

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2014
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NAME OF PROVIDER OR SUPPLIER ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 5, 6, 7, 8, 11, 12, 13, 14, 2014.</p> <p>Facility number: 004268 Provider number: 155735 AIM number: 200504460</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Karina Gates, Generalist (August 5, 6, 7, 8, 11, 13, 14, 2014.)</p> <p>Census bed type: SNF: 30 SNF/NF: 24 Residential: 31 Total: 85</p> <p>Census payor type: Medicare: 15 Medicaid: 22 Other: 48 Total: 85</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 and 16.2 -5.</p>	F000000	Preparation and/or execution of this plan of correct does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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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F000157 SS=D	<p>Quality review completed on August 19, 2014 by Cheryl Fielden, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the</p>			

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	<p>resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician of an increase in the size of a wound for 1 of 2 residents reviewed for pressure sores. (Resident #62)</p> <p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 8/13/14 at 10:00 a.m. The diagnoses for Resident #62 included, but were not limited to, sacral wound.</p> <p>The Other Skin Impairment Assessment for Resident #62 was completed weekly by the facility since 5/18/14 for an area an her sacrum. The 7/14/14, 7/21/14, and 7/28/14 assessments indicated the size of the wound was 0.1 cm x 0.1 cm x <0.1 cm. The 8/4/14 assessment indicated the size of the wound increased to 0.5 cm x 0.5 cm x <0.1 cm. No information was found in the clinical record to indicate the</p>	F000157	<p>Nurse Practioner for resident # 62 was immediately notified of increase in size of wound and status. Physician updated his previous dictation on 8/27/14 to reflect the accurate location. All residents at risk for skin impairment have the potential to be affected. Unit Manager was in-serviced on Physician Notification guidelines, A checklist was developed to ensure residents who have an increase in wound size also have timely Physician or Nurse Practioner notification. These checklist will be completed one time per week for 8 weeks, then monthly thereafter. Until substantial compliance is achieved. Results of audits will be discussed with the QA team monthly X 6 months for ongoing needs and action. DHS or designee will complete these audits.</p>	09/13/2014

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	<p>physician was notified of the increase in size of the wound.</p> <p>An observation of the wound was made on 8/13/14 at 1:40 p.m., with LPN #3. The wound was about the size of a nickel, and purplish in color.</p> <p>An interview was conducted with the DHS (Director of Health Services) on 8/13/14 at 2:30 p.m., regarding the facility policy for notifying the physician, and whether the physician was notified of the increased wound size indicated on the 8/4/14 assessment. She indicated, "We should notify the M.D. if the wound got larger."</p> <p>On 8/14/14 at 10:22 a.m., the DHS indicated NP (Nurse Practitioner) #7 documented on the wound on 8/12/14. The DHS stated, "She (NP #7) just put the note in the chart today. I don't know why no one told [the doctor]. Typically, we notify the M.D. after 2 weeks of a wound getting worse, because that's what I thought our policy was, but I can't find a policy that says anything about M.D. notification." No policy was provided regarding physician notification.</p> <p>An interview was conducted with NP #7 on 8/14/14 at 10:27 a.m., regarding whether she was notified of the increased</p>			

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F000272 SS=D	<p>size of Resident #62's wound after the 8/4/14 assessment. She indicated, "No. I absolutely should have. I don't know why no one said anything to me. I'm always in the building. They should have called me if the size got bigger."</p> <p>3.1-5(a)(2)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;</p>			

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	<p>Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to include a physician diagnosed pressure ulcer on a resident's quarterly MDS for 1 of 21 residents reviewed for MDS assessments. (Resident #62)</p> <p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 8/13/14 at 10:00 a.m. The diagnoses for Resident #62 included, but were not limited to, stage 2 decubitus (stage 2 pressur ulcer).</p> <p>The 7/16/14 Quarterly MDS (minimum data set) Assessment for Resident #62 indicated she had no pressure ulcers, open lesions, surgical wounds, burns,</p>	F000272	<p>MDS Coordinator modified current assessment for resident #62 to reflect pressure ulcer. Weekly skin assessments were also modified to reflect pressure ulcer. All residents with any skin impairment have the potential to be affected. Home office support in-serviced MDS Coordinator on proper coding for section M. A checklist was developed to ensure proper coding on section M. These checklists will be completed monthly for 6 months until substantial compliance is achieved. Results of audits will discussed with QA team monthly X 6 months for ongoing needs and actions. MDS Coordinator or designee will complete the audits.</p>	09/13/2014

