

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/27/2016
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NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 20, 21, 22, 23, 24 and 27, 2016.</p> <p>Facility number: 000181 Provider number: 155283 AIM number: 100266860</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 1 Medicaid: 24 Other: 8 Total: 33</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 6/28/16.</p>	F 0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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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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F 0221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to the use of a seat belt for 1 of 3 residents reviewed for physical restraints. (Resident #20)</p> <p>Finding includes:</p> <p>On 6/20/16 at 12:21 p.m., Resident #20 was observed sitting in a wheelchair by the Nurses' station. At that time, the resident was observed with a seat belt fastened around her waist. The resident was not observed leaning sideways, slouching or leaning forward. The resident made no attempts to self transfer or to ambulate by herself.</p> <p>On 6/22/16 at 9:01 a.m., the resident was observed sitting in a wheelchair by the Nurses' station, next to a staff member. At that time, the resident was observed</p>	F 0221	<p>F221</p> <p><b>1.Whatcorrective actions will be accomplished for those Residents found to have beenaffected by the deficient practice?</b></p> <p>Resident # 20's restraint assessment andplan of care has been updated. Resident 20's physician been has been informedof the results of the assessment and of the IDT's recommendation for areduction of the restraint. The physician has approved the reduction plan. Resident #20 will use a pummel cushion whilein the wheelchair and seatbelt has been discontinued.</p> <p><b>1.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</b></p> <p>Although none ofthe residents were adversely impacted by the alleged</p>	07/27/2016			

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	<p>with a seat belt fastened around her waist. The resident was not observed leaning sideways, slouching or leaning forward. The resident made no attempts to self transfer or to ambulate by herself.</p> <p>On 6/27/16 at 9:15 a.m., Resident #20 was unable to release the seat belt on command hen asked by Nurse Consultant #1.</p> <p>The record for Resident #20 was reviewed on 6/22/16 at 9:39 a.m. The resident's diagnoses included, but were not limited to, anxiety, depression, and delusional disorder.</p> <p>The current and updated plan of care dated 11/16/15, indicated the resident had a physical restraint, a seat belt. The Nursing Intervention was to review the restraint at least quarterly.</p> <p>Physician Orders with an original date of 8/15/14 and listed on the current Physician Order Summary (POS), indicated, self release belt to wheelchair and check placement and function every shift.</p> <p>The most recent restraint evaluation review dated 1/6/16, indicated the reason for the physical restraint was due to dementia, poor safety, and multiple falls.</p>		<p>deficient practice, all residents have the potential to be affected. All residents with a current restraint in use were reviewed by the IDT. The IDT reviewed each individual for the potential for reduction and to ensure that the device is the least restrictive device and remains necessary to treat the resident's medical symptoms. Each of the residents quarterly assessments were reviewed by the Director of Nursing to ensure that each has been updated.</p> <p><b>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>A nursing in-service has been scheduled to include content regarding the use of restraints. The IDT has also been re-educated on completion of restraint assessments routinely and the need to routinely consider the potential for restraint reduction for any resident using a restraint. A monitoring tool will be utilized to ensure that each resident that is currently using a restraint is assessed as per frequency mandated in the state rule by the IDT and reductions are considered and implemented as appropriate.</p> <p><b>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p>		

