

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 09/08/2011	
NAME OF PROVIDER OR SUPPLIER KEEPSAKE VILLAGE OF COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2564 FOXPOINTE DR COLUMBUS, IN47201			
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: September 6, 7, and 8, 2011</p> <p>Facility number: 010680 Provider number: 010680 AIM number: N/A</p> <p>Survey Team: Janie Faulkner, RN-TC Diana Sidell, RN Cheryl Fielden, RN Jill Ross, RN</p> <p>Census bed type: Residential 32 Total 32</p> <p>Census Payor type: Other 32 Total 32</p> <p>Residential sample: 7 Supplemental sample: 1</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review 9/13/11 by Suzanne Williams, RN</p>			R0000	<p>Submission and implementation of this plan of correction shall not constitute an admission by Keepsake Village of Columbus to any allegations or conclusions within the survey report. Rather, this plan of correction is submitted for compliance with State and Federal rules.</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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R0117	<p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure there was at least one first aid certified employee awake and present in the facility at all times. This deficient practice had the potential to affect all 32 residents in the building. This occurred 9 of 27 days reviewed for presence of staff trained in First Aid and CPR [cardiopulmonary resuscitation].</p> <p>Findings included:</p> <p>Review of the lists of CPR and First Aid</p>	R0117	All current licensed L.P.N.s shall be certified in first aid for residents affected. All newly hired L.P.N.s shall receive first aid training during new employee orientation, and shall not work on the floor with the residents until that training is complete. First Aid training is good for three years; however, Keepsake Village reviewed policy and procedure for training and have mandated that all LPN's will receive First Aid training every two years to be done in conjunction with CPR training to ensure compliance. Director of Nursing will monitor all	09/30/2011	

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	<p>certified employees provided by the ADON [Assistant Director of Nursing] on 9/8/2011, indicated the facility had 8 CPR and 14 First Aid certified employees. Review of employee work schedules from August 13, 2011 through September 8, 2011, indicated there was no First Aid certified employee on the following days and shifts: August 5, 2011 night shift, August 19, 2011 evening and night shifts, August 20, 2011 night shift, August 21, 2011 night shift, August 25, 2011 night shift, August 29, 2011 night shift, September 3, 2011 night shift, September 4, 2011 night shift, September 8, 2011 night shift. This totaled 9 night shifts and 1 evening shift without a First Aid certified employee present in the building.</p> <p>Interview with the Administrator at 4:45 P.M. on 9/8/2011, indicated there was not a first aid certified employee at the facility at all times. She stated, "I am going to require every new staff member to get their first aid and CPR certifications on or before hire."</p>		<p>certifications and ensure that all L.P.N.s are current in their certifications via nursing log. Systemic changes will be completed by 9/30/2011.</p>	

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R0123	<p>(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <p>(1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation.</p> <p>Based on record review and interview, the facility failed to maintain complete and accurate personnel records related to reference checks and employee job description signatures, for 2 of 5 employee files reviewed (#3, #4).</p> <p>Findings included:</p> <p>Review of Employee #3/Housekeeping employee file on 9/8/2011 at 11:00 A.M., indicated 2 pages titled "Confidential Reference Request" with no applicant signature and no date on either page for the authorization of release of information requested on this confidential reference request. There was a signature and date of</p>	R0123	Employee # 3 completed new reference request and signed and dated two new forms. Two new reference checks were completed for this employee. Employee # 4 was given a new job description form and signed and completed the form. Business Office Manager will institute a new form to check all new employee paperwork to ensure that all paperwork is signed and completed accurately by all employees(see Exhibit A). Audits were completed on all current employee files to ensure all signatures and job descriptions were complete and accurate. Business Office Manager will monitor new form and ensure deficient practice does not	09/30/2011	