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	<p>skin tears, or moisture associated skin damage.</p> <p>The 6/25/14 Physician Note, completed by M.D. #6, indicated, "She does have a small open area on the coccyx which is being treated by the wound care team and has remained relatively unchanged....The ulcer on the coccyx is very small, less than dime size, stage 2 with good demarcation and no secondary infection....Assessment: coccygeal decubitus."</p> <p>The Other Skin Impairment Assessment form for Resident #62 was completed weekly by the facility from 5/18/14 through 8/11/14 for the above mentioned wound.</p> <p>An interview was conducted with the DHS (Director of Health Services) on 8/13/14 at 11:27 a.m. She indicated she was unaware of the 6/25/14 Physician Note. She stated, "I did not know he was calling it a pressure in his note. I totally disagree with that. I call it a shear....It is not located where there would be pressure, and it does not look like pressure. It did not present as pressure. It presented as purple and linear, then turned into a hard raised boil, then opened up." She indicated no one had asked the doctor about his diagnosis of</p>			

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	<p>pressure.</p> <p>An observation of the wound was made on 8/13/14 at 1:40 p.m. with LPN #3. The wound was about nickel size on the upper right buttock. The wound bed was purplish in color. LPN #3 indicated Resident #62 had pressure ulcer/ulcers in the past.</p> <p>During an interview with LPN #3 on 8/13/14 at 2:10 p.m., she indicated she was not wound care certified, and neither was any of the facility staff.</p> <p>An interview was conducted with NP #7, who worked with MD #6, on 8/14/14 at 10:27 a.m., regarding her thoughts on M.D. #6's diagnosis of a pressure ulcer. She indicated, "He's an amazing doctor, I wouldn't want to disagree with him. It started as a shearing." She indicated she was not wound care certified.</p> <p>An interview was conducted with the DHS on 8/14/14 at 11:45 a.m. She indicated the 7/16/14 Quarterly MDS should indicated the wound on Resident #62's buttock.</p> <p>An interview was conducted with the MDS Coordinator on 8/14/14 at 12:54 p.m. She indicated, I didn't put it on the MDS because I don't consider it an open</p>			

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F000282 SS=D	<p>lesion or a pressure."</p> <p>3.1-31(c)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow physician's orders regarding insulin administration for 1 of 5 residents reviewed for unnecessary medications. (Resident #73)</p> <p>Findings include:</p> <p>The clinical record for Resident #73 was reviewed on 8/11/14 at 10:45 a.m. The diagnoses for Resident #73 included, but were not limited to, uncontrolled type 2 diabetes mellitus.</p> <p>The 7/25/14 Individualized Care Plan for Resident #73 indicated, "I have potential for hypo/hyperglycemia r/t (related to</p>	F000282	Resident # 73 MAR was immediately corrected to reflect current physician order. Medication error guidelines were immediately initiated and followed up on. All residents receiving insulin have the potential to be affected. All Employees who administer insulin were in-serviced on guidelines for medication orders. Licensed nurses who work night shift will be responsible to checking orders are written and transcribed accurately with a 2nd nurse signing off as correct. A checklist was developed to ensure new physician orders are written and transcribed correctly. These checklists will be completed 5x week for 4 weeks, then 2x week for 4 weeks, then monthly thereafter until substantial compliance is achieved. Results	09/13/2014			

