood pressure.</p> <p>Nurse's notes dated 4-28-2014 at 9:00 AM indicated Resident #F sustained a 2.4 centimeter (cm) skin tear to his right hand. Additionally, the note indicated 3 steri strips had been applied to the skin tear. There was no indication in the note the physician had been notified of the skin tear or of the extent of the first aid rendered.</p> <p>A review of Resident #F's physician's orders for the dates of 4-28 through 5-1 did not indicate an order had been given to treat the area.</p> <p>A review of Resident #F's Treatment Administration Record (TAR) dated April 2014 indicated a treatment had been initiated on 4-28-2014. The TAR indicated to apply telfa and kling to right hand skin tear daily until healed.</p> <p>In an interview on 7-9-2014 at 10:24 Am, the Director of Nursing (DON) indicated physician notification should have been completed when the initial assessment was completed and physician orders should have been written on the physician order sheet at the time they</p>			

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R000297	<p>were obtained.</p> <p>This State tag relates to Complaint IN00150605.</p> <p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to assure medications were available for administration per physician's order for 1 of 5 residents reviewed for medication availability in a sample of 16. (Resident #H)</p> <p>Findings include:</p> <p>Resident #H's record was reviewed 7-8-2014 at 11:39 AM. Resident #H's diagnoses included but were not limited to anxiety, dementia, and high blood pressure.</p> <p>A Medication Administration Record (MAR) dated 5-2014 indicated the medication Celexa (an antidepressant)</p>	R000297	<p>R297: Pharmaceutical Services</p> <p>1. Resident #H physician notified of Aricept not given on May 21, 2014 and Celxa not given on dates of May 21, 2014 – May 31, 2014. Wellness Director will review current Medication Administration Records to make sure current medication available for resident.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. Director of Nursing and/or designee will review July 2014 Medication Administration Record to make sure resident is receiving medication as ordered.</p>	08/22/2014

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	<p>had been circled from 5-21 through 5-31. On the back of the May MAR, a note dated 5-26-2014, indicated the medication was unavailable.</p> <p>A Medication Administration Record (MAR) dated 5-2014 indicated the medication Aricept (a medication to enhance memory) had been circled on 5-21. On the back of the May MAR, a note dated 5-21-2014, indicated the medication was unavailable.</p> <p>In an interview on 7-8-2014 at 11:42 AM, LPN #1 indicated medications were unavailable from time to time due to the pharmacy not sending medications in a timely manner.</p> <p>This State tag relates to Complaint IN00150605.</p>		<p>3. Facility will ensure their compliance by having Director of Nursing be notified by phone of any missing medication. Pharmacy will be notified if medication is unavailable for administration so needed medication is delivered to the facility. Staff will follow facility policy when obtaining medications. If unable to obtain medication, nursing staff will report to Director of Nursing and/or designee by placing it on the 24 hour report for appropriate follow up.</p> <p>4. Director of Nursing will monitor for the above stated concerns weekly for 6 weeks, then bi-monthly for 6 weeks, and monthly for 3 months. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. Systemic changes will be completed by August 22, 2014.</p>	

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R000349	<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 accurate documentation on the Medication Administration (MAR) records and Treatment Administration Records (TAR) for 5 of 7 residents reviewed for MAR and TAR accuracy. (Resident #F, Resident #G, Resident #H, Resident #I, and Resident #R) Additionally, the facility failed to ensure documentation of a complete assessment for 1 of 5 residents reviewed for complete assessments in a sample of 16. (Resident #Q)</p> <p>Findings include:</p> <p>1. Resident # F's record was reviewed on 7-9-2014 at 9:36 AM. Resident #F's diagnoses included but were not limited to depression and high blood pressure.</p> <p>A physician's order dated 6-6-2014</p>	R000349	<p>R349 Non Compliance with clinical record</p> <p>1. Resident #F on July 24, 2014 physician notified of skin and treatment. Area healed as of June 24, 2014. Treatment Administration Record will be audited weekly to make sure treatment orders are completed. Resident #G Medication Administration Records complete for May 31, 2014. Physician notified and nurses note complete on July 9, 2014 explaining circumstances upon admission. Resident # H physician was notified of medication not given at dates of May 21, 2014 – May 31, 2014 on July 10, 2014 all medication available for resident. Wellness Director will review current Medication Administration Records to make sure current medication available for resident. Resident #I Physician notified on July 24, 2014 that medication order needs to be adjusted to better serve resident. Physician researching order for</p>	08/22/2014			

