

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  COUNTRY CHARM	STREET ADDRESS, CITY, STATE, ZIP CODE 3177 MERIDIAN PARKE DR GREENWOOD, IN 46142
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 7, 8, and 9, 2014</p> <p>Facility number: 011478 Provider number: 011478 AIM number: N/A</p> <p>Survey team: Patti Allen, SW-TC Marcy Smith, RN Dottie Plummer, RN Karyn Homan, RN</p> <p>Census bed type: Residential: 85 Total: 85</p> <p>Census payor type: Medicaid: 47 Other: 38 Total: 85</p> <p>Sample: 7</p> <p>These state findings are cited accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on July 16, 2014; by Kimberly Perigo, RN.</p>	R000000	<p>" This plan of correction is submitted as required under either or both State and Federal Law. The submission of this Plan of Correction on 7/23/14 does not constitute an admission of fault or liability to the government entity or any third party, on the part of Country Charm Community, as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis and the Community reserves its right to object to the admission of this Statement of Deficiency or the Plan of Correction under any other theory of law. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney,</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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R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited</p>		or shareholder of the Community or affiliated companies.				

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	<p>to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on interview and record review, the facility failed to ensure 4 of 10 employees reviewed received a completed Health Screening prior to having contact with the residents. (Certified Nurse Aide #02 &amp; #05, Housekeeper #08, Dietary aide #21)</p> <p>Findings include:</p> <p>Review of employee files on 7/7/14 at 2:00 p.m., indicated 4 of 10 employees had a health screening signed after their start date. The facility failed to acquire a completed health screening before employees began working with residents for 4 of 10 employees.</p> <p>1.) Certified Nurse Aide #02, Hire date of 11/26/13, had a health screen signed 12/23/13.</p> <p>2.) Certified Nurse Aide # 05, Hire date of 04/28/14, had a health screen signed 05/24/14.</p> <p>3.) Housekeeper # 08, Hire date of 03/31/14, had a health screen signed 10/23/13.</p> <p>4.) Dietary aide #21, Hire date of</p>	R000121	<p>1. The four employees' records were completed per state and company requirements.2. A new hire policy was created that requires the proper screening to include the following: TB testing, Background checks, excluded party check, physical health clearance, and drug test prior to hire and resident contact.3. The Executive Director's designee will be responsible for completion of all requirements prior to hire and resident contact which shall include a TB test, background check, drug test, physical health clearnace, excluded party check and reference checks. The Executive Director will check and sign off for approval for hire and resident contact.4. The Executive Director designee will conduct an orientation with all new hires prior to working independantly. That orientation will include: instruction for specialized population which will include dementia and aging instruction; review the facility policy manual and applicable procedures; first aid and emergency procedures; fire and disaster preparedness which include evacuation procedures; HIPPA regulation; and istruction relevant to the position of the new hire inregards to residnt care and services. Upon completion of orientatio nit will be reviewed by the Executive Director for</p>	07/09/2014			

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R000216	<p>06/01/14, had a health screen signed 06/23/14.</p> <p>Interview with the administrator on 07/08/14 at 4: 00 p.m., indicated the health screens were done before the employees started to work with the residents, the doctor is not there everyday so they wait for the 2 step ppd (tuberculin skin test) to be completed for the doctor to sign.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to ensure residents who had physician's orders to keep as needed medications in their rooms were assessed for their ability to self administrate these medications for 2 of 4 residents reviewed for having self administration evaluations in a sample of 7. (Residents #3 and #64)</p>			R000216	<p>approval of completion of orientation before the new hire works independently. 5. The Executive Director shall be responsible for continued compliance. The Executive Director shall make note of completion of all requirements and keep that information in the new hire binder. When completed, the Executive Director shall clear the employee for hire and contact with the residents and to work independently.</p> <p>1. The residents noted in the tag were reassessed according to regulation.2. All residents self-administering medication were assessed according to the regulation.3. A new form was created to use with the Community's quarterly assessment for all residents that self-administer. The Executive</p>		07/18/2014