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	<p>my diabetes....Nursing to administer my insulin as ordered--see my current orders."</p> <p>The 8/8/14 Physician Telephone Order for Resident #73 indicated, "Change humalog (insulin) to 3 units before each meal, plus sliding scale." Another 8/8/14 Physician Telephone Order specified the sliding scale insulin amounts, with their corresponding blood sugar readings.</p> <p>The August, 2014 MAR (medication administration record) indicated the sliding scale insulin was administered, as ordered, on 8/8/14, 8/9/14, 8/10/14, and 8/11/14. It indicated the Humalog 3 units before each meal was not administered until breakfast on 8/11/14.</p> <p>An interview was conducted with the DHS (Director of Health Services) on 8/11/14 at 12:19 p.m. She indicated, "The 3 units before each meal was not done. I noticed that today. There's no process for catching it over the weekend. Me and (name of LPN #3) and sometimes (name of LPN #11) are the ones to check all orders. We check orders the following business day, and since this order was written on Friday, we didn't catch it until Monday morning. There was no Unit Manager over the weekend." The DHS indicated 4</p>		<p>of audits will be discussed with QA team monthly for 6 months for ongoing needs and actions. DHS or designee will complete the audits.</p>				

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F000309 SS=D	<p>different nurses administered the sliding scale insulin, but missed the regularly scheduled insulin from 8/8/14 to 8/10/14.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure venous access site monitoring was performed by nursing staff. This practice affected 1 of 1 residents reviewed for dialysis. (Resident #47)</p> <p>Resident #47's record was reviewed on 8/6/14 at 11:01 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, insulin dependent diabetes mellitus, aphasia, chronic kidney disease, coronary artery disease, CVA(cerebrovascular accident)</p>	F000309	Resident #47 MAR was immediately corrected to monitor dialysis access site for bleeding and signs & symptoms of infection every shift and as needed. Resident #47 care plan was immediately updated to direct staff to monitor dialysis access site for bleeding and signs and symptoms for infection. All residents receiving dialysis services have the potential to be affected. All licensed nurses were in-serviced on guidelines for monitoring access sites. A checklist was developed to ensure venous access sites are monitored and care planned.	09/13/2014

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	<p>with right sided hemiparesis, seizure disorder, cardiovascular disease, anxiety, hypothyroidism, hyperlipidemia, anemia, hypertension, and osteoporosis.</p> <p>The resident's medications included, but were not limited to, levemir and novolog insulin, clonidine, lasix, kepra, metoprolol, renal softgel caplets, renvela. Other physician orders included: weekly weights (done at dialysis).</p> <p>A care plan, dated 4/21/14, indicated Resident #47 receives dialysis treatments three times weekly on an outpatient basis. The care plan indicated the resident's dialysis port site dressing is changed by the dialysis agency.</p> <p>An MDS (minimum data set) Assessment, dated 5/14/14, indicated Resident #47 received dialysis services while a resident of the facility.</p> <p>On 8/7/14 at 12:37 p.m., during an observation, Resident #47 was in her bed resting. She was alert, pleasant, and in no distress. She indicated she had not eaten lunch yet. The resident was able to reveal the dialysis central venous port site which was observed to be covered by a white dressing which was intact and had no drainage.</p>		<p>These checklists will be completed 5X week for 4 weeks, then 2X week for 4 weeks, and then monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for 6 months for on going needs and actions. DHS or designee will complete the audits.</p>				

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	<p>On 8/11/14 at 2:09 p.m., during an interview, the Facility Consultant indicated nursing staff should assess venous access sites daily for any resident receiving dialysis services and record the assessment in the medication or treatment administration record.</p> <p>On 8/12/14 at 10:21 a.m., the DHS indicated nursing staff should assess any resident who has a central venous dialysis access port site each shift. She indicated some of the things nursing staff would look for in the assessment were "bleeding" and signs or symptoms of infection. She indicated the medication and treatment administration records for Resident #47 did not indicate daily assessments for Resident #47's dialysis port site were completed. She indicated the facility does not have a policy on assessment and documenting central venous catheter dialysis port sites. The DHS indicated a new physician's order was obtained to monitor Resident #47's central venous catheter site each shift. She indicated the monitoring should be recorded in the medication administration record.</p> <p>A physician's order, dated 8/11/14, indicated for nursing staff to "...Monitor access site for bleeding +(and) s/sx (signs and/or symptoms) of infection Q (every)</p>			

