

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 07/15/2015
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NAME OF PROVIDER OR SUPPLIER  KEYSTONE WOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 2335 N MADISON AVE ANDERSON, IN 46011
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: July 13, 14, and 15, 2015</p> <p>Facility Number: 010409 Provider Number: 010409 AIM Number: N/A</p> <p>Census Bed Type: Residential: 59 Total: 59</p> <p>Census Payor Type: Other: 59 Total: 59</p> <p>Sample: 7</p> <p>These state findings are in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Keystone Woods POC 2015</p> <p><b>This plan of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on 7/27/2015 does not constitute an admission of fault of liability to the government entity of any third party, on the part of Keystone Woods, as to the accuracy of the surveyors' findings of 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 communities policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 47 of the Federal Rules of Evidence and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the 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 is inadmissible by any third party in any civil or criminal action against the community or any employee,</b></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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R 0241  Bldg. 00	<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. Based on record review, observation, and interview, the facility failed to ensure nurses obtained blood sugar readings for which sliding scale insulin administration was based, and failed to administer sliding scale insulin in accordance with physician's orders for 1 of 2 residents reviewed with sliding scale insulin coverage (Resident #R10), and failed to ensure nursing staff obtained a physician ordered laboratory test for 1 of 5 residents reviewed for laboratory testing. (Resident #R46)</p> <p>Findings include:</p> <p>1. Resident #R10 was observed during a blood sugar reading and insulin administration on 7/13/15 at 11:36 a.m., with LPN #1.</p> <p>The clinical record for Resident #R10</p>			R 0241	<p><b>agent, officer, director, attorney, or shareholder of the community or affiliated companies.</b></p> <p>RE: R241 Offense Q1-Resident #R10's diabetic protocol was reviewed by each licensed nurse from the facility to ensure all professionals were familiar with the sliding scale coverage parameters. The DON compared the diabetic protocol for Resident #10 to the MARS &amp; Diabetic Testing log to ensure accuracy of physician orders on all documents on July 16, 2015. Resident #10 did not display an adverse reaction from the lack of insulin dose on those days noted. Q2-The remaining residents with diabetic protocols will be reviewed by their respective physicians and each licensed nurse from the facility to ensure all professionals are familiar with the parameters ordered by July 27, 2015. The DON compared the diabetic protocols to the MARS &amp; Diabetic Testing logs to ensure accuracy of physician orders on all documents on July 27, 2015.</p>		07/29/2015

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	<p>was reviewed on 7/13/15 at 3:33 p.m. The diagnoses for Resident #R10 included, but were not limited to, diabetes, congestive heart failure, and depression.</p> <p>Current physician orders for Resident #R10 included, but were not limited to, the following:</p> <p>a. Blood sugar monitoring before meals and at bedtime. The original date of this order was 3/25/15.</p> <p>b. Novolog (insulin) per sliding scale</p> <p>150 - 174 = 3 units 175 - 199 = 4 units 200 - 249 = 5 units 250 - 274 = 6 units 275 - 299 = 8 units 300 - 324 = 9 units 325 - 349 = 10 units 350 - 374 = 11 units 375 - 399 = 12 units</p> <p>If less than 60 or greater than 400 call the physician The original date of this order was 3/13/15.</p> <p>c. Glipizide (a diabetic medication) 5 milligrams (mg) 1 tablet by mouth twice daily. The original date of this order was</p>		<p>Q3- All licensed staff will be in-serviced on medication administration and documentation policy, sliding scales, and diabetic protocol policy on July 27 and 28, 2015 by Joyce Harris, DON. Audits will be performed in August, 2015 by Maria Cash, RN., Quality and Clinical Director of Capital Senior Living To establish a best practice for checking administration of sliding scale coverage, for the next 90 days the licensed nurse will have a 2nd person verify the amount of insulin to be given before each dose is administered. The best practice will be documented on the Diabetic Testing Log by both staff persons.</p> <p>Q4-The DON will review the Diabetic Testing Logs five days a week every week for the first four weeks, then three days a week for four weeks, then one day a week for four weeks and then monthly until next survey to ensure the diabetic protocol parameters were followed. The diabetic protocol will be updated yearly or as needed, when a change in the orders is received. The charge nurse will notify the DON of a change in the diabetic protocol and the DON will send the revised Diabetic Protocol to the physician for signature and ensure each licensed nurse has reviewed the revised Diabetic Protocol. The DON will compare the revised Diabetic Protocol with MARS &amp; Diabetic Testing Log to ensure accuracy. The DON will review the findings from</p>				

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	<p>3/13/15.</p> <p>d. Januvia (a diabetic medication) 100 mg 1 tablet by mouth once daily. The original date of this order was 3/13/15.</p> <p>Review of the June 2015, "Keystone Woods Diabetic Testing Log", indicated the following:</p> <p>June 2, 7:00 a.m., the blood sugar result was 163, and no insulin was documented as given. The resident should have received 3 units of insulin.</p> <p>June 15, 9:00 p.m., no blood sugar result was documented. The Medication Administration Record (MAR) was not initialed for the 9:00 p.m. blood sugar reading.</p> <p>June 19, 9:00 p.m., the blood sugar result was 150, the dose of insulin given was not documented. The resident should have received 3 units of insulin.</p> <p>June 25, 9:00 p.m., the blood sugar result was 199, and no insulin was documented as given. The resident should have received 4 units of insulin.</p> <p>This resulted in 3 missed doses of sliding scale insulin coverage in June, 2015. This also resulted in one missed blood</p>		<p>the audits at the quarterly QA meeting.</p> <p>Q5- Completion date of these system changes – July 28, 2015</p> <p>Q1- Resident #R46 did not display an adverse reaction due to lab not being completed. Lab has been completed with no change in orders.</p> <p>Q2-The DON or designee will review all of the remaining residents with lab orders for incomplete orders by July 29, 2015.</p> <p>Q3-The lab orders will now be put on the MARs and a copy of the order will be given to the DON, or designee who will review five days a week every week for the first four weeks, then three days a week for four weeks, then one day a week for four weeks and then monthly until next survey to ensure labs are ordered and completed accordingly. The licensed staff will be in-serviced on the protocol for lab orders on July 27 and 28, 2015 by Joyce Harris, DON.</p> <p>Q4-The DON will review the findings of the lab order audits at the quarterly QA meeting.</p> <p>Q5- Completion date- July 29, 2015</p>				

