

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 01/27/2016
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 26 and 27, 2016.</p> <p>Facility: 005729 Provider: 005729 AIM number: n/a</p> <p>Census bed type: Residential: 52 Total: 52</p> <p>Census payor type: Medicaid: 50 Other: 2 Total: 52</p> <p>Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on February 2, 2016.</p>	R 0000		
R 0240	410 IAC 16.2-5-4(d) Health Services - Deficiency			

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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Bldg. 00	<p>(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on interview and record review, the facility failed to provide personal care in accordance with a resident's individual needs, regarding medication administration, by not effectively addressing an MD response to a pharmacy recommendation for 1 of 5 residents reviewed for a pharmacist drug regimen review. (Resident #13)</p> <p>Findings include:</p> <p>The clinical record for Resident #13 was reviewed on 1/26/16 at 12:30 p.m. The diagnoses for Resident #13 included, but were not limited to: stage 4 chronic kidney disease.</p> <p>The 8/17/15 Level of Service Assessment/Evaluation for Resident #13 indicated one of her services to be provided was, "Caregiver administration and/or observation of medications requiring judgement for necessity, dosage and/or effect."</p> <p>The January, 2016 Physician's Orders for Resident #13 indicated to inject 40 MCG/1 mL of Aranesp, subcutaneously, every 2 weeks, effective 9/3/15. The orders indicated a CBC (complete blood</p>	R 0240	<p>In RE of R0240 Submission of this plan of correction does not constitute admission of guilt. All residents in the facility were found to have been at risk for the potential of harm by such deficiency. No residents were found to have been harmed. In regards to the resident is question: as soon as the order was brought to the attention of the nursing staff by the surveyor team, the Director of Healthcare Services immediately contacted the PCP for clarification of the order. Clarification was received; Resident was monitored for 24 hours for any signs or symptoms of adverse reactions. NO Adverse reactions were noted. Resident was seen in house the next day by the NP from the resident's PCP office. No further follow up was needed. In regards to the other residents in the facility a chart audit is being conducted to ensure that this same oversight did not occur with any other resident. To prevent this oversight from happening again we have developed a new procedure to be followed regarding orders. A Transcribing Orders policy has been created, all clinical staff will be trained on the correct policy to be followed a copy of the new policy will be posted in the chart</p>	02/29/2016

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	<p>count) lab to be drawn monthly.</p> <p>The 11/4/15 pharmacy Note To Attending Physician/Prescribe indicated, "Please provide hold parameters for (name of Resident #13's) Aranesp order (i.e. Hold if Hgb [hemoglobin] > 10). Thank you for your time."</p> <p>The 11/17/15 faxed response from Resident #13's Physician indicated a "10" with a circle around it, signed by the physician.</p> <p>The 11/17/15 HGB lab results for Resident #13 were 11.3 g/dL. The November, 2015 Medication Record for Resident #13 indicated the Aranesp was administered on 11/19/15, not held per pharmacy recommendation.</p> <p>The 12/15/15 HGB lab results for Resident #13 were 12.3 g/dL. The December, 2015 Medication Record for Resident #13 indicated the Aranesp was administered on 12/8/15 and 12/22/15, not held per pharmacy recommendation.</p> <p>The 1/5/16 and 1/12/16 HGB lab results for Resident #13 were both 13.3 g/dL. The January, 2016 Medication Record for Resident #13 indicated the Aranesp was administered on 1/14/16, not held per pharmacy recommendation.</p>		<p>room as well. The policy has been prepared and presented in a very simple step by step methodology which includes documentation to be completed in the 24 hour report book which will be monitored by all nursing staff and the Director of Healthcare Services will monitor this on a regular daily basis to ensure that the new policy is being followed. This policy will be put into place and will be followed and monitored indefinitely. A copy of the policy has been attached for your review.</p>		

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	<p>An interview was conducted with Resident #13 on 1/26/16 at 1:05 p.m. She indicated the nurse administered her Aranesp injections every 2 weeks. She indicated an injection was never skipped or held, and received her last Aranesp injection a couple of weeks ago.</p> <p>An interview was conducted with LPN #3 on 1/26/16 at 1:20 p.m. She reviewed Resident #13's January, 2016 Medication Record and indicated it looked like the Aranesp should be held if her HGB was greater than 10. LPN #3 then reviewed Resident #13's 1/12/16 HGB lab results and indicated the Aranesp should have been held on 1/14/16.</p> <p>An interview was conducted with the Director of Health Services (DHS) on 1/26/16 at 1:30 p.m. The DHS reviewed Resident #13's November, 2015, December, 2015, and January, 2016 HGB results and Medication Records. She indicated, "It looks like med (medication) errors all the way around." She indicated all administrations of Aranesp after 11/17/15 should have been held.</p> <p>On 1/26/16, at 3:11 p.m., the DHS provided the 1/26/16 Physicians Order Sheet for Resident #13. It indicated, "Clarification order-Hold Aranesp if</p>			