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	<p>Review of the Nurse's Notes from 4/6/16 through 6/12/16, indicated the resident fell three times, one of which occurred while the seat belt restraint was applied to the resident in her wheelchair.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 4/19/16, indicated the resident was cognitively impaired and a one person assist with bed mobility, transfers, locomotion, toilet use, dressing and personal hygiene. The MDS further indicated the resident was always incontinent of urine and was not on a toileting program.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 6/22/16 at 10:35 a.m., indicated the quarterly assessment for the physical restraint was missed.</p> <p>Interview with the DON (Director of Nursing) on 6/22/16 at 11:12 a.m., indicated the resident was a 1-2 person assist with ADL's (Activities of Daily Living) and had a seat belt restraint due to attempts to get up unassisted. The DON further indicated the resident was in need of a quarterly restraint evaluation and a reduction of the seat belt usage due to the resident's behaviors having stabilized.</p>		<p>The DON or designee will be responsible for reviewing the assessments and completing the monitoring form on scheduled workdays as follows: weekly for two weeks, then bi-weekly for two months then monthly thereafter to ensure that each resident with a restraint is properly assessed and a reduction program is being considered and implemented as appropriate. The DON or designee will also be responsible to ensure that all resident assessments are completed routinely as per facility policy. Should a concern be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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F 0223 SS=D Bldg. 00	<p>The policy titled "Restraint Use (Physical)" was provided by the DON on 6/22/16 a 11:11 a.m. This current policy indicated, "Purpose: to enhance resident quality of life by attempting to protect the resident and/or assist the resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being...The facility prohibits the use of restraints for the purpose of discipline or convenience...."</p> <p>3.1-3(w)</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from abuse related to a substantiated allegation of verbal abuse for 1 of 3 abuse allegations reviewed and 1 of 3 residents reviewed for abuse. (Resident #50)</p>	F 0223	F223  <b>1.Whatcorrective actions will be accomplished for those Residents found to have beenaffected by the deficient practice?</b>  RN #2 was terminated at	07/27/2016			

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	<p>Finding includes:</p> <p>The closed record for Resident #50 was reviewed on 6/21/16 at 3:27 p.m. The resident's diagnoses included, but were not limited to, right hip fracture and hypertension.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 4/26/16, indicated the resident was cognitively intact.</p> <p>Review of an incident investigation dated 5/31/16 at 10:15 a.m., indicated Resident #50 had reported to the Administrator that the previous night RN #2 "had it out for him", was yelling in the dining room at him about personal things, flipped him off, and said 'F' you twice.</p> <p>The written investigation further indicated RN #2 was not working at the time the allegation was reported to the Administrator. The Administrator interviewed RN #2 via telephone on 5/31/16 at 1:00 p.m. RN #2 indicated she had been angry and frustrated with Resident #50 and they had not been getting along. She indicated she felt the resident was harassing her and she had lost her temper with him. She further indicated that she had "said things to him</p>		<p>the conclusion of the facility investigation pertaining to the report given to the Administrator by Resident #50. An all staff in-service has been completed regarding abuse prohibition. Although resident #50 has since discharged, at the time of the event, Resident #50 was assessed and monitored for adverse outcomes related to the actions of RN #2. Resident #50 did not display any physical or mental anguish related to the event.</p> <p><b>1. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Although no further residents were negatively impacted, all residents have the potential to be affected. Resident interviews and observations were completed and no other reports of, or suspicion of, abuse was identified. All staff has received recent re-education regarding the facility abuse prohibition policies.</p> <p><b>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>The HFA or designee will be responsible for reviewing and investigating any reports of or allegation/suspicion of abuse.</p>	