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F000323 SS=D	<p>shift and PRN (as needed).</p> <p>A care plan for Resident #47's dialysis port, dated 4/17/14, did not direct staff to monitor the resident for signs of bleeding or infection related to the dialysis port site prior to 8/12/14.</p> <p>A facility policy dated January 2014, and titled "GUIDELINES FOR MONITORING SHUNT: HEMODIALYSIS ARTERIOVASCULAR ACCESS (AV) (Fistula, Graft or Central Venous Catheter) indicated the following: "...Monitor AV shunt daily for redness..." and "...swelling..." and "...signs and or symptoms of infections..." The policy also indicated for nursing staff to "...Document assessment findings in resident medical record..."</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>						

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	<p>assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement a fall intervention, as care planned, and to ensure a resident's bed side table was maintained in proper working condition to prevent a potential accident, for 2 of 3 residents reviewed for accidents. (Resident #16 and #25).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #16 was reviewed on 8/5/14 at 2:00 p.m. The diagnoses for Resident #16 included, but were not limited to, dementia.</p> <p>An interview was conducted with LPN #10 on 8/5/14 at 2:34 p.m. She indicated Resident #16 had a fall approximately 2 weeks ago.</p> <p>The 7/22/14 Fall Circumstance, Assessment and Intervention form for Resident #16 indicated her fall occurred on the 100 hall at 8:45 a.m., on 7/22/14. It indicated she hit her head, had injury to her right forehead, and an ice pack was applied. The activity at the time of the fall indicated, "Unknown - res (resident) sitting in w/c (wheel chair) in 100 hall. Chair alarm sounded. Observed on floor." It indicated Resident #16 required assistance to transfer, and was unable to</p>	F000323	Resident # 16 was laid down after breakfast at approx. 10:15am. The drawer with the broken handle was replaced immediately once it was brought to the attention of the facility. Work order guidelines were in-serviced for all staff to identify any areas in need of repair or replacement. All residents have the potential to be affected. All nursing staff were in-serviced on fall management program guidelines. A checklist was developed to ensure all fall interventions are in place and staff are aware of the expectation of fall interventions. These checklists will be completed 5x week for four weeks, then 3x week for four weeks, then monthly until substantial compliance is achieved. Results of audits will be discussed with the QA team monthly for 6 months for ongoing needs and action. DHS or designee to complete the audits. Work order follow up will be monitored weekly for 5 weeks, then monthly for 6 months with results reviewed by QA team monthly for ongoing needs and action. DPO or designee will complete the reviews.	09/13/2014			

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	<p>maintain balance while sitting, standing or walking without assistance." The Care Plan section of the form indicated an update of, "Staff education to lay down after meals." The 7/23/14 IDT (Interdisciplinary Team) Review section, signed by the DHS (Director of Health Services), indicated the root cause was, "Leaned forward in w/c & fell out", and that the care plan intervention update to lay down after meals was appropriate.</p> <p>The 8/11/14 Individualized Care Plan for Resident #16 indicated, "I like to lay down after meals. Because of my dementia, I am at risk for falls...I forget that I am not able to transfer myself, so do not leave me alone in B/R (bathroom), and when taken to my room after meals, nursing to assist me directly to bed after toileting. I like to be laid down after meals. Nursing to assist to bed after meals. I tend to slide in my w/c increasing my risk of falling."</p> <p>An observation was made on 8/14/14 at 10:15 a.m. Resident #16 was by herself, in her wheel chair, in the 100 hall, just outside of her room. Resident #16 was not lying in bed, even though it was after breakfast.</p> <p>An interview was conducted with CNA #8 on 8/14/14 at 10:55 a.m., regarding</p>			