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R0241	<p>8/11/11 in the "Reference checked by" section.</p> <p>Review of Employee #4/CNA employee file on 9/8/2011 at 11:30 A.M., indicated a job description signed and dated 7/29/2011, by the DON (Director of Nursing) instead of Employee #2/CNA on date of hire. During interview with the DON on 9/8/2011 at 4:30 P.M., she stated, "I messed that one up; I will have the employee sign a new job description form."</p> <p>(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 observation, record review, and interview, the facility failed to administer medications as ordered by the physician, in that 1 resident was given Colace (stool softener) in a once a day dose instead of the physician's ordered twice a day dose, and 1 resident was given incorrect doses of an acid reducer and calcium supplement. This affected 2 of 7 residents observed during 1 of 2 medication administration observations. (Residents #7 and 25)</p>			R0241	<p>recur.Systemic changes will be completed by 9/30/2011.</p> <p>Resident #7 Medication Administration Record was updated per nursing to indicate Colace be given twice a day, per physician's order. M.D. notified of medication error and family notified as well, per policy. No signs or symptoms of distress noted for the resident due to medication error.Resident # 25's medications were purchased in the correct doseages. Family and M.D. notified of the medication errors. Family was instructed to bring in proper medications, with correct doseages. Nursing staff to be inserviced on medication</p>		09/30/2011

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	<p>Findings include:</p> <p>1. During a medication administration observation on 9/7/11 at 8:20 a.m., LPN #1 was observed pouring Resident #7's medications. The order for Colace on the Medication Administration Record (MAR) indicated Colace 100 milligrams by mouth twice a day was to be given. The time on the MAR for the Colace administration was 8:00 a.m. with no time listed for the second dose. There was no documentation on the MAR that indicated the second dose of Colace had been given between 9/1/11 and 9/6/11.</p> <p>On 9/7/11 at 9:01 a.m., LPN #1 indicated she would have to "check on it" to see what the order should be.</p> <p>On 9/7/11 at 9:30 a.m., review of Resident #7's MARs for 8/2011 indicated documentation Colace had been given once daily every day for the 31 days in August, instead of the physician's ordered twice a day.</p> <p>Physician's recapitulation orders dated 9/2011 indicated an order for Colace, one by mouth twice a day, with a start date of 5/26/2011.</p> <p>On 9/8/11 at 10:30 a.m. the Director of Nurses (DON) indicated she had reported</p>				<p>administration and to check and log in all medications and labels, making sure that medications are the right doseages. For both residents #7 & 25, staff will be inserviced on following physician's orders and proper transcription of the orders to the re-writes and medication administration record. For all residents who have the potential to be affected, the medication administration record (MAR)/re-writes will be checked and double-checked (See Exhibit B) for accuracy by two licensed staff persons who will sign and initial for accuracy on the MAR/re-writes. Staff will also be inserviced on medication administration, following M.D. orders, and proper transcription of orders to the MAR/re-writes. Inservice shall also include checking all medications that families provide for proper doseages and accuracy of medications. Facility will adopt new practice of checking and double-checking medications for accuracy by two licensed nurses. On the medication log that families sign when providing medications, we will also add a column to the log that the nurse has to initial that indicates the correct medication and correct dose were provided. (See Exhibit C). Director of Nursing will monitor systemic changes and review MAR/re-writes monthly to ensure changes are completed and</p>		

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	<p>the medication error to the physician and provided this faxed document: "Due to med error [Resident #7's name] only received 1 Colace (100 mg) q (every) day instead of 2. He has not c/o (complained of) any constipation. He is now receiving it per order of BID (twice a day)."</p> <p>2. During the medication administration observation on 9/7/11 at 9:15 a.m., LPN #1 was observed pouring Resident #25's medications. An order on the MAR indicated an acid reducer 75 milligrams, one by mouth every day. When the LPN selected the pill, the milligram dose on the over the counter bottle was 10 milligrams and the bottle had no pharmacy label. When LPN #1 selected the calcium carbonate, the milligram dose on the MAR indicated 600 milligrams by mouth, twice a day. The milligram dosage on the bottle was 500 milligrams, and the bottle had no pharmacy label.</p> <p>On 9/7/11 at 9:01 a.m., LPN #1 indicated these two medications had an incorrect dose, and that she would have to "check on it" to see what the order should be. LPN #1 did not give the acid reducer nor the calcium to Resident #25 at that time.</p> <p>Review of Resident #25's physician's recapitulation orders on 9/7/11 at 9:40 a.m. indicated an order for acid reducer 75</p>		<p>efficient. She will also QA system monthly in QA meeting to determine how well the process is going. She will also bring medication log to QA for review as well to ensure practices are being followed. Systemic changes will be completed by 9/30/11.</p>		