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F 0282 SS=D Bldg. 00	<p>that she shouldn't have" and admitted that she had cursed at him.</p> <p>The written findings of the facility's investigation indicated the interview with RN #2 had substantiated part of Resident #50's concern. RN #2's employment was terminated at the time of the telephone conversation with the Administrator on 5/31/16.</p> <p>Interview with the Administrator on 6/24/16 at 2:10 p.m. indicated in his interview with RN #2 she had substantiated part of Resident #50's allegation. He indicated RN #2 had been terminated at the time of the interview.</p> <p>3.1-27(b)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>		<p>Should said allegation occur, as with this occurrence, the HFA or designee shall thoroughly investigate and respond appropriately as per facility policy. The facility staff has been educated on abuse prohibition policies and this education is provided on a routine and as needed basis.</p> <p><b>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The HFA or designee will be responsible for reviewing and immediately investigating any reports of oral allegation/suspicion of abuse. Should said allegation occur, as with this occurrence, the HFA or designee shall thoroughly investigate and respond appropriately as per facility policy. The facility staff has been educated on abuse prohibition policies and this education is provided on a routine and as needed basis. Should any concern be noted regarding abuse prohibition, immediate corrective action will occur. Any allegation of resident abuse and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to provide services in accordance with a resident's written plan of care related to sliding scale insulin administration, post dialysis assessments, and dialysis access site assessments for 2 of 18 residents whose plan of care was reviewed. The facility also failed to evaluate the use of a physical restraint for 1 of 3 residents reviewed for physical restraints and did not follow the Physicain's Order to assess a residents heart rate before administering a medication for 1 of 5 residents reviewed for unnecessary medications. (Residents #14, #39, and #20)</p> <p>Findings include:</p> <p>1. The record for Resident #14 was reviewed on 6/21/16 at 2:01 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and hypertension.</p> <p>Review of the June 2016 Physician Order Summary indicated an order for a post dialysis assessment every Monday, Wednesday, and Friday.</p> <p>Review of the Post Dialysis Assessment</p>	F 0282	<p>F282</p> <p><b>1.Whatcorrective actions will be accomplished for those Residents found to have beenaffected by the deficient practice?</b></p> <p>Resident #14 has been assessed including the dialysis access site and the physician has been updated regarding the findings of the assessment with no new orders at the time of this writing. Resident #9 was assessed for any blood sugar complications and no concerns were identified,however Resident #9's physician was given a general condition report and updated on recent blood sugars results with no changes. Resident # 20's restraint assessment and plan of care has been updated. Resident 20's physician has been informed of the results of the assessment and of the IDT's recommendation for a reduction of the restraint. The physician has approved the reduction plan. Resident #20 will use of a pummel cushion while in the wheelchair and seatbelt has been discontinued.</p> <p><b>1.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</b></p>	07/27/2016			

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	<p>forms indicated a post dialysis assessment had not been completed on 5/2/16, 5/4/16, 5/6/16, 5/9/16, and 5/13/16.</p> <p>Review of the Review of the Dialysis Treatment Data sheets from the Dialysis Center in the Dialysis Communication Binder indicated the resident had a left internal jugular dialysis catheter that was being used for dialysis treatments.</p> <p>Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) for May 2016 and June 2016, lacked documentation the dialysis access site had been assessed every shift.</p> <p>Review of the Progress Notes for May 2016 and June 2016 lacked documentation the dialysis access site had been assessed every shift or a post dialysis assessment had been completed on 5/2/16, 5/4/16, 5/6/16, 5/9/16, and 5/13/16.</p> <p>Resident #14 had a care plan for risk for complications related to hemodialysis. The nursing interventions included "...Observe site for redness and signs and symptoms of infection...complete an assessment of resident upon return from dialysis and document..."</p>		<p>Although none of the residents were adversely impacted by the alleged deficient practice, All residents have the potential to be affected. All residents plans of care were assessed and updated as necessary. The glucose monitoring flow sheets were reviewed and all discrepancies noted were properly addressed, and as needed, the Physician updated. There are currently no other residents receiving dialysis services. The IDT reviewed each individual using a restraint for the potential for reduction. Each resident was also reviewed to ensure that the device is the least restrictive device and remains necessary to treat the resident's medical symptoms. All of the residents quarterly assessments were reviewed by the Director of Nursing to ensure that each has been updated.</p> <p><b>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>A nursing in-service has been scheduled to include content regarding the proper use of restraints, obtaining blood sugars and administration of sliding scale insulin as ordered by the physician, and following physician orders related to blood sugars that fall outside of the call parameters. The in-service will also include content regarding</p>				

