

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 690 STATE STREET FRANKLIN, IN 46131
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: February 29, March 1, 2 and 3, 2016.</p> <p>Facility number: 013460 Provider number: 013460 AIM number: N/A</p> <p>Census bed type: Residential: 85 Total: 85</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on March 04, 2016.</p>	R 0000	The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc. that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. It is thus submitted as a matter of stature only.	
R 0214 Bldg. 00	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency</p> <p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request.</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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	<p>A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to ensure a preadmission evaluation was completed for 2 of 7 residents reviewed. (Residents #22 and #28)</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #22 completed on 2/29/2016 at 1:00 p.m., indicated an admission date of 6/22/2015. Diagnoses included, but were not limited to, diabetes mellitus type 2 and depressive disorder.</p> <p>A review of the clinical record for Resident #22, lacked a preadmission evaluation completed prior to 6/22/2015.</p> <p>During an interview on 3/2/2015 at 10:02 a.m., the Wellness Director indicated a preadmission evaluation was not found for Resident #22. The Wellness Director indicated the resident moved from Independent Living and was unaware that Resident #22 needed a preadmission evaluation completed.</p> <p>2. The clinical record of Resident #28 was reviewed on 2/19/16 at 12:30 p.m. Diagnoses for the resident included, but were not limited to, dementia, coronary artery disease, and diabetes mellitus.</p>	R 0214	#22 and # 28 had evaluations completed todetermine their individual needs All other residents were audited to determine ifpre-admission evaluations were complete. If an assessment could not be located, an assessment was completed todetermine their individual needs A new Resident policy and procedure was createdfor the admission process along with a checklist of items that need to becompleted prior to admission. Education was provided to the Admission, MedicalRecords and Nursing Administration regarding pre-admission evaluations Prior to admission, the DON or designee willreview residents admitting to the facility to ensure that an evaluation iscompleted The DON or designee will ensure that thepre-admission evaluation is completed prior to admission by auditing all newresidents to the facility. The DON ordesignee will audit all new residents admitting to the facility for the next 12months The results of the audits will be reviewed andthe monthly QAPI meeting	03/18/2016			

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R 0299 Bldg. 00	<p>The resident was admitted to the facility on 11/25/15. A preadmission evaluation, to ensure the care Resident #28 required could be provided by the facility, was not found in the resident's record.</p> <p>On 3/1/16, at 9:26 a.m., the Wellness Director indicated a preadmission evaluation had not been done for the resident.</p> <p>On 3/3/16 at 12:15 p.m., the Wellness Director and the Assistant Director of Nursing indicated the facility did not have a policy regarding preadmission evaluations.</p> <p>410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy.</p>			
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	<p>Based on record review and interview, the facility failed to ensure a physician was notified of a pharmacy recommendation and the recommendation was followed up on for 1 of 7 residents reviewed (Resident #1).</p> <p>Findings include:</p> <p>The clinical record review for Resident #1 was completed on 3/1/2016 at 9:10 a.m. Diagnoses included, but were not limited to, insomnia.</p> <p>A review of a pharmacy recommendation dated 12/18/2016, indicated, "...The FDA [Food and Drug Administration] has received reports of lingering therapeutic effects in patients upon waking which could endanger the patient and others with whom patients interact. Women appear to be more susceptible to this risk because they eliminate zolpidem [Ambien] from their bodies more slowly than men...Resident has orders for Ambien 10 mg QHs [every evening at bedtime] routinely...Suggest ... reduce to zolpidem 5 mg [milligram] qHs..." No documentation indicating the facility followed up on the pharmacy recommendation was found in Resident #1's clinical record.</p> <p>Review of physician's orders for</p>	R 0299	<p>The physician was notified for resident #1's pharmacy recommendation. Resident #1's zolpidem was reduced and discontinued. Pharmacy recommendations for the past 4 months were audited to ensure that the recommendations for residents were reviewed by the physician. A policy and procedure was created for the timeliness of the physician's response to the pharmacy recommendations. The facility will have 14 days to have recommendations reviewed by the physician. Nursing administration staff will be responsible to ensure that the recommendations have been reviewed by the physician. The DON or designee will audit all pharmacy recommendations made monthly by the consulting Pharmacist for the next 12 months. The results of the audits will be reviewed at the monthly QAPI meeting.</p>	03/18/2016			