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	<p>Resident #16 being in the hallway in her wheel chair after breakfast, and not lying in bed. She indicated she and another CNA typically lay her down after they finish passing breakfast trays. She indicated they helped Resident #16 to bed a half hour ago (10:25 a.m.). She stated, "I know her care plan says to lay her in bed after meals, but no one has told me specifically when, or to do it immediately after meals. Breakfast is over at 9:00 a.m., so she was back around 9:15 a.m. It was a good hour before we put her to bed." Regarding whether Resident #16 was able to ambulate herself back to the 100 hall after breakfast, or whether she required assistance, she indicated, "Someone had to assist her back here after breakfast."</p> <p>An interview was conducted with the DHS on 8/14/14 at 11:06 a.m., regarding her expectation for assisting Resident #16 to bed after meals. She indicated, "I expect them to be laid down within 2 hours, because it's tough after breakfast." Regarding whether Resident #16 should be assisted directly to bed after meals as care planned, and because her 7/22/14 fall occurred at 8:45 a.m., right after breakfast, she indicated, Resident #16 probably should lay down right after breakfast. She indicated, in hindsight, she should have informed staff to</p>			

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	<p>immediately assist her to bed after meals.</p> <p>The Falls Management Program Guidelines was provided by the DHS on 8/14/14 at 11:17 a.m. It indicated, "(Name of facility company) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures."</p> <p>2. The clinical record for Resident #25 was reviewed on 8/6/14 at 11:00 a.m. The diagnoses for Resident #25 included, but were not limited to, dementia.</p> <p>A telephone interview was conducted with Family Member #9 on 8/6/14 at 12:00 p.m. Regarding any concerns she had for Resident #25, she indicated, "Her nightstand has a drawer handle that's broken off, and I'm afraid she's going to cut her hand on it. Sometimes she tries to go through her drawers, when she's in one of her states. Usually maintenance is pretty good about stuff like that, but it's been like that for 2 weeks."</p> <p>An observation of Resident #25's nightstand was made on 8/6/14 at 12:02 p.m. The top drawer handle was broken, leaving 2 very sharp edges on each side, easily accessible.</p> <p>An observation of Resident #25's night</p>						

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F000329 SS=D	<p>stand was made with the Plant Operations Manager on 8/6/14 at 12:07 p.m. He indicated, "Our housekeeping staff goes in the rooms at least twice a week, so they can report anything to us." He looked at the drawer handle and stated, "Yeah, that's a cut hazard. I've cut my hand on one of those myself. I don't have a work order on that. No one has reported that to me."</p> <p>The Staff Development Coordinator provided the Furniture Maintenance Policy on 8/11/14 at 1:17 p.m. It indicated, "It is imperative for us to constantly monitor the condition of the furniture daily."</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse</p>			

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	<p>consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor a resident's blood pressure as required related to the administration of blood pressure medication. This affected 1 of 5 residents reviewed for unnecessary medication usage. (Resident #43)</p> <p>Resident #43's record was reviewed on 8/5/14 at 10:22 a.m. The resident's diagnoses included, but were not limited to, right sided weakness, hypertension, and seizures.</p> <p>Resident #43's medications included, but were not limited to, hydralazine, carvedilol, lasix, and potassium chloride.</p> <p>A 4/23/14 MDS (minimum data set)</p>	F000329	<p>All staff who administer medications were in-serviced on medication administration procedures in relation to obtaining and recording vital signs prior to administration of anti-hypertensive medications. All residents receiving anti-hypertensive medications have the potential to be affected. A form was developed to ensure vital signs that are taken are recorded promptly in the MAR. A checklist was developed to audit to ensure vital signs and blood pressure monitoring are being recorded. These checklist will be completed 5 x week for four weeks, then 2x week for four weeks, then monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for 6 months for ongoing needs and action. Audits will be completed by DHS or designee.</p>	09/13/2014

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	<p>Assessment indicated Resident #43's BIMS score (brief interview for mental status) was 13, which indicated the resident was interviewable and could reliably answer questions. The assessment also indicated Resident #43's diagnoses included a diagnosis of hypertension.</p> <p>On 8/7/14 at 1:35 p.m., during an interview, the DHS indicated the medication administration record should have Resident #43's blood pressure assessed daily prior to the administration of any blood pressure medications.</p> <p>On 8/7/14 at 1:46 p.m., the DHS provided Resident #43's medication administration record for the entire months of June and July, 2014 and for a partial month of August, 2014.</p> <p>On 8/11/14 at 12:53 p.m., the DHS indicated Resident #43 should have had a care plan in place for daily blood pressure monitoring. she indicated there was not such a care plan or care plan intervention in Resident #43's record.</p> <p>Resident #43's medication administration record for July, 2014 indicated for a blood pressure to be recorded prior to the administration of carvedilol, a blood pressure and heart medication. The</p>			