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	<p>Interview with RN #1 on 6/23/16 at 2:25pm indicated she usually checked the resident's vital signs and completed a mini head to toe assessment when the resident returned from dialysis. She indicated she thought the resident's dialysis access site was checked every morning.</p> <p>Interview with the Director of Nursing (DON) on 6/22/16 at 11:02 a.m. indicated she could not locate post dialysis assessments for 5/2/16, 5/4/16, 5/6/16, 5/9/16, and 5/13/16. She further indicated an assessment of the dialysis access site should have been done every shift at least to monitor for bleeding.</p> <p>2. The record for Resident #9 was reviewed on 6/22/16 at 9:33 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, esophagitis, and cerebrovascular accident.</p> <p>Review of the Physician's Recapitulation Orders, dated June 2016, indicated an order for sliding scale (insulin given per blood glucose test result) Humalog (insulin) three times per day, according to the following scale: 150-199 = 1 unit 200-249 = 2 units</p>		<p>assessment and documentation of residents receiving dialysis services. The IDT has also been re-educated on completion of restraint assessments and the need to routinely consider the potential for restraint reduction for any resident using a restraint. Monitoring tools will be utilized to:</p> <ol style="list-style-type: none"> <li>1.) ensure that each resident that is currently using a restraint is assessed routinely by the IDT and reductions are considered as appropriate.</li> <li>2.) Ensure that each resident with dialysis services are being properly assessed and the assessment properly documented on each dialysis visit and</li> <li>3.) All residents requiring blood sugar monitoring are being monitored as per physician order, obtaining the correct sliding scale dose as ordered, and the physician is notified if the resident falls outside of the call parameters per the resident's plan of care.</li> <li>4.) Ensure that all residents plan of care being followed.</li> </ol> <p><b>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> The DON or designee will be responsible for reviewing the assessments and completing the monitoring tools on scheduled work days as follows: Restraint Monitoring Tool- weekly for two weeks, then bi-weekly for two months then monthly thereafter to ensure that each resident with a</p>		

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	<p>250-300 = 3 units 301-349 = 4 units 350-400 = 5 units &gt; (greater than) 400 = 6 units and call Physician</p> <p>The Medication Administration Record (MAR) dated May 2016 indicated the resident's blood glucose test result on 5/2/16 at 5:00 p.m. was 152 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/10/16 at 5:00 p.m. was 151 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/12/16 at 5:00 p.m. was 191 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/14/16 at 7:00 a.m. was 164 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/17/16 at 5:00 p.m. was 181 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/18/16 at 5:00 p.m. was 169 and no insulin was given. The resident should have received 1 unit of insulin.</p> <p>Interview with the Director of Nursing</p>		<p>restraint is properly assessed and a reduction program is being considered as appropriate. The DON or designee will also be responsible to ensure that all resident assessments are completed routinely as per facility policy. Should a concern be noted, immediate corrective action will occur. Blood Sugar Monitoring Tool- daily for two weeks and then weekly for one month and then monthly thereafter to ensure that each resident blood sugar is monitored as ordered and the proper sliding scale insulin is administered, and the physician notified of any blood sugars that fall outside of the call parameters. Should a concern be noted, immediate corrective action will occur. Dialysis Monitoring Tool- daily for two weeks and then weekly for one month and then monthly thereafter to ensure that each resident receiving dialysis is properly assessed on each treatment and the assessment is properly documented.. Should a concern be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated. Monitoring to ensure all plans of care followed shall be completed weekly for one month then bi-weekly for a month and then</p>		

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	<p>(DON) on 6/22/16 at 2:55 p.m. indicated she could not find any further documentation of the insulin administration in the Nurse's Notes and the insulin had not been administered as ordered.3. On 6/20/16 at 12:21 p.m., Resident #20 was observed sitting in a wheelchair by the Nurses' station. At that time, the resident was observed with a seat belt fastened around her waist. The resident was not observed leaning sideways, slouching or leaning forward. The resident made no attempts to self transfer or to ambulate by herself.</p> <p>On 6/22/16 at 9:01 a.m., the resident was observed sitting in a wheelchair by the Nurses' station, next to a staff member. At that time, the resident was observed with a seat belt fastened around her waist. The resident was not observed leaning sideways, slouching or leaning forward. The resident made no attempts to self transfer or to ambulate by herself.</p> <p>On 6/27/16 at 9:15 a.m., the resident was unable to release the seat belt on command when asked by Nurse Consultant #1.</p> <p>The record review for Resident #20 was reviewed on 6/22/16 at 9:39 a.m. The resident's diagnoses included, but were not limited to, anxiety, hypertension</p>		monthly thereafter to ensure that each resident plan of care followed.	