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R 0408 Bldg. 00	<p>December 05, 2015 through March 01, 2016; indicated Resident #1 was to receive Zolpidem tartrate 10 milligrams daily at bedtime.</p> <p>During an interview on 3/2/2016 at 3:15 p.m., the Assistant Director of Nursing indicated no documentation was found indicating the physician was notified regarding the pharmacy recommendation completed on 12/18/2015.</p> <p>On 3/3/2016 at 12:35 p.m., the Wellness Director indicated the facility did not currently have a policy regarding pharmacy recommendations and the process for notifying the physician.</p> <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 record review and interview, the facility failed to ensure a resident admitted to the facility, received a chest X-ray prior to admission, for 1 of 7 residents reviewed for receiving preadmission chest X-rays. (Resident #28)</p> <p>Findings include: The clinical record of Resident #28 was</p>	R 0408	<p>Resident #28 had a chest X-ray on 12/31/2015 with no active disease. All residents were audited to ensure that they had a chest X-ray completed upon admission. If a chest X-ray was not completed prior to admission, The DON or designee will ensure that those residents have received a chest X-ray. A new policy and procedure was created for the admission process along with a checklist of items that</p>	03/18/2016

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R 0410 Bldg. 00	<p>reviewed on 2/19/16 at 12:30 p.m. Diagnoses for the resident included, but were not limited to, dementia, coronary artery disease, and diabetes mellitus.</p> <p>The resident was admitted to the facility on 11/25/15. A chest X-ray completed within the 6 months prior to her admission was not found in the resident's record.</p> <p>On 3/1/16 at 9:35 a.m., the Wellness Director indicated a chest X-ray for the resident had not been done within 6 months prior to her admission.</p> <p>On 3/2/16 at 2:19 a.m., the Wellness Director provided an, "Admission Checklist," and indicated it was the current checklist used by the facility. One of the items listed on the checklist was, "Chest X-ray."</p> <p>On 3/3/16 at 12:15 P.M., the Wellness Director and the Assistant Director of Nursing indicated the facility did not have a policy regarding preadmission chest X-rays.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be</p>		<p>need to be completed prior to admission to the facility. Education was provided to the Admission staff, Medical Records and Nursing Administration that residents admitting to the facility must have a chest X-ray no more than 6 months prior to admission. Prior to admission, The DON or designee will review residents admitting to the facility to ensure that a chest X-ray was completed as required. The DON or designee will ensure that a chest X-ray is completed prior to admission by auditing all new residents to the facility. The DON or designee will audit all new residents admitting to the facility for the next 12 months. The results of the audits will be reviewed at the monthly QAPI meeting.</p>	

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	<p>completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin 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>Based on record review and interview, the facility failed to ensure a resident received a tuberculin skin test prior to admission for 1 of 7 residents reviewed for receiving tuberculin skin tests at the time of, or within 3 months prior to, admission. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record of Resident #28 was reviewed on 2/19/16 at 12:30 p.m. Diagnoses for the resident included, but were not limited to, dementia, coronary artery disease, and diabetes mellitus.</p> <p>Resident #28 was admitted to the facility</p>	R 0410	<p>Resident #28 had negative PPD results on 03/01/2016,04/10/2015 and a tuberculin skin test was administered on 03/11/2016 using the two-step method</p> <p>All residents were audited to ensure that had a tuberculinskin test unless contraindicated prior to or on admission. If a tuberculin skin test was not completed,the DON or designee will ensure that those residents have had the tuberculinskin test as required.</p> <p>A new policy and procedure was created for the admissionprocess along with a checklist of items that need to be completed prior toadmission to the facility.</p> <p>Education was provided to the Admission staff, MedicalRecords and</p>	03/18/2016			

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	<p>on 11/25/15. Tuberculin skin test results, administered at the time of her admission, were not found in the resident's record.</p> <p>On 3/1/16 at 9:35 a.m., the Wellness Director indicated Resident #28 had not received a tuberculin skin test prior to her admission.</p> <p>On 3/3/16 at 12:15 p.m., the Wellness Director and the Assistant Director of Nursing indicated the facility did not have a policy regarding new residents receiving tuberculin skin tests.</p>		<p>Nursing Administration regarding the new policy and procedure for admissions and the tuberculin skin test requirements prior to admission.</p> <p>Prior to admission, the DON or designee will review residents admitting to the facility to ensure that a tuberculin skin test was completed or will be completed upon admission to the facility. The two-step process will be used for those residents that do not have a negative skin test 3 months prior to admission.</p> <p>The DON or designee will ensure that all residents admitting to the facility have a tuberculin skin test prior to admission or upon admitting to the facility by auditing all new residents admitting to the facility for the next 12 months. The two-step process will be employed for those residents that do not have a negative tuberculin skin test prior to admission.</p> <p>The results of the audits will be reviewed at the monthly QAPI meeting.</p>				