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	<p>Findings include:</p> <p>1. The clinical record of Resident #3 was reviewed on 7/7/14 at 1:00 p.m. Diagnoses for the resident included, but were not limited to, arthritis, degenerative joint disease and memory loss. She was admitted to the facility on 1/3/12.</p> <p>A recapitulated physician's order for July, 2014, with an original date of 9/20/13, indicated Resident #14 could keep all her as needed (prn) and over the counter medications in her room. The nursing staff was to administer the rest of her medications.</p> <p>As needed medications ordered for Resident #3 included Tylenol, Miralax (a laxative), Robitussin, (a cough syrup) and Milk of Magnesia (a laxative).</p> <p>A Level of Service Assessment/Evaluation was completed for Resident #3 on 5/15/14. The evaluation indicated she could not remember or use information, her decision-making was severely impaired, and she was constantly confused or disoriented.</p> <p>A medication self-administration</p>		Director shall monitor monthly to ensure the new form is being used.4. The Director of Nursing is responsible for the on-going compliance with this regulation				

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	<p>assessment was done on Resident #3 at the time of her admission in 2012. No documentation was found in her record, which indicated a medication self-administration assessment had been done since her admission. On 7/7/14 at 2:30 p.m., the Director of Nursing indicated an evaluation of Resident #3 to assess her ability to administer her as needed medications had not been done since her admission. She indicated the self-administration assessment should have been done.</p> <p>2. Resident #64's clinical record was reviewed on 7/7/2014 at 11:30 a.m. Diagnoses included, but were not limited to, dementia (loss of brain function affecting memory, thinking, judgement and behaviors) and depression.</p> <p>Physician order dated 2/24/2013, indicated, "General Ophthalmic Drops [eye drops] instill 1 or 2 drops into affected eye as directed as needed *MKAB and SA* [may keep at bedside and self administer]."</p> <p>No assessment of Resident #64's ability to administer her own medications was found since 8/24/2012.</p> <p>On 7/8/2014 at 9:05 a.m., the DoN</p>			

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	<p>(Director of Nursing) indicated she was unable to locate a self medication administration assessment completed since 8/24/2012.</p> <p>On 7/8/2014 at 11:00 a.m., LPN #6 indicated Resident #64 does keep her eye drops in her room and self administers them when needed.</p> <p>Service plan dated 7/6/2014, assessed Resident #64 as, "... Periods of confusion.... forgetfulness often.... Decisions are poor, requiring cueing &amp; supervision, correcting daily routines.... Difficulty remembering/using information. Requiring daily cueing.... Difficulty understanding needs, but will cooperate if given direction or explanation...."</p> <p>On 7/8/2014 at 9:00 a.m., the Executive Director provided the Self Medication Policy, dated 6/1/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "All residents upon move in are required to have an assessment which includes self-medication...."</p> <p>The policy did not indicate that self medication assessments needed to be completed semi-annually or when a change of condition occurred.</p>			

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R000217	<p>On 7/8/2014 at 4:35 p.m., the DoN indicated the facility had not been completing self medication assessments semi-annually.</p> <p>On 7/8/2014 at 4:35 p.m., the Executive Director indicated the policy given was not a complete policy. The policy should include that self medication administration needs to be reevaluated every six months or if there is a change in the resident's condition. She continued to indicate the policy would be updated.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p>			

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	<p>(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.</p> <p>(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.</p> <p>(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, the facility failed to ensure the clinical record of a resident was complete and accurate regarding the resident's preference for Do Not Resuscitate (DNR) for 1 of 7 residents reviewed. (Resident #93)</p> <p>Findings include:</p> <p>The clinical record of Resident #93 was reviewed on 7/7/14 at 11:30 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hypertension, hypothyroidism, depression, and chronic obstructive lung disease (COPD).</p> <p>Resident #93 was admitted to the facility on 6/27/14. The History and Physical/Physician's Statement form signed and dated 5/30/14, for Resident #93 did not indicate a code status for the resident. The fields for code status, DNR</p>	R000217	<p>1. The resident's missing information was corrected. 2. All resident records were audited to ensure compliance with this regulation. 3. In-service training was conducted regarding the need for proper entrance forms which includes completed CPR preference and TB test with results or a chest x ray with results prior to a resident's move-in date. The in-service was held to ensure accurate resident information is received and documented before the time of move-in. 4. The Office Manager is responsible to assure that the paperwork is completed correctly prior to the Sales Director getting a move-in date for a resident. 5. The Executive Director will audit all move in documents for a period of three months to ensure follow-through with this correction.</p>	07/30/2014			