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	<p>indicated to change dressing to left forearm skin tear daily . Cleanse with soap and water then apply telfa, and wrap with gauze.</p> <p>The TAR dated 6-2014 was not initialed as completed on 6-7 and 6-12-2014.</p> <p>In an interview on 7-9-2014 at 10:21 AM, the Director of Nursing (DON) indicated the staff were to complete documentation of treatments after the treatment had been rendered.</p> <p>2. Resident #G's record was reviewed 7-8-2014 at 9:32 AM. Resident #G's diagnoses included, but were not limited to, high blood pressure, Parkinson's disease, and depression.</p> <p>A review of Resident #G's MARs indicated there was no MAR for May 2014 available for review.</p> <p>In an interview on 7-9-14 at 10:58 AM, the DON indicated there was no MAR completed for the medications to be given in May, but the nurse on duty had completed a late entry in Resident #G's record. The DON further indicated the nurse should have completed a MAR for any medication doses given.</p> <p>Nurse's notes dated 7-9-2014 at 6:15 AM</p>		<p>possible change. Resident #R July 24, 2014 physician notified that levenox June 11-19, 2014 with no documentation on the back of the Medication Administration Records. Wellness Director will review current Medication Administration Records weekly to make sure resident is receiving medication as ordered. Resident #Q Late entry completed for resident fall on May 16, 2014. Nurse did complete a head to toe assessment at that time on May 16, 2014 with no injuries noted. Physician notified at time of fall. Wellness Director will review incident reports for last 60 days to ensure physician notification.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. Director of Nursing and/ or designee will review incident reports for the last 60 days to insure physician notification; will review July 2014 Medication Administration Records to make sure resident is receiving medication as ordered; will audit resident records for updated service plans and update those out of compliance. Updated service plans will be entered into Assisted Living Intelligent Solutions system for tracking. The Director of Nursing and/or designee</p> <p>3. Facility will ensure compliance by having Director of</p>				

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	<p>indicated the note had been a late entry for 5-31-2014. The note indicated Resident #G's responsible party had requested his medications scheduled for 8 PM be given at 7:30 PM. The note then indicated it was 8:25 PM when the licensed nurse reached the room, and the responsible party indicated Resident #G had had his medications for the day. There was no indication the nurse had reviewed the 8 PM medications with the responsible party to assure the medications ordered for 8 PM had been given.</p> <p>3. Resident #H's record was reviewed 7-8-2014 at 11:39 AM. Resident #H's diagnoses included but were not limited to anxiety, dementia, and high blood pressure.</p> <p>A review of Resident #H's MAR dated May 2014 indicated the medication Celexa (an antidepressant) ordered 20 mg once per day had been circled for the dates of May 21 through May 31, 2014. The back of the MAR indicated the medication had been unavailable on 5-26, but there was no indication why the medication had not been given on the other days circled.</p> <p>In an interview on 7-9-2014 at 10:21 AM, the DON indicated the staff were to</p>		<p>Nursing will be notified by phone of any skin tear or skin issue. Nurse will measure initially and properly document skin issue. First aid to the area will be fulfilled and treatment orders obtained when notifying the physician. The Director of Nursing and/ or designee will review resident record on the next business day to verify physician notification, treatment order obtained and skin issue is properly documented. If there is a medication discrepancy, the physician will be notified. Pharmacy will be notified if medication is unavailable for administration so needed medication is delivered to the facility. Staff will follow facility policy when obtaining medications. If unable to obtain medication, nursing staff will report to Director of Nursing and/or designee by placing it on the 24 hour report for appropriate follow up. Updated service plans will be entered into Assisted Living Intelligent Solutions system for tracking. The Director of Nursing and/or designee will print list of service plans to be completed each month and give to Executive Director. Director of Nursing and/or designee will complete updated service plan for residents due each month. The Regional Director of Clinical Service will in-service the Director of Nursing and/or designee on requirements to be included in service plan including signatures and tracking system to</p>				