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	<p>medication was to be given twice a day, "...upon rising..." and at "...HS (hour of sleep)..." The only blood pressure recorded for carvedilol in July, 2014 was taken on 8/13/14, at HS. All other dates showed no blood pressure readings for carvedilol.</p> <p>Another blood pressure medication listed in Resident #43's July, 2014 medication administration record (MAR) was hydralazine. The MAR entry indicated "...HOLD IF SYSTOLIC (blood pressure) LESS THAN 110..." The medication was listed as being ordered twice daily. No blood pressure readings were identified on the July, 2014 MAR next to hydralazine. The MAR for June, 2014 indicated no blood pressure readings were taken prior to the administration of hydralazine.</p> <p>On 8/7/14 at 2:19 p.m., the DHS indicated she could not verify nursing staff assessed Resident #43's blood pressure daily as ordered during June 2014, July 2014, and August 1st through August 7th, 2014.</p> <p>A facility policy titled "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES" indicated "...Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary</p>			

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F000371 SS=F	<p>prior to medication administration..."</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure bread products were properly stored for safety. This had the potential to affect 54 residents in the facility who eat food from the kitchen.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the Director of Dining Services on 8/7/14 at 10:10 a.m.</p> <p>The dry storage area contained 4 packages of unsealed, opened, bread products. The Director of Dining Services threw all 4 bread products into the trash can. In an interview with the</p>	F000371	<p>Bread that was identified as unsealed was immediately disposed of during tour of kitchen with surveyor. All Dining services employees were in-serviced on 8/7/14 on proper storage of bread products after opening. A checklist has been developed to ensure proper procedures for bread products are being followed. These checklists will be completed 5 x week for four weeks, then 2x week for four weeks, then monthly thereafter until substantial compliance is achieved. Results of audits will be discussed with QA team monthly for 6 months for ongoing needs and action. Audits will be completed by DFS or designee.</p>	09/13/2014			

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F000441 SS=F	<p>Director of Dining Services, on 8/7/14, at 10:25 a.m., she indicated the products should have been sealed.</p> <p>The Administrator provided a copy of the 8/7/14 Dietary Inservice on 8/7/14 at 2:30 p.m. It indicated, "Proper storage of bread products after opening. Once a bread product is opened, it shall be re-tied and dated with the "open" date of the product."</p> <p>The Administrator provided a copy of the Storage Procedures policy on 8/7/14 at 2:30 p.m. It indicated, "Open packages are labeled, dated, and stored in closed containers."</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to</p>			

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	<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record, the facility failed to ensure: A. an infection control policy followed the Centers for Disease Control (CDC) guidelines regarding Clostridium difficile (C.diff) isolation precautions. This had</p>	F000441	Infection control policy was updated immediately to reflect CDC guidelines regarding c-diff isolation precautions. All residents have the potential to be affected. All staff immediately were inserviced on updated	09/13/2014

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	<p>the potential to affecte 54 residents that resided in the facility.</p> <p>B. "contaminated" gloves were disposed of before touching a light switch. This had the potential to affect 1 of 1 residents reviewed for a wound care observation. (Resident #62)</p> <p>Findings include:</p> <p>A.1. The clinical record for Resident #63 was reviewed on 8/6/14 at 1:05 p.m. The diagnosis for Resident #63 included, but was not limited to, C. diff (Clostridium difficile).</p> <p>During an observation of Resident #63's room, on 8/6/14 at 2:20 p.m., no isolation gowns were noted in the room or at the entrance of the room.</p> <p>During an interview with LPN #1, on 8/6/14 at 2:40 p.m., she indicated isolation gowns should be available in Resident #63's room because Resident #63 had C.diff.</p> <p>At 2:45 p.m., on 8/6/14, the Director of Health Services indicated isolation gowns were kept in the "Clean Room." She further indicated staff were expected to follow the Facility policy and put on gowns only when contact with bodily fluids was a possibility.</p>		<p>infection control policy regarding c-diff isolation. All nursing staff were also inserviced on standard precaution guidelines related to proper glove usage. Random observations will be completed to ensure standard precautions and c-diff isolation precautions are being followed 3x/week for four weeks, then 2x/ week for 4 weeks, then monthly thereafter until substantial compliance is achieved. Results of observations will be discussed with QA team monthly for 6 months for ongoing needs and action. DHS or designee will complete observations.</p>	