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	<p>and Full Code, were blank.</p> <p>An "Out of Hospital Do No Resuscitate Declaration and Order" signed and dated 6/26/14, by Resident #93 and two witnesses (a facility staff member and the daughter/power of attorney of Resident #93) was found in the clinical record. The form did not contain a physician's signature. A review of the recapitulation of physician's orders dated 6/27/14, did not indicate a code status for the resident. The fields for Code status Full Code, No Code, and Other were blank.</p> <p>An orange sticker was affixed to the front of the clinical record of Resident #93 and indicated, "Full Code."</p> <p>During an interview with the Director of Nursing (DoN) on 7/7/14 at 12:30 p.m., the DoN indicated the resident would be considered a Full Code until the facility received the signed copy of the "Out of Hospital Do No Resuscitate Declaration and Order" from the physician. The DoN indicated in the event of the heart stopping for Resident #93, cardiopulmonary resuscitation (CPR) would be initiated despite the resident's preference to be DNR. The DoN indicated once the form was signed and returned, then the resident would be considered DNR.</p>			

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	<p>During an interview with the DoN on 7/7/14 at 1:45 p.m., the DoN indicated the form was faxed to the physician on 6/26/14, and if the form was not received by the facility in the next couple of days, then the facility would check with the physician.</p> <p>On 7/8/14 at 9:00 a.m., the Executive Director (ED) provided an undated policy titled, "Code Status Policy Upon Admission," and indicated the policy was the one currently used by the facility. "...FULL CODE/DNR forms signed by said person/family will not be effective/valid until signed by a physician even if said person/family has signed the form."</p> <p>The clinical record of Resident #93 was reviewed on 7/8/14 at 1:30 p.m., 12 days after the DNR form was signed by the resident, and 11 days after the resident was admitted to the facility. No physician's order was found regarding code status.</p> <p>During an interview with the DoN on 7/8/14 at 1:45 p.m., the DoN indicated the facility had contacted the physician on 7/7/14, regarding the DNR form, but had not heard back from the physician.</p>			

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R000246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure as needed (prn) medications given to a resident by Qualified Medication Aides (QMA) were authorized by a licensed nurse prior to administration for 1 of 5 residents reviewed for receiving prn medications. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record of Resident #14 was reviewed on 7/7/14 at 2:20 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and neuropathy, (a disorder of the nervous system) and history of a fractured femur(the long bone of the upper leg).</p>	R000246	<p>1. The Director of Nursing reviewed the resident's record in question to determine if additional documentation is necessary regarding the recording of the resident's medication administration. 2. The Director of Nursing reviewed those residents' medication administration records receiving PRN medications to determine if additional documentation is necessary regarding the recording of those residents' medication administration. 3. The Director of Nursing shall conduct an in-service on all shifts for all licensed nurses and all qualified medication aides to discuss the delgation of administering PRNs to residents and the need for proper documentation. The training included that PRN</p>	07/29/2014

