

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 08/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 28 and 29, 2012</p> <p>Facility number: 010887 Provider number: 010887 AIM number: N/A</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: Residential: 33 Total: 33</p> <p>Census payor type: Other: 33 Total: 33</p> <p>Sample: 7 Supplemental sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 30, 2012 by Bev Faulkner, RN</p>	R0000	<p>The following is the Plan of Correction for Sterling House of Merrillville in regards to the Statement of Deficiencies for the annual survey completed on 8-29-12. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</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.

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 08/29/2012	
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF MERRILLVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
R0241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (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 record review and interview, the facility failed to administer medications as ordered by residents' physicians, related to Digoxin (heart medication) administration for 1 of 7 residents reviewed for medication administration in a total sample of 7. (Resident #22)</p> <p>Findings include:</p> <p>Resident #22's record was reviewed on 08/28/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated an order for Digoxin 125 mcg (micrograms) every other day, which was originally ordered on 06/29/12.</p> <p>The Medication Administration Record (MAR), dated 07/12, indicated an order for Digoxin 125 mcg (micrograms) every other day, hold if pulse is less than 60. The MAR indicated the resident received</p>	R0241	<p>R 241 Health Services (Offense) What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident 22 suffered no adverse effects or change in condition from the alleged deficient practice. · The physician was notified of the occurrence and new orders were obtained. Labs were ordered and were found to be within normal limits. · The responsible party was notified of the occurrence and follow-up. · The Medication Administration Record (MAR) was updated to demonstrate the current medication order, as well as to indicate a space to initial and log the pulse checks to be completed prior to administering the medication. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · MAR audits were completed by the Health and Wellness Director/Nurse Designee to</p>	09/28/2012			

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 08/29/2012	
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF MERRILLVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the Digoxin daily and lacked documentation the resident's pulse was obtained prior to receiving the Digoxin.</p> <p>The Medication Administration Record (MAR), dated 08/12, indicated an order for Digoxin 125 mcg (micrograms) every other day, hold if pulse is less than 60. The MAR indicated the resident received the Digoxin every day.</p> <p>During an interview on 08/28/12 at 2 p.m., the Director of Nursing indicated the resident had been receiving the Digoxin every day instead of every other day as ordered.</p>		<p>determine if other residents who receive this medication were affected, and if the accurate documentation was in place to reflect the need for vital sign checks for similar medications. No additional residents were identified. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · The Health and Wellness Director/Designee has provided re-education to the nurses regarding appropriate Medication Administration Documentation, the need to document vital signs where ordered, and the corrective action that will occur in the event of non-compliance. · MAR audits will be completed as least every shift by the nursing staff, and documentation will be noted at the time of change of shift narcotics count. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · The Health and Wellness Director/Nurse Designee will audit the Medication Administration Record daily for compliance. · Results of these audits will be communicated verbally and/or in writing, to the Executive Director by the Health and Wellness Director (RN)/Designee on a weekly basis. · The Executive</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 08/29/2012
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF MERRILLVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			Director will make recommendations for further corrective action, based on these audit findings. By what date will these systemic changes be implemented? · 9-28-12		