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	<p>sugar reading and the possible need of sliding scale coverage in June, 2015.</p> <p>During an interview with the Director of Nursing (DON) on 7/15/15 at 8:58 a.m., she indicated the only place the blood sugar results and sliding scale insulin coverages were documented would be on the diabetic log. The MAR was initialed by the staff when the tasks (the blood sugar reading obtained and insulin given if needed) were completed.</p> <p>During an interview with LPN #2 on 7/15/15 at 11:17 a.m., she indicated blood sugar results and sliding scale insulin coverage "is documented on the diabetic log and no where else."</p> <p>Review of the current, undated, facility policy, titled "Administration of Medication : Insulin", provided by the Administrator on 7/15/15 at 11:30 a.m., included, but was not limited to,</p> <p>"Purpose: To assure that resident's insulin is administered as ordered and in a safe and dignified manner.... ...11. If a sliding scale is ordered, follow this procedure for that dose as well."</p> <p>2. The clinical record for Resident #R46 was reviewed on 7/14/15 at 10:25 a.m. Diagnoses for Resident #R46 included,</p>			

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	<p>but were not limited to, diabetes, anxiety, vertigo and bipolar disorder.</p> <p>An order, dated 6/24/15, indicated R#46 was to have a Depakote level (a laboratory test for drug toxicity), one time in the morning. The clinical record lacked any results for a Depakote level.</p> <p>During an interview on 7/15/15 at 11:24 a.m., LPN #3 indicated she could not find a Depakote level for Resident #R46. LPN #3 called the laboratory and the laboratory did not have a Depakote level from June 2015, for Resident #R46. LPN #3 indicated all laboratory orders were to be faxed to the laboratory (Community Hospital). The laboratory would send someone to draw the laboratory test to the facility. LPN #3 could not find a fax conformation for the Depakote level order from 6/24/15 for Resident #46 in the "lab order book."</p> <p>During an interview on 7/15/15 at 11:38 a.m., the Director of Nursing indicated "the staff on third shift follows-up on physician orders and it appears the Depakote order did not make it to the laboratory."</p> <p>During an interview on 7/15/15 at 1:08 p.m., the Administrator indicated they did not have a policy related to laboratory</p>			

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R 0410 Bldg. 00	<p>testing.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be 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. (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. (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 Mantoux test for tuberculosis (TB test) prior to or upon admission for 1 of 4 newly admitted residents reviewed for TB tests prior to or upon admission. (Resident #R46)</p> <p>Findings include:</p>	R 0410	<p>RE: R410 Non-compliance Q1- Resident #R46 did not display an adverse reaction due to TB test not being completed upon admission. Testing was done on 3/10/15 when brought to the attention of nursing that it had not been given prior to or at admission. Q2- All remaining residents' charts have been audited for completion of TB testing. Q3 - The TB test will be documented</p>	07/23/2015

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	<p>The clinical record for Resident #R46 was reviewed on 7/14/15 at 10:25 a.m. Diagnoses for Resident #R46 included, but were not limited to, diabetes, anxiety, and vertigo.</p> <p>The clinical record indicated a Tuberculin (TB) test had been administered on 3/10/15 and 3/25/15. Resident #R46 was admitted on 2/21/15.</p> <p>During an interview with the Director of Nursing (DON) on 7/14/15 at 10:42 a.m., she indicated the resident had moved/transferred from another facility. Additional information related to the resident's TB testing prior to her admission to this facility was requested.</p> <p>During an interview with the DON on 7/15/15 at 8:58 a.m., she indicated the previous facility was to include the TB testing with their records. The DON contacted the previous facility when the TB testing records were not received and was told the resident did not have the TB testing completed because she lived in the assisted living area of the facility.</p> <p>During an interview with the Administrator on 7/15/15 at 9:48 a.m., she indicated she had been informed by the previous facility Resident R#46 did not require a TB test at their facility</p>		<p>on the MARs upon admission. Q4 – The DON will in-service nursing staff on infection control and the TB policy. The designee will document all TB tests in the residents' chart. The DON will monitor all PPDs after each new resident move in. and annually for each resident. Q5- Completion date – July 23, 2015</p>	

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	<p>because the facility was unlicensed and did not require TB testing.</p> <p>The undated, current, "MANTOUX TESTING", policy was provided by the Administrator on 7/15/15 at 11:10 a.m. The policy indicated the following : "...All Residents must have a Mantoux method TB test within 14 days of their move-in date to the Community [or per state regulation], unless they have a documented history of a positive TB test...."</p> <p>The "Assisted Living Residency Agreement", was provided by the Administrator. The agreement indicated the following "...You agree that if you have not had a diagnostic chest x-ray within six [6] months prior to your Commencement Date and a Mantoux test within three [3] months prior to your Commencement Date, you will have them performed and your physician deliver the results of both to us no less than forty-eight [48] hours before the Commencement Date...."</p>			