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	<p>(high blood pressure), depression, and delusional disorder.</p> <p>The current and updated plan of care 11/16/15, indicated the resident had a physical restraint, a seat belt. The Nursing Intervention was to review the restraint at least quarterly.</p> <p>Physician Orders with an original date of 8/15/14 and on the current Physician Order Summary (POS), indicated self release belt to wheelchair and check placement and function every shift.</p> <p>The most recent restraint evaluation review dated 1/6/16, indicated the reason for the physical restraint was due to dementia, poor safety, and multiple falls.</p> <p>Review of the Nurse's Notes from 4/6/16 through 6/12/16, indicated the resident fell three times, once being while the seat belt restraint was applied to the resident in her wheelchair.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 4/19/16, indicated the resident was cognitively impaired and a one person assist with bed mobility, transfers, locomotion, toilet use, dressing and personal hygiene. The MDS further indicated the resident was always incontinent of urine and was not on a</p>			

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	<p>toileting program.</p> <p>Interview with the ADON (Assistant Director of Nursing on 6/22/16 at 10:35 a.m., indicated the quarterly assessment for the physical restraint was missed.</p> <p>Interview with the DON (Director of Nursing) on 6/22/16 at 11:12 a.m., indicated the resident was a 1-2 person assist with ADL's (Activities of Daily Living) and had a seat belt restraint due to attempts to get up unassisted. The DON further indicated the resident was in need of a quarterly restraint evaluation and a reduction of the seat belt use due to the resident's behaviors having stabilized.</p> <p>4. The record review for Resident #20 was reviewed on 6/22/16 at 9:39 a.m. The resident's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), depression, and delusional disorder.</p> <p>Review of the Physician's Order dated 6/3/16, indicated to notify the Physician if the resident's heart was below 50 before the administration of metoprolol tartate (blood pressure reducing medication) 25 mg (milligrams) twice a day.</p> <p>Review of the June 2016 Medication</p>			

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F 0309 SS=D Bldg. 00	<p>Administration Record (MAR), indicated metoprolol tartate was given at 8:00 a.m. and 8:00 p.m. daily with no heart rate recorded, except on 6/4/16 and on 6/11/16 at 8:00 a.m., for which the heart rate was above 50.</p> <p>Interview with the Director of Nursing (DON) on 6/23/16 at 10:13 a.m., indicated the heart rate was not being monitored as per the Physician's Order for metoprolol tartate.</p> <p>3.1-3(w) 3.1-35 (g)(2)</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. Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to assessment of the dialysis access site and post dialysis assessments for 1 of 1 residents reviewed</p>	F 0309	<p>F309</p> <p><b>1. What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</b></p>	07/27/2016			

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	<p>for dialysis of the 1 resident who met the criteria for dialysis. (Resident #14)</p> <p>Finding includes:</p> <p>The record for Resident #14 was reviewed on 6/21/16 at 2:01 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease and hypertension.</p> <p>Review of the June 2016 Physician Order Summary indicated an order for a post dialysis assessment every Monday, Wednesday, and Friday.</p> <p>Review of the Post Dialysis Assessment forms indicated a post dialysis assessment had not been completed on 5/2/16, 5/4/16, 5/6/16, 5/9/16, and 5/13/16.</p> <p>Review of the Dialysis Treatment Data sheets from the Dialysis Center in the Dialysis Communication Binder indicated the resident had a left internal jugular dialysis catheter that was being used for dialysis treatments.</p> <p>Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) for May 2016 and June 2016, lacked documentation the dialysis access site</p>		<p>Resident #14 dialysis orders and care plan have been reviewed. Resident #14 has been assessed, including the dialysis access site. No concerns were identified with the assessment. The physician has been updated regarding the findings of the assessment with no changes in the orders as they pertain to dialysis at the time of this writing.</p> <p><b>1. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Although none of the residents were adversely impacted by the alleged deficient practice, residents receiving dialysis, have the potential to be affected. The facility currently does not have any other residents receiving dialysis services. A nursing in-service has been scheduled to include content regarding proper assessment and documentation regarding residents receiving dialysis services.</p> <p><b>2. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>A nursing in-service has been scheduled to include content</p>		