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	<p>A recapitulated physician's orders for April, 2014, and June, 2014, indicated Resident #14 could receive hydrocodone/apap 10/325 milligrams (mg) every 8 hours prn (as needed). Hydrocodone is a narcotic pain reliever.</p> <p>The Medication Administration Record (MAR) for April, 2014, indicated she received this hydrocodone/apap 10/325 mg. at 8:00 p.m. on April 6, and at 1:45 p.m. on April 10 from QMA #4; and at 8:00 p.m. on April 19, 20, 26 and 27, 2014, from QMA #5. No documentation was found in the resident's record, which indicated these prn medications had been authorized by a licensed nurse.</p> <p>The MAR for June, 2014, indicated Resident #14 received hydrocodone/apap 10/325 mg. at 8:00 p.m. on June 28 and 29th, administered by QMA #5. No documentation was found in the resident's record, which indicated these prn medications had been authorized by a licensed nurse.</p> <p>On 7/8/14 at 12:00 p.m., LPN #6 indicated she was not able to find any information, which indicated the above prn medications had been authorized by a licensed nurse.</p>		<p>medications can be administered by a QMA only upon authorization by a licensed nurse or physicia. Appropriate authorization for each administration of a PRN medication must be recieved and documented and initialed by a nurse. 4. The Executive Director shall review or designate to the DON to review the Medication Administration Records weekly of all residents receiving PRN medications. Upon hire all nursing staff will be orientated to their scope of practice per the state guidelines.</p>				

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R000298	<p>On 7/7/14 at 3:25 p.m., the Executive Director provided a policy titled, "Policy for QMA to Administer PRN Medications," and indicated it was the current policy used by the facility. The policy indicated, "When administering a PRN a nurse needs to assess the resident prior to the QMA administering the PRN medication, after the nurse's assessment the QMA may give the medication. The nurse will initial next to the QMA initials verifying the resident has been assessed by the nurse."</p> <p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, record review, and interview, the facility failed to ensure medications requiring refrigeration were</p>	R000298	1. To be in compliance with the regulation for refrigerator temperatures the pharmacy was called to acquire the proper	07/15/2014			

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	<p>stored safely, for 1 of 1 medication refrigerators.</p> <p>Findings include:</p> <p>During an observation of the facility medication refrigerator on 7/8/14 at 2:10 p.m., with Licensed Practical Nurse (LPN) #2, the temperature of the refrigerator was 30 degrees Fahrenheit (F). The medication refrigerator contained 57 insulin pens, 6 insulin vials, an Emergency Drug Kit, 90 eye drop applications, 156 suppositories and 1 bottle of eye drop medication.</p> <p>At that time, LPN #2 indicated she was not sure what the temperature of the medication refrigerator was supposed to be.</p> <p>During an interview with LPN #1 on 7/8/14 at 2:20 p.m., she indicated she was not sure what the medication refrigerator temperature was supposed to be. She indicated she would ask the Executive Director (ED). At 2:25 p.m., LPN #1 indicated the ED did not think the facility had a policy for temperatures of the medication refrigerator.</p> <p>On 7/8/14 at 2:30 p.m., the Director of Nursing indicated she was not sure what the temperature of the medication</p>		<p>temperature for the medications.2. The Executive Director adjusted the temperature gauge and check the refrigerator for 24 hours to assure the proper temperature was kept.3.To assure the temperature was properly kept the Executive Director placed a note on the refrigerator on 7/8/15 stating the proper temperature and policy of proper temperatures cannot be achieved.4. An in-service was held on 7/15/14 to properly train all LPNs and QMAs on the proper temperatures of the medication refrigerator.5. To assure that the temperature is being kept and the refrigerator is at the proper temperature the Executive Director will check every Friday during morning facility checks and any issues will be brought to the DON.</p>				

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	<p>refrigerator was supposed to be.</p> <p>During a telephone interview on 7/8/14 at 2:35 p.m., with Pharmacist #3, one of the facility's pharmacists, he indicated the medication refrigerator temperature should be between 36 degrees F. and 46 degrees F.</p> <p>Review of the facility's Refrigerator and Freezer Temperature logs indicated the following:</p> <p>Temperatures for July, 2014, were between 34 degrees F. and 38 degrees F.            Temperatures for June, 2014, were between 32 degrees F. and 34 degrees F.            Temperatures for May, 2014, were between 30 degrees F. and 36 degrees F.            Temperatures for April 2014, were between 32 degrees F. and 38 degrees F.            Temperatures for March, 2014, were between 32 degrees F. and 34 degrees F.            Temperatures for February, 2014, were between 28 degrees F. and 34 degrees F.            Temperatures for January, 2014, were between 23 degrees F. and 32 degrees F.</p> <p>During an interview with the Executive Director on 7/8/14 at 3:25 p.m., she indicated she was not aware of a temperature requirement for the medication refrigerator. At that time she provided an undated policy, titled</p>			