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	<p>milligrams, one tablet by mouth daily, and an order for calcium carbonate 600 milligrams, take one tablet by mouth twice daily.</p> <p>On 9/8/11 at 9:15 a.m., the Assistant Director of Nurses (ADON) indicated the family supplies this resident's medications, they had brought in a new bottle of acid reducer on 8/17/11 and that bottle was 10 milligrams instead of the physician's ordered 75 milligrams.</p> <p>On 9/8/11 at 10:30 a.m., the Director of Nurses (DON) indicated she had reported the medication error to the family and physician and provided a faxed document that included "Family brought in wrong type of Calcium and wrong dose of acid reducer so, from 8/4 until present time He received lower dose of acid reducer and wrong type of Calcium. Correct meds have been obtained."</p> <p>A policy and procedure for "PHYSICIAN ORDERS", with an effective date of 5/21/08, was provided by the ADON on 9/8/11 at 8:30 a.m. The policy included, but was not limited to: "1. Keepsake Village of Columbus must have proper physician's orders before providing assistance with any medication or treatment. Orders may be received from a physician in any of the formats outlined</p>						

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	<p>below...4. In the space labeled "orders", write down the complete order as given by the physician or his/her Nurse, including the medication name, date, route of administration, frequency, reason being given, time(s) of administration, strength, and number of tablets/capsules...." "NEW ORDERS...2. Record the order when it is received onto the resident's existing medication record in the next available space. If the order is a medication order, write the name of the medication, strength, amount, and route of administration, frequency, and reason for being taken...."</p> <p>On 9/8/11 at 10:35 a.m., the ADON provided a policy and procedure for "Administration: Medication Error", with an effective date of 2/21/08. The policy indicated, but was not limited to: Types of medication errors include: a. Incorrect medication b. Incorrect time c. Incorrect dose d. Incorrect route e. Incorrect resident f. Missed dose...Procedure: For incorrect medication, time, dose, or route, the person administering medications and treatments should: 1. Notify the nurse, Resident Director, Health Care Specialist or designee immediately and do not give and (sic) further medications until instructions are given by nurse based on the nurse's professional judgment or in consultation with the physician...."</p>						

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R0302	<p>(6) Over-the-counter medications must be identified with the following:</p> <p>(A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper labeling of three over the counter (OTC) medications found during 2 of 2 medication administration observations. This affected 2 of 7 residents observed during medication administration observations. (Residents #25 and #9)</p> <p>Findings include:</p> <p>1. During the medication administration observation on 9/7/11 at 9:15 a.m., LPN #1 was observed pouring Resident #25's medications. An order on the MAR indicated an acid reducer 75 mg (milligrams), one by mouth every day. When the LPN selected the pill, the milligram dose on the over the counter bottle indicated the medication was 10 milligrams and the bottle had an over the counter label with no information regarding the resident's name or instructions for use. When LPN #1</p>			R0302	<p>Resident #25 & #9 Over the Counter Medications were labeled with the resident's name, physician's name, expiration date, name of drug and strength per policy and regulations. All residents over the counter medications were also examined and proper labels made for all medications, that included the regulation and policy information for compliance. Facility will label all over the counter medications, (see Exhibit D) correctly and accurately. Labels will be completed by licensed nursing staff upon receipt of over the counter medications. Director of Nursing will provide labels and will monitor use weekly by checking medication log and inspection of over the counter medications in the medication cart. Systemic changes will be completed by 9/30/2011.</p>		09/30/2011