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	<p>On 8/6/14, at 2:51 p.m., CRCA #2 (Certified Resident Care Assistant) indicated she worked on the hall on which Resident #63 resides all day. CRCA #2 indicated there had not been any isolation gowns in Resident #63's room until 2nd shift. CRCA #2 further indicated she only puts on a gown if bodily fluids might come in contact with her clothes. CRCA #2 indicated if she walked into Resident #63's and realized that she might need a isolation gown because of possible contact, she would leave the room and would grab a gown from the "Clean Room." CRCA #2 indicated Resident #63 was still having diarrhea that day.</p> <p>"How can Clostridium difficile Infection Be Prevented in Hospitals and Other Healthcare Settings," (3/6/12) was retrieved on 8/6/14 at 2:40 p.m., from the Centers of Disease Control (CDC) website. The guidance indicated to, "...use gowns when entering patient's rooms and during care....continue these precautions until diarrhea ceases...."</p> <p>A policy titled, Guidelines, Standard Precautions, dated 12/10, was received from the Director of Health Services (DHS), on 8/5/14 at 2:30 p.m. The policy indicated, "...1. Contact</p>			

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	<p>Precautions should be used for individuals known or suspected to be infected or colonized with microorganisms...a. Examples of infections requiring Contact Precautions include but are not limited to:...2. Diarrhea associated with Clostridium difficile....1. A clean, non-sterile gown should be worn when entering the room if:</p> <p>a. It is anticipated that clothing will have substantial contact with an actively infected resident, environmental surfaces, or items in the resident room.</p> <p>b. The actively infected individual is incontinent, has diarrhea, an ileostomy, a colostomy or wound drainage not contained by a dressing.</p> <p>During an interview with the DHS, on 8/7/14 at 2:10 p.m., she indicated the Facility's Corporate Office was going to revise their policy to reflect the CDC guidelines of having staff wear an isolation gown anytime a staff member enters a room of a Resident with C. diff. The DHS further indicated gowns will be kept near the entrance the room, at all times, with a Resident that has C. diff.</p> <p>On 8/7/14, at 2:45 p.m., the Administrator indicated the Facility received an email that day around 11:46 a.m. from the Corporate Office. The</p>			

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	<p>email indicated the Infection Control policy regarding isolation precautions for C. diff would be revised to follow CDC guidelines and an inservice was needed immediately to educate staff on isolation precautions for C. diff.</p> <p>2. During an random wound care observation on Resident #62, with LPN #3 on 8/13/14 at 1:44 p.m., she cleaned a sacral/buttock wound, placed medication on the wound, and dressed the wound. After LPN #3 completed the wound care on Resident #62, LPN #3 turned off the light over Resident #62's bed with her gloves still on that touched the area around Resident #62 sacral/buttock wound.</p> <p>During an interview with LPN #3, on 8/13/14 at 1:50 p.m., she indicated she still had on the gloves that touched Resident #62 when she turned off the over bed light. LPN #3 further indicated she should have discarded the contaminated gloves before turning the light off.</p> <p>A policy titled, Standard/Universal Precautions Guidelines, dated 3/12, was received from the DHS on 8/14/14 at 11:04 a.m. The policy indicated, "...d. Do NOT handle medical equipment, or other devices with contaminated</p>			

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R000217	<p>gloves....f. Remove gloves after contact with a resident or that of contaminated equipment...."</p> <p>On 8/14/14 at 11:05 a.m., the DHS indicated LPN #3 should've discarded her gloves after touching the resident since the gloves were considered contaminated.</p> <p>3.1-18(a) 3.1-18(b)(2)</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</p>			