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	<p>note the reason for inability to give a medication on the back of the MAR.</p> <p>4. Resident #I's record was reviewed 7-9-2014 at 10:32 AM. Resident #I's diagnoses included, but were not limited to, stroke, high blood pressure, and anemia.</p> <p>A physician's order dated 5-10-2014 indicated Resident #I was to receive Oxycodone/APAP (a medication for pain) 5-325 milligrams (mg) every 4 hours while awake.</p> <p>A review of Resident #I's MAR dated June 2014 indicated the Oxycodone medication had been circled for the following dates and times: 1 AM doses from June 1st through the 14th, and June 16th through the 30th. 5 AM doses on June 1st through the 30th. On the back of the MAR the following doses had noted Resident #I was sleeping: 1 AM on June 2, 4, and 20. 5 Am doses June 2, 4, and 20. There was no further indication any of the doses were not given because Resident #I had been sleeping.</p> <p>5. Resident #R's record was reviewed 7-9-2014 at 1:31 PM. Resident #R's diagnoses included but were not limited to osteoporosis, depression, and stroke.</p>		<p>ensure service plans are completed prior to admission, and quarterly thereafter. The Director of</p> <p>Pg7</p> <p>Nursing or designee will review resident record on next business day to verify physician notification, treatment order obtained and skin issue is properly documented.</p> <p>4. Wellness Director will monitor for the above stated concerns weekly for 6 weeks, then bi-monthly for 6 weeks, and monthly for 3 months. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>5. Systemic changes will be completed by August 22, 2014.</p>	

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	<p>A physician's order dated 5-27-2014 indicated Resident #R was to receive Lovenox (an anticoagulant) 40 milligrams (mg) daily.</p> <p>A further review of physician's orders indicated on 6-19-2014 to discontinue the Lovenox use.</p> <p>A review of Resident #R's Medication Administration Record dated June 2014 indicated the Lovenox had been given as ordered on June 1st through the 10th. The MAR further indicated the doses on the dates of June 11th through the 19th had been circled. A review of the back of the MAR did not indicate why the medication had not been given.</p> <p>A review of Nurse's notes dated 6-11 through 6-19-2104 did not indicate why the medication Lovenox had not been given.</p> <p>A review of physician progress notes did not indicate why the Lovenox had not been given.</p> <p>In an interview on 7-9-2014 at 2:10 PM, the DON indicated there was no reason to her knowledge the Lovenox had not been given. The DON further indicated the physician should have been notified if the medication was unable to be given more</p>			

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	<p>than 3 days in a row.</p> <p>A current policy titled Missed medication reporting dated 12-31-2013 provided by the Corporate Nurse on 7-9-2014 at 10:23 AM indicated " DON/ Designee will notify the physician of any repeated and/or consistently missed/ refused medications. "</p> <p>6. Resident #Q's record was reviewed on 7-8-2014 at 10:28 AM. Resident #Q's diagnoses included but were not limited to: dementia, Chronic lung disease, and heart disease.</p> <p>Nurse's notes dated 5-6-2014 at 4:45 PM, indicated Resident #Q was found sitting on the floor. The note further indicated Resident #Q was walking without her walker and fell while turning. There was no indication an assessment had been completed after the fall.</p> <p>In an interview on 7-8-2014 at 2:15 PM, LPN #1 indicated an assessment had been completed, but was not documented in the Nurse's notes, because the assessment was documented on the incident report. LPN #1 further indicated the assessment of the resident should have been documented in the Nurse's notes.</p> <p>A review of the incident report dated</p>			

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

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	5-6-2014 indicated there were no signs or symptoms of injury.  This State tag relates to Complaint IN00150605.				