

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 01/03/2013
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NAME OF PROVIDER OR SUPPLIER SUGAR GROVE ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
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R0000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00120636.</p> <p>Complaint IN00120636 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 2 and 3, 2013</p> <p>Facility number: 012394 Provider number: 012394 AIM number: N/A</p> <p>Survey team: Heather Lay, RN - TC Lori Brettnacher, RN</p> <p>Census bed type: Residential: 114 Total: 114</p> <p>Census payor type: Other: 114 Total: 114</p> <p>Sample: 8</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2-5.</p>	R0000	<p>The Plan of Correction is neither an agreement with nor an admission of wrong doing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of January 25, 2013 and requests paper compliance for this survey.</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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	Quality Review completed on 01/08/2013 by Brenda Nunan, RN.				

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R0148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility.</p> <p>(2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes.</p> <p>(3) All plumbing shall function properly and comply with state plumbing codes.</p> <p>(4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on interview and record review, the facility failed to maintain the function of a secure door in 1 of 1 locked dementia unit resulting in the elopement of a resident. This deficient practice affected 1 of 1 resident reviewed for elopement from the locked dementia unit in a sample of 8 residents reviewed. [Resident #81]</p> <p>Findings include:</p> <p>On 1/2/13 at 10:15 A.M., the facility investigation of the self-reported incident that involved Resident #81 on 1/19/12 was requested from the</p>	R0148	As was stated in the initial report of January 19, 2012, the doors were repaired at the time of incident. Although the resident eloped, staff observed her to suffer no negative outcomes from the elopement. A review of all other incidents of elopement showed that no other elopements were the result of the failure of doors. As mentioned during the survey, alarms were placed on the doors and a new policy implemented following the incident of January 19, 2012. Going forward, the policy was revised to require that the doors be checked weekly for proper functioning and positioning. The door checks will be monitored for	01/23/2013			

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	<p>General Manager.</p> <p>On 1/2/13 at 12:00 P.M., the General Manager provided, "Incident Investigation" dated 1/19/12. The investigation report indicated, "No staff witnessed resident [Resident #81] exit the unit... Resident [#81] was seen leaving the building by the nursing assistant in the main dining room... Nursing staff attempted to verify that the door was secure and noticed that the lock failed to click and the door was not secure... Brief Description of Incident: A nurse walking in the adjacent dining room in assisted living noticed a resident [Resident #81] of the secure memory care unit walking with her coat and purse in the courtyard [outside, non-secure area]... Type of injury: No injuries... Immediate action taken: Returned to [locked] unit... Maintenance staff immediately checked the doors [dementia unit doors] to determine function... doors did fail to fully close on one occurrence... the doors were adjusted and reset to prevent a reoccurrence... Preventive measures to be taken: The doors [dementia unit doors] will be checked daily by maintenance to ensure that the doors do not sag and begin to rub against one another again..."</p>		<p>completion by the General Manager or her representative on a monthly basis for the next six months. This change will be effective January 23, 2013.</p>				

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	<p>On 1/3/13 at 1:40 P.M., in an interview with the General Manger and the Director of Environmental Services, they indicated that prior to Resident #81 eloping from the secured unit on 1/19/12, the policy for checking the functioning of the secure doors was to check daily and more often if needed; however, they were unable to provide a log of the daily checks or a policy regarding the checks prior to the incident on 1/19/12.</p> <p>On 1/3/13 at 1:40 P.M., the General Manger provided an undated policy titled, "Alarms Memory Care in Residential Care." The General Manger indicated she did not date her policies; however, the policy and procedure provided was created after the 1/19/12 incident with Resident #81.</p> <p>The policy and procedure indicated, "Policy: The memory care community has alarmed doors leading to the outside of the building to provide a safe environment for our residents. The tendency to wander inside and outside the community is a common behavior by residents.... Procedure: The doors that lead to the outside are equipped with an alarm system to</p>						