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	<p>had been assessed every shift.</p> <p>Review of the Progress Notes for May 2016 and June 2016, lacked documentation the dialysis access site had been assessed every shift or a post dialysis assessment had been completed on 5/2/16, 5/4/16, 5/6/16, 5/9/16, and 5/13/16.</p> <p>Resident #14 had a care plan for risk for complications related to hemodialysis. The nursing interventions included "...Observe site for redness and signs and symptoms of infection...complete an assessment of resident upon return from dialysis and document..."</p> <p>Interview with RN #1 on 6/23/16 at 2:25 p.m. indicated she usually checked the resident's vital signs and completed a mini head to toe assessment when the resident returned from dialysis. She indicated she thought the resident's dialysis access site was checked every morning.</p> <p>Interview with the Director of Nursing (DON) on 6/22/16 at 11:02 a.m. indicated she could not locate post dialysis assessments for 5/2/16, 5/4/16, 5/6/16, 5/9/16, and 5/13/16. She further indicated an assessment of the dialysis access site should have been done every</p>		<p>regarding proper assessment and documentation regarding residents receiving dialysis services. A Monitoring tool will be utilized to: ensure that each resident with dialysis services is being properly assessed and the assessment properly documented on each dialysis visit.</p> <p><b>3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The DON or designee will be responsible for reviewing the assessments and completing the monitoring tools on scheduled work days as follows: daily for two weeks and then weekly for one month and then monthly thereafter to ensure that each resident receiving dialysis is properly assessed on each treatment and the assessment is properly documented. . Should a concern be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>				

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F 0325 SS=D Bldg. 00	<p>shift at least to monitor for bleeding.</p> <p>A facility policy, titled Dialysis Coordination/Facility Services, dated 10/2014, and received from the DON as current on 6/22/16, indicated "...3. Upon return from dialysis, resident's access site and physical status shall be evaluated by licensed nurse with evaluation documented...7. Licensed nursing personnel will monitor the resident with a shunt/access or central line utilized for dialysis every shift ...If a central line is in place, presence of closed clamps in place shall be denoted...The following should be addressed on the Treatment Administration Record every shift of the resident on dialysis who has a central line in place: Dressing dry and intact, clamps present/closed."</p> <p>3.1-37(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is</p>			

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	<p>a nutritional problem.</p> <p>Based on record review and interview, the facility failed to notify the Registered Dietitian of a significant weight loss in a timely manner for 1 of 4 residents reviewed for nutrition of the 9 residents who met the criteria for nutrition and 1 who met the criteria for dialysis. (Resident #2)</p> <p>Finding includes:</p> <p>The closed record for Resident #2 was reviewed on 6/21/16 at 2:44 p.m. The resident's diagnoses included, but were not limited to diabetes mellitus, chronic kidney disease, cellulite (fluid in tissue) of right lower limb, dementia and heart failure.</p> <p>Review of the resident's weights indicated on 2/8/16, the resident was 211 pounds and on 3/9/16 was 198 pounds, indicating a 13 pound weight loss in a month.</p> <p>Review of the Nurse Notes from 2/8/16 through 3/24/16, lacked documentation the Registered Dietician (RD) had been made aware of the significant weight loss.</p> <p>Review of the "RD Nutritional Assessment" dated 3/24/16, indicated</p>	F 0325	<p>F325</p> <p><b>1.) What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice?</b></p> <p>Resident #2 has been discharged. A nursing staff in-service has been scheduled to include content regarding notification of the RD of weight loss, and proper documentation of food consumption.</p> <p><b>2.) How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Although no further residents were negatively impacted by the alleged deficient practice all residents have the potential to be affected. All resident weights will be reviewed. Any significant weight changes will be reported to the RD, as well as the physician. The food consumption records will be reviewed to ensure that each resident meal intakes are documented consistently with each meal.</p> <p><b>1. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p>	07/27/2016			