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	<p>selected the calcium carbonate, the milligram dose on the MAR indicated 600 milligrams by mouth, twice a day. The milligram dosage on the bottle indicated 500 milligrams, and the bottle had an over the counter label, with no information regarding the resident's name or instructions for use.</p> <p>2. During a medication administration observation on 9/8/11 at 8:37 a.m., LPN #2 was observed as she poured Resident # 9's medications. An order on the MAR indicated Calcium 600 mg with vitamin D 400 IU (international units). When the Calcium 600 milligrams with vitamin D 400 IU was poured, the medication was observed to be in an over the counter bottle that lacked a label with the resident's name or instructions for use.</p> <p>During the exit conference on 9/8/11 at 4:30 P.M., the Administrator indicated if a family brings in an over the counter medication, it usually isn't labeled by the pharmacy.</p> <p>On 9/8/11 at 11:55 a.m., the Administrator provided a policy for "Labeling" that had an effective date of 2/21/08. The policy indicated: "All medications and treatments (including over-the-counter and sample medications) should be labeled with the necessary information to</p>				

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R0349	<p>provide safe assistance procedures. The label should be consistent with a physician's order and with applicable regulatory requirements...."</p> <p>(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 record review and interview, the facility failed to maintain clinical records on each resident that were complete and accurately documented in that 1 resident failed to have BM (bowel movement) tracking records completed. This affected 1 of 7 residents reviewed for complete and accurate clinical records in a sample of 7. (Resident #7)</p> <p>Findings include:</p> <p>Resident #7's record was reviewed on 9/7/11 at 9:10 a.m. The record indicated Resident #7 was admitted with diagnoses that included, but were not limited to, diabetes mellitus, anxiety disorder, urinary incontinence, and bipolar disorder.</p> <p>An acuity assessment tool dated 8/9/11 indicated Resident #7 was independent</p>	R0349	Resident # 7 was provided with a calendar to assist staff with recording bowel movement records that are accurate. Certified nursing assistants and licensed nursing staff will be inserviced on the calendar and complete and accurate charting. To help identify other residents having the potential to be affected, facility will also address importance of complete and accurate charting via inservice to C.N.A's and licensed nurses. We have instituted a new policy and procedure that bowel movement tracking records will be checked daily by a licensed nurse. (See Exhibit E). Director of Nursing will monitor systemic changes via daily communications with nurses and weekly audits of the bowel movement tracking records. Systemic changes will be implemented by 9/30/2011.	09/30/2011			

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	<p>with communication and mobility, was incontinent of bladder, continent of bowel, and required no assistance to the bathroom.</p> <p>An abdominal imaging report from a local hospital dated 10/21/10 (prior to admission) indicated: "...There is mild to moderate colonic fecal retention compatible with constipation...with findings suggesting mild ileus. Early small bowel obstruction would remain in the differential with an ileus."</p> <p>Monthly resident BM tracking records for July 2011 indicated Resident #7 had no BMs documented between 7/10/11 and 7/16/11, for a total of 7 days, and no BMs documented between 7/22/11 and 7/31/11, for a total of 10 days.</p> <p>Monthly resident BM tracking records for August 2011 indicated no BMs documented between 8/8/11 and 8/17/11 for a total of 10 days, and between 8/28/11 and 8/31/11 for a total of 4 days.</p> <p>On 9/8/11 at 9:25 a.m., the Assistant Director of Nursing (ADON) indicated Resident #7 doesn't always let staff know when he has a BM and he occasionally gets mad or agitated with staff if they ask. She said he is a private person and this is a dignity issue for him.</p>				

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 09/08/2011
NAME OF PROVIDER OR SUPPLIER KEEPSAKE VILLAGE OF COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2564 FOXPOINTE DR COLUMBUS, IN47201		
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	<p>On 9/8/11 at 11:45 a.m., the Director of Nurses indicated they will also try a calendar in his bathroom and encourage him to write on the calendar to track his BMs and staff can monitor the calendar.</p> <p>During an interview on 9/8/11 at 11:07 a.m., Resident #7 indicated he has had no problems with his bowels since his abdominal surgery, and he has 3 or 4 BMs every week.</p> <p>On 9/8/11 at 8:20 a.m., the ADON provided a policy for complete and accurate records, titled "RESIDENT SERVICES DOCUMENTATION" that had a last review date of 2/27/11. The policy indicated, but was not limited to: "...When documenting in a resident's Chart, staff should remember that this documentation would be considered a legal document if brought into court of law. These guidelines should be followed when making entries in resident Chart...Be complete, making sure that everything significant to the resident's condition is recorded...."</p>				