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	<p>alert staff members when a door has been opened.... It is the responsibility of staff to respond..."</p> <p>The policy did not include any reference to checking the function of the secure door.</p>			

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R0217	<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:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (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 identify services to be provided to a resident with anxiety who received as needed anti-anxiety medications [Xanax] in 1 of 1 resident reviewed for as needed anti-anxiety medication use [Resident #81]. In addition, the facility failed to</p>	R0217	Resident #81's health services plan was amended to include documentation of anti-anxiety interventions on the health services plan, and it was validated that the power of attorney was aware of and in agreement with the health services plan. For Resident #77, it was validated that the power of	01/24/2013

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	<p>obtain a resident's signature of acknowledgement for an agreed upon service plan. This deficient practice affected 2 of 8 residents reviewed for complete service plans. [Resident #81 and #77]</p> <p>Findings include:</p> <p>1. On 1/3/13 at 9:50 A.M., Resident #81's record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, and insomnia.</p> <p>Resident #81 was admitted to the facility's locked dementia unit on 8/15/11.</p> <p>A "Service Evaluation and Health Assessment" dated 7/3/12, included, but was not limited to, "Scheduled [service plan]... Walks independently... Socialization: [marked]: Engaged, Active, Quiet, Happy, Enjoys life, Agreeable, Good Humored... Memory and Cognition: [marked]: Interacts socially, Participates in hobbies, Respects others belongings, Exhibits appropriate behaviors..."</p> <p>A physician's orders, dated 12/21/12, included, but was not limited to the following medications, "Xanax 0.5</p>		<p>attorney was aware of and in agreement with the health services plan. A review of the documentation revealed additional residents with PRN anti-anxiety medications without documentation of the interventions on the health services plan. The appropriate interventions were added to the health services plan. A review of the health services plans revealed additional residents whose health services plans did not have signatures for the current update to the health services plan. For each of these health services plans, it was validated that the resident and/or power of attorney was aware of and in agreement with the health services plan. Staff will be educated on the need for interventions for anxiety up to and including medication on the health services plan. The Health Services Plan was amended to allow for additional signature locations for resident or responsible party to allow for validation of updates to the health services plan. Staff was provided education on the requirement of resident or responsible party validation of the contents of the health services plans. The Director of Health Services or her designee will audit ten health services plans per week for four weeks followed by ten health services plans per month for five additional months to ensure</p>				

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	<p>milligrams by mouth every 6 hours as needed for agitation... [original order for Xanax 3/30/12]..."</p> <p>Resident #81's "Service Evaluation and Health Assessment" did not indicate any non-pharmacological services to be provided before administration of the as needed medication, Xanax.</p> <p>A "Narcotic Count Sheet" for Alprazolam [Xanax] 0.5 milligrams, included, but was not limited to the following dates and times of medication administration:</p> <p>10/26/12 at 1:30 A.M. 10/30/12 at 11:00 P.M. 11/7/12 at 1:00 A.M. 11/10/12 at 1:00 A.M. 11/15/12 at 4:00 P.M. 11/16/12 at 11:30 P.M. 11/17/12 at 6:00 P.M. 11/27/12 at 5:00 A.M. 12/15/12 at 6:00 P.M. 12/16/12 at 6:00 P.M. 12/22/12 at 7:00 P.M. 12/27/12 at 10:45 P.M. 12/29/12 at 7:00 P.M.</p> <p>The last nurse's notes for Resident #81 was dated 10/9/12. There was no documentation in the resident's clinical record regarding the need for</p>		compliance. This change will be effective January 24, 2013.				