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	<p>mighty shakes were being ordered twice a day due to the resident's significant weight loss and a care plan for alteration in nutritional status was initiated.</p> <p>Review of the "Meal Consumption" log for February 2016 lacked any intake documentation for the following dates: 2/11/16 breakfast and lunch 2/13/16 breakfast 2/14/16 breakfast and lunch 2/16/16 lunch 2/23/16 lunch 2/24/16 breakfast and lunch 2/26/16 lunch 2/27/16 lunch 2/28/16 breakfast and lunch 2/29/16 breakfast and lunch</p> <p>Interview on 6/23/16 at 2:11 p.m. with the Director of Nursing (DON), indicated the CNAs weighed the residents, reported the weight to the Nurse, then the Assistant Director of Nursing (ADON) reviewed the weights and monitored if needed.</p> <p>Interview with the ADON on 6/23/16 at 2:24 p.m., indicated the resident's weights were compared from month to month, then SWAT (a nutritional monitoring program) was initiated for weight loss or weight gain. The ADON further indicated Resident #2's weight</p>		<p>Anursing in-service has been scheduled to include content regarding the facility policy pertaining to notification of the RD of significant weight changes. Their service will also include information regarding completion of documentation related to resident food intake. A monitoring tool will be implemented to ensure that the RD is notified of significant weight changes and the meal consumption records are completed per facility policy.</p> <p><b>2. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The DON or designee will be responsible for reviewing and monitoring significant weight changes to ensure that the weight changes are reported to the RD in a timely manner. The DON or designee will also be responsible to ensure that the meal consumption records are completed as per facility policy. The monitoring tool will be utilized and completed on scheduled work days as follows: weekly for one month and then monthly thereafter to ensure that each resident with a significant weight change is reported to the RD for review and the meal consumption records are completed as per facility policy. Should a concern</p>	

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	<p>loss was missed and should have been reported to the RD and followed in SWAT.</p> <p>Interview with the RD on 6/23/16 at 1:39 p.m., indicated the weights were reviewed every two weeks and Resident #2 had not been weighed until 3/9/16. The RD indicated she was not notified of the significant weight loss on 3/9/16. The RD further indicated the Dietary Manager was new to the position and had not been trained by the RD.</p> <p>The policy titled " Using the Registered Dietitian Referral Form" was provided by the RD on 6/23/16 at 2:07 p.m. This current policy indicated, " Policy: It is the policy of the Dietary Department that the Dietary Manager and members of the Nursing Staff will "flag" residents for the RD to review...5. Residents should be flagged on the RD Referral Form for the following issues:...d. Significant Weight Changes...."</p> <p>3.1-46(a)(1)</p>		<p>be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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F 0329 SS=D Bldg. 00	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure sliding scale insulin (insulin given per blood glucose test result) was administered as ordered and a heart rate was assessed before the administration of a medication for 2 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications. (Residents #39 and #20)</p> <p>Findings include:</p>	F 0329	<p>F329</p> <p><b>1.Whatcorrective actions will be accomplished for those Residents found to have beenaffected by the deficient practice?</b></p> <p>Resident #9 wasassessed for any potential blood sugar complications and no concerns were identified,however Resident #9's physician was given a general condition report andupdated on recent blood sugars results with no changes. Resident #20 andResident #39</p>	07/27/2016	