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R000383	<p>Policies on Refrigerator Temperatures, which indicated, "All refrigerators for medication storage must be kept at 36 to 46 degrees at all times. If below or above these temperatures please notify maintenance and move meds to back up refrigerator in med room."</p> <p>410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements.</p> <p>Based on interview and record review, the facility failed to ensure a resident receiving mental health services had a comprehensive care plan in place for 1 of 7 residents reviewed. (Resident #2)</p> <p>Findings include:</p>	R000383	<p>1. The resident in question comprehensive care plan was updated.2. The Director of Nursing shall review all resident records for those receiving mental health services to ensure their care plan is complete.3. Mental Health Services will be included in the Community's new quarterly assessment forms. All</p>	07/31/2014			

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	<p>The clinical record of Resident #2 was reviewed on 7/7/14 at 12:35 p.m. Diagnoses included, but where not limited to, cerebral palsy with spastic paraparesis, hypertension, and bipolar disorder.</p> <p>The clinical record of Resident #2 lacked documentation of a treatment plan and progress notes regarding current mental health services. The most recent service plan for Resident #2, dated 6/1/14, lacked documentation indicating the resident was currently receiving mental health services.</p> <p>During an interview with the Director of Nursing (DoN) on 7/8/14 at 2:10 p.m., the DoN indicated the resident was currently receiving psychiatric services outside of the facility. "The resident takes care of all of the appointments and we do not have any information from the appointments." The DoN indicated the facility did not have any documentation regarding the services the resident was currently receiving, including the current treatment plan for the resident, and a collaborative plan of care was not in place.</p>		nurses will attend an in-service on 7/25/14 to receive instruction on this assessment and how to incorporate into the treatment plan and collaborative plan of care.4. The Executive Director and the Director of Nursing shall ensure that all information is complete and shall review care plans monthly of those receiving mental health services.	

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R000408	<p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure a chest x-ray was completed prior to admission for 1 of 7 residents reviewed. (Resident #93)</p> <p>Findings include:</p> <p>The clinical record of Resident #93 was reviewed on 7/7/14 at 11:30 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hypertension, hypothyroidism, depression, and chronic obstructive lung disease (COPD).</p> <p>Resident #93 was admitted to the facility on 6/27/14. The History and Physical/Physician's Statement form signed and dated 5/30/14, for Resident #93, indicated a chest x-ray had not been completed within the past 6 months. The clinical record did not contain documentation or a report of a completed</p>	R000408	<p>1. The Resident shall receive a chest x-ray if necessary and his/her record shall be completed regarding the surveyor's finding related to this deficiency.2. The records of all residents admitted after January 1, 2014 shall be reviewed to ensure that we are in compliance with this regulation.3. Going forward, a copy of the chest x-ray report shall be received prior to admission and will be reviewed by the Office Manager and Director of Nursing.4. The Executive Director will audit monthly all move-ins to ensure this correctirve action is on-going.</p>	07/25/2014

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	<p>chest x-ray.</p> <p>During an interview with the Director of Nursing (DoN) on 7/7/14 at 12:45 p.m., the DoN indicated the facility does not usually have a copy of the chest x-ray reports for new admissions, as the History and Physical/Physician's Statement form indicated whether a chest x-ray was completed and where the x-ray was located. After reviewing the clinical record for Resident #93, the DoN indicated the resident did not have a chest x-ray completed prior to admission and had not had one completed as of 7/7/14 at 1:45 p.m.</p> <p>On 7/7/14 at 11:00 a.m., the Executive Director (ED) provided an undated policy, "Resident Agreement Policy and Procedure," and indicated the policy was the one currently used by the facility. The policy indicated, "... 5.) The Resident agrees to...C.) Prior to admission, Resident shall provide a recent, less than six (6) months old, chest x-ray report indicating no active disease, certified by an individual licensed to perform such an examination..."</p>						