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	<p>Xanax or any services provided to the resident prior to the administration of the medication.</p> <p>On 1/3/13 at 11:00 A.M., in an interview, the Director of Health Services indicated she could not provide any other nursing documentation in regard to the usage of the as needed Xanax. She indicated staff should have documented the reason for giving all as needed medications.</p> <p>On 1/3/13 at 12:19 P.M., in an interview, the Director of Health Services indicated the facility staff assessed behaviors, such as anxiety, and the interventions [non-pharmacological] for each resident; however, the facility did not have documentation to indicated the assessments.</p> <p>A semi-annual service plan, dated 1/18/12, for Resident #81 did not have a resident or responsible party signature.</p> <p>2. On 1/3/13 at 1:10 P.M., Resident #77's record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, anxiety, depression, status post hysterectomy and hip fracture.</p>			

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	<p>A "Re-Admit Service Evaluation and Health Assessment" dated 12/4/12 did not include a resident or responsible representative signature.</p> <p>On 1/3/13 at 3:00 P.M., in an interview, the Director of Health Services indicated she was not aware the service plan had not been signed on re-admission.</p> <p>On 1/3/13 at 4:00 P.M., in an interview, the facility General Manager and the Director of Health Services indicated they did not have any further documentation to provide for Resident #81 or #77.</p>			

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R0296	<p>410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.</p> <p>Based on observation and interview, the facility failed to develop and maintain a policy and procedure regarding medication administration. This deficient practice affected 1 of 1 resident observed who received a nebulizer [breathing] treatment in a sample of 5 residents observed during medication pass. [Resident #109]</p> <p>Findings include:</p> <p>On 1/3/13 at 10:37 A.M., administration of a nebulizer treatment was observed on Resident #109 by Licensed Practical Nurse [LPN] #2. The medication was Duoneb 0.5 milligrams - 3 milligrams per 3 milliliters.</p> <p>A lung assessment prior to or following the nebulizer treatment was not observed by LPN #2.</p> <p>On 1/3/13 at 11:00 A.M., in an interview, the Director of Health Services indicated staff should assess a resident prior to giving a</p>	R0296	Resident #109 did not show any negative outcomes requiring intervention from the lack of a nebulizer policy and procedure. Of the three additional residents utilizing nebulizer treatments, none showed any negative outcomes requiring intervention from a lack of nebulizer policy and procedure. The facility has a policy and procedure regarding nebulizer treatments. All LPNS and RNs will be educated on the policy and procedure. The Director of Health Services or her designee will observe one nebulizer treatment per week for one month, and one nebulizer treatment per month for five months thereafter to ensure compliance with the policy and procedure. This change will be effective January 24, 2013.	01/24/2013			

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	<p>nebulizer treatment. At that time, the policy and procedure regarding nebulizer treatment administration was requested.</p> <p>On 1/3/13 at 12:00 P.M., the General Manger indicated the facility did not have a policy or procedure for nebulizer treatment administration.</p>			

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R0297	<p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure a resident's daily dementia medication was available over a 3 day period. This deficient practice affected 1 of 8 residents reviewed for medication availability. [Resident #81]</p> <p>Findings include:</p> <p>On 1/3/13 at 9:50 A.M., Resident #81's record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, and insomnia.</p> <p>A "Physician's Orders" dated 11/20/12, included, but was not limited to, "Namenda 10 mg tablet give 1 tablet orally daily at bedtime - Alzheimer's... dates not given and charted as unavailable included 12/3, 12/4, and 12/5..."</p> <p>On 1/3/13 at 11:00 A.M., in an interview, the Director of Health Services indicated the daughter of</p>	R0297	<p>The resident did not demonstrate a negative outcome from not having her medication on 12/3, 12/4 and 12/5. An audit of the medication administration records for all residents revealed three additional residents for whom the facility was unable to administer medication because it was unavailable. An audit of the charts of these three residents did not reveal any negative outcomes from the failure to have the medication available. The policy and procedure was amended to include, "In the event that the community is administering the last dose of a medication and the medication has not yet arrived from either pharmacy, staff will request a "stat" delivery of the medication from the contracted pharmacy provider." Nursing staff members were educated on this procedure. The Director of Health Services or her designee will audit ten charts of residents who do not utilize the contracted pharmacy per week for four weeks followed by ten charts of resident who do not utilize the contracted</p>	01/24/2013			