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	<p>1. The record for Resident #9 was reviewed on 6/22/16 at 9:33 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, esophagitis, and cerebrovascular accident.</p> <p>Review of the Physician's Recapitulation Orders, dated June 2016, indicated an order for sliding scale (insulin given per blood glucose test result) Humalog (insulin) three times per day, according to the following scale: 150-199 = 1 unit 200-249 = 2 units 250-300 = 3 units 301-349 = 4 units 350-400 = 5 units &gt; (greater than) 400 = 6 units and call Physician</p> <p>The Medication Administration Record (MAR) dated May 2016 indicated the resident's blood glucose test result on 5/2/16 at 5:00 p.m. was 152 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/10/16 at 5:00 p.m. was 151 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/12/16 at 5:00 p.m. was 191 and no insulin was given. The resident should</p>		<p>were assessed for any potential complications related to bloodpressure and pulse and no concerns were identified, however the physician hasbeen given a general condition report and updated on the recent blood pressureand pulse results for Resident #20 and #39.</p> <p><b>2.Howother Residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken?</b></p> <p>Although nofurther residents were negatively impacted by the alleged deficient practice,all residents have the potential to be affected. The Medication AdministrationRecords were reviewed with focus on any resident with ordered pulse and bloodpressure monitoring and blood sugar monitoring. Any residents with discrepancies identified were assessed and thephysician updated.</p> <p><b>1.Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur.</b></p> <p>Anursing in-service has been scheduled to include content regarding the facilitypolicy pertaining to obtaining blood pressures and pulse as ordered by thephysician. The in-service</p>		

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	<p>have received 1 unit of insulin. The resident's blood glucose test result on 5/14/16 at 7:00 a.m. was 164 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/17/16 at 5:00 p.m. was 181 and no insulin was given. The resident should have received 1 unit of insulin. The resident's blood glucose test result on 5/18/16 at 5:00 p.m. was 169 and no insulin was given. The resident should have received 1 unit of insulin.</p> <p>Interview with the Director of Nursing (DON) on 6/22/16 at 2:55 p.m. indicated she could not find any documentation of the insulin administration in the Nurse's Notes and the insulin had not been administered as ordered.</p> <p>2. The record for Resident #20 was reviewed on 6/22/16 at 9:39 a.m. The resident's diagnoses included, but were not limited to, anxiety, hypertension (high blood pressure), depression, and delusional disorder.</p> <p>Review of the Physician's Order dated 6/3/16, indicated to notify the Physician if the resident's heart was below 50 before the administration of metoprolol tartate (blood pressure reducing medication) 25 mg (milligrams) twice a day.</p>		<p>will also include information regarding completing blood sugar monitoring and administration of sliding scale insulin. Their in-service will also include content regarding physician notification as it relates to call/hold parameters on certain medications as well as insulin. A monitoring tool will be implemented to ensure that the nursing staff is obtaining blood sugars, pulses, and blood pressures as ordered and the physician is notified if the resident falls outside of the call parameters.</p> <p><b>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The DON or designee will be responsible for reviewing the medication administration records and blood sugar monitoring forms. The DON or designee will complete the monitoring tools on scheduled work days as follows: daily for two weeks and then weekly for one month and then monthly thereafter to ensure that each resident with orders for blood pressure and pulse monitoring, and blood sugar monitoring are being completed as ordered and the physician is properly informed if the resident falls outside of the call parameters. Should a concern be noted,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/27/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
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	<p>Review of the June 2016 Medication Administration Record (MAR), indicated metoprolol tartate was given at 8:00 a.m. and 8:00 p.m. with no heart rate recorded, except on 6/4/16 and on 6/11/16 at 8:00 a.m., for which the heart rate was above 50.</p> <p>Interview with the Director of Nursing (DON) on 6/23/16 at 10:13 a.m., indicated the heart rate was not being monitored as per the Physician's Order for metoprolol tartate.</p> <p>The policy titled "Physician Orders" was provided by the DON on 6/23/16 at 10:21 a.m. This current policy indicated, "...5. Transcribe new order onto MAR or TAR (Treatment Administration Record), as indicated. Ensure any follow through is completed...8. Make sure a notation on the 24-hour condition report to ensure new order information is communicated to oncoming shift..."</p> <p>3.1-48(a)(6)</p>		<p>immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		