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R 0273 Bldg. 00	<p>HGB > 10 - Have resident f/u (follow up) (symbol for "with") NP (Nurse Practitioner) on Wednesday 1/27/16." The DHS indicated when nursing received the 11/17/15 response from the physician, they should have clarified if the Aranesp was to be held if her HGB was greater than 10 and written a clarification, like she just did.</p> <p>The Medication Review/Recommendations policy was provided by the DHS on 1/26/16 at 2:57 p.m. It indicated, "The Consultant Pharmacist will visit on a routine basis and make recommendations to the facility regarding various aspects of the facility's pharmaceutical services....Any irregularities, which are noted in said reviews, will be communicated to the Administrator/Executive Director, who will address the same with the nurse on site or on call."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure open dates were on food containers and food was appropriately covered/sealed in</p>	R 0273	In RE of R0273 Submission of the plan of correction does not constitute admission of guilt. All residents in this facility were found to have been at risk for the	02/29/2016

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	<p>the dry storage area and walk-in cooler. The facility also failed to have a rinse temperature monitoring system in place for the dishwasher. This had the potential to affect 52 of 52 residents residing in the facility.</p> <p>Findings include:</p> <p>1. An observation of the dishwashing machine was made on 1/26/16 at 11:15 a.m. Cook #3 turned the machine on and then walked to the other side of the kitchen. The wash temperature for the machine reached 162 degrees Fahrenheit and Rinse cycle reached 137 degrees Fahrenheit. Cook #3 returned to the area after the cycle was complete. At this time Cook #3 indicated the Rinse cycle always reached 180 degrees Fahrenheit, so he ran the dishwasher again. The dishwasher reached 164 degrees Fahrenheit during the wash and 140 degrees during the rinse cycle. Cook #3 indicated at this time he needed to contact Maintenance to check the machine, since the rinse cycle was not reaching 180 degrees.</p> <p>A review of the Dishmachine Temperature & PPM (parts per million) Log for January 2016, indicated 1 temperature was obtained daily for each meal. There was no indication if the</p>		<p>potential of harm. No residents were found to have been harmed. During our recent survey the survey team found items in the dry storage and cooler that had been opened and were not labeled and or dated properly. These items in question were immediately discarded to prevent the potential of harm of a resident. All dietary staff have in-serviced on the proper storage of all food items whether they be in the cooler, freezer or dry goods or bulk storage. This in-service was completed in person with each staff person. Each shift cook will be responsible for monitoring the food items in storage and will be responsible to check routinely during their shift. This particular incident was traced to one particular cook and that cook has already been re-in serviced as to necessity for proper labeling and dating of all food items. The Dietary Manager or her designee will monitor this on a daily basis. This will be an ongoing process. In Re of R0273 Submission of this plan of correction does not constitute admission of guilt. All residents in the facility would be at risk for the potential of harm by such deficiency. No residents were found to be harmed. A new temperature log for the dish machine has been created and was presented to the survey team prior to their departure from the facility and it was also</p>				

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	<p>temperature was for the wash cycle or the rinse cycle.</p> <p>During an observation, on 1/26/16 at 12:00 p.m., the dishwasher reached 162 degrees Fahrenheit during the wash cycle and 188 degrees Fahrenheit during the rinse cycle. Cook #3 indicated at this time that "booster" needed to be reset.</p> <p>During an interview with the Dietary Manager, on 1/26/16 at 1:10 p.m., the Dietary Manager indicated the dishwasher was a wash/dry dishwasher versus a chemical dishwasher. The Dietary Manager further indicated the wash temperature was the only temperature documented and they just watched the rinse temperature. The Dietary Manager indicated she had no documentation to provide that the rinse cycle was reaching 180 degrees prior to the observation above.</p> <p>2. During a tour of the kitchen with Cook #3, on 1/26/16 at 11:25 a.m., a box of ziti pasta was opened and the bag inside was also open to air in the dry storage area. There was no open date on the bag or box of the pasta. In the walk-in cooler, a container of liquid eggs was opened, there was no open date on the container. The walk-in cooler also contained an opened to air box/bag of</p>		<p>implemented at that time. A service call was placed to our repairman as to why our power booster required a reset at that time. It was found that the High limit switch was worn out and was in need of replacement. This part was replaced and the power booster on the dish machine is running well and the temperature is being maintained and monitored. The wash and rinse cycle will be monitored and recorded during each shift. This process will continue indefinitely. This will be monitored by the Dietary Manager or her designee on a regular daily basis All staff has been in serviced on the new temperature log sheet. A copy of the document has been downloadedfor your review</p>	

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	<p>lettuce. The bag was dated 12/23/15.</p> <p>During an interview with Cook #3, on 1/26/16 at 11:22 a.m., Cook #3 indicated all opened food should have open dates and all food should be closed/sealed/tied. Cook #3 indicated he was unsure of when the last time the lettuce was used and threw the lettuce away.</p> <p>On 1/26/16 at 12:32 p.m., the Administrator indicated all food should have open dates on them and should be closed/sealed/tied.</p> <p>At 2:45 p.m., on 1/26/16, the Administrator indicated the facility does not have specific kitchen policies and the kitchen was to follow the Retail Food Establishment Sanitation Requirements.</p>			