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	<p>Resident #81 was responsible for her medication delivery. However, Resident #81's daughter didn't always pick up the medication when needed. The Director of Health Services indicated Resident #81's daughter became angry if the facility ordered the medication from the facility's contracted pharmacy provider as per facility policy.</p> <p>On 1/3/13 at 12:00 P.M., the Director of Health Services provided an undated policy titled, "Medication Availability." The "Medication Availability" policy, included, but was not limited to, "In order to most appropriately provide for the care of those residents for whom this community is administering medications, the community must have a supply of medications ready to administer... If the resident and or the responsible party have not provided the medication prior to the administration of the last dose and the medication is not available in the community's EDK [emergency drug kit], the community will order the required medication from the community's contracted pharmacy provider..."</p> <p>On 1/3/13 at 3:00 P.M., the Director of Health Services provided a, "Check</p>		pharmacy per month for five additional months to ensure compliance. This change will be effective January 24, 2013.				

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NAME OF PROVIDER OR SUPPLIER SUGAR GROVE ASSISTED LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168
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	<p>Fill Status" from the resident's pharmacy, dated 11/29/12, that indicated the resident's Namenda was ready for pick up. At that time, in an interview, the Director of Health Services indicated staff should have ordered the medication from the facility's contracted pharmacy.</p>			

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to adequately document the reason for usage of an as needed anti-anxiety medication [Xanax]. This deficient practice affected 1 of 1 resident reviewed for as needed anti-anxiety medication usage in a sample of 8 residents reviewed. [Resident #81]</p> <p>Findings include:</p> <p>On 1/3/13 at 9:50 A.M., Resident #81's record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, anxiety, and insomnia.</p> <p>A physician's orders, dated 12/21/12, included, but was not limited to the following medications, "Xanax 0.5 milligrams by mouth every 6 hours as needed for agitation... [original order for Xanax 3/30/12]..."</p>	R0349	<p>A review of Resident #81's medical record revealed no negative outcomes from the administration of the "as needed" anti-anxiety medications. A review of the documentation revealed additional residents with "as needed" anti-anxiety medications without documentation of the non-pharmacological interventions or the specific reason for the need for the medication prior to administration. No negative outcomes from the administration of the "as needed" anti-anxiety medications were discovered in the documentation. Nursing will be educated on documentation of the reason for administration of anti-anxiety medication and the non-pharmacological interventions attempted prior to administration of anti-anxiety medication. The Director of Health Services or her designee will audit charts and medicine administration records of ten residents per week for four weeks</p>	01/24/2013			

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	<p>A "Narcotic Count Sheet" for Alprazolam [Xanax] 0.5 milligrams, included, but was not limited to the following dates and times of medication administration:</p> <p>10/26/12 at 1:30 A.M. 10/30/12 at 11:00 P.M. 11/7/12 at 1:00 A.M. 11/10/12 at 1:00 A.M. 11/15/12 at 4:00 P.M. 11/16/12 at 11:30 P.M. 11/17/12 at 6:00 P.M. 11/27/12 at 5:00 A.M. 12/15/12 at 6:00 P.M. 12/16/12 at 6:00 P.M. 12/22/12 at 7:00 P.M. 12/27/12 at 10:45 P.M. 12/29/12 at 7:00 P.M.</p> <p>The last nurse's notes for Resident #81 was dated 10/9/12.</p> <p>There was no documentation in the resident's clinical record regarding the need for Xanax.</p> <p>On 1/3/12 at 11:00 A.M., in an interview, the Director of Health Services indicated she could not provide any other nursing documentation in regard to the usage of the as needed Xanax. She indicated staff should have documented the reason for giving all</p>		<p>followed by charts and medicine administration records of ten residents per month for five additional months to ensure compliance. This change will be effective January 24, 2013.</p>				

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	as needed medications.			