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	<p>resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(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> <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 a Resident signed a Service Plan. This affected 1 of 7 residents reviewed for clinical records. (Resident #27)</p> <p>Findings include:</p> <p>The clinical record for Resident #27 was reviewed on 8/14/14 at 11:00 a.m. The diagnoses for Resident #27 included, but were not limited to, diabetes mellitus, diabetic neuropathy, anemia, and bilateral venous insufficiency.</p>	R000217	Resident #27 reviewed service plan for accuracy. Assisted Living unit manager was inserviced on obtaining signatures of residents for each service plan completed. Checklist was developed to indicate most recent service plan with signature for auditing purposes. ED or designee will monitor monthly for compliance with results discussed in QA with team monthly.	09/13/2014			

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	<p>An Evaluation and Service Plan, dated 6/25/14, had a section titled, "Signature and Date of Service Plan Team." The section indicated a signature was needed by the Resident and/or Responsible Party. This section of the Evaluation and Service Plan was completely blank, without any signatures or dates.</p> <p>During an interview with CRCA #5, on 8/14/14 at 10:30 a.m., she indicated Resident #27 was interviewable and oriented.</p> <p>The Director of Health Services (DHS) indicated on 8/14/14 at 11:20 a.m., she did not see a signature on the Evaluation and Service Plan. The DHS further indicated the Resident and/or Responsible Party was updated if there was a change in their plan and would have the Resident/Responsible Party sign the Service Plan then. Otherwise, the Facility typically does not have the Resident/Responsible Party sign the Service Plan. The DHS also indicated Resident #27 was interviewable. The DHS indicated at this time, she will look for the policy regarding Service Plans.</p> <p>On 8/14/14 at 11:45 a.m., the Administrator indicated if there was no change in a Resident's Service Plan, the Facility typically does not have the</p>			

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R000273	<p>Resident/Responsible Party sign the Service Plan. The Administrator further indicated Resident #27 was interviewable.</p> <p>A policy titled, Guidelines for Level of Care and Service Plan Communication, no date, was received from the Assistant Director of Health Services on 8/14/14 at 12:16 p.m. The policy did not indicate a signature was needed on the Service Plan, by the Resident/Responsible Party.</p> <p>During an interview with the Administrator, on 8/14/14 12:29 p.m., she indicated Resident #27 should've signed the Service Plan as indicated by the State Residential Rules.</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure trash cans were covered, when not in</p>	R000273	DFS or designee to monitor and maintain all sanitary guidelines regarding garbage cans and lid usage. All dining service staff will be inserviced and proper	09/13/2014

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	<p>continuous use, in the kitchen. This had the potential to affect 31 residents in the facility who eat food from the kitchen.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the Director of Dining Services on 8/7/14 at 10:10 a.m.</p> <p>The Director of Dining Services threw 4 bread products into a trash can in the kitchen. The trash can lid had a large hole cut into the center. The trash can was not in use. The 4 bread products were observed through the large hole in the lid. Regarding the large hole in the lid of the trash can, the Director of Dietary Services indicated, "I was told it was okay, because the lid is on. It's just more convenient, so staff doesn't have to take the lid off while preparing food." A second trash can was observed in the kitchen with a large hole cut into the center of the lid.</p> <p>The Administrator provided the dimensions of the holes in each of the observed trash cans on 8/7/14 at 2:30 p.m. One had a diameter of 9 1/2 inches. The other had a diameter of 1 foot.</p> <p>The Administrator provided a copy of the Garbage and Refuse policy on 8/7/14 at</p>		<p>practices. This will be monitored by random checks 3 times week for four weeks, then 1x week for four, and monthly thereafter with results submitted to QA team for review and discussion for ongoing needs and actions. DFS or designee will be responsible for observations.</p>	

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	2:30 p.m. It indicated, "Garbage receptacles will be lined with sturdy garbage bags and covered at all times, except during active use, and when being transported to the dumpster area."				