

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2014
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NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
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F000000	<p>This visit was for the Investigation of Complaint number IN00151974.</p> <p>Complaint number IN00151974 Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309, and F514.</p> <p>Survey dates: July 16, and 17, 2014</p> <p>Facility number: 011150 Provider number: 155760 AIM number: 200831020</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: SNF: 39 SNF/NF: 20 Total: 59</p> <p>Census payor type: Medicare: 20 Medicaid: 18 Other: 21 Total: 59</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000	<p>The preparation or execution of this plan on correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey on July 16-17, 2014. Please accept this Plan of Correction as The Maples at Waterford Crossing's credible allegation of compliance effective August 16, 2014. The Maples at Waterford Crossing respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F000157 SS=D	<p>16.2-3.1.</p> <p>Quality review completed on July 18, 2014 by Randy Fry 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 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</p>				

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	<p>the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to notify the physician of low blood sugars according to facility policy for 1 of 3 residents (Resident #X); the facility further failed to notify the physician for clarification of call order parameters for 2 of 3 residents (Resident #X and Resident #Y) reviewed for physician notification in a sample of 4.</p> <p>Findings include:</p> <p>1. Resident #X's record was reviewed 7-17-2014 at 8:50 AM. Resident #X's diagnoses included, but were not limited to, diabetes, high blood pressure, and anemia.</p> <p>A review of Resident #X's MAR (medication administration record) dated 7-2014 indicated Resident #X had a blood sugar of 51 on 7-3-2014, before supper. The MAR indicated Resident #X received Orange juice. In the area marked MD called, an "N" was indicated. Additionally, on 7-13-2014, before breakfast, the MAR indicated Resident #X had a blood sugar of 60. The MAR did not indicate Resident #X had any intervention, and the area marked MD called had an "N" recorded.</p>	F000157	<p>1) Resident X and Y have been discharged. 2) Current insulin dependent Diabetics MAR's have been reviewed for past 30 days for routine insulin and sliding scale orders, and physician call parameters. 3) Nursing staff will be re-inserviced in regards to insulin review, MD call parameters, proper insulin dosing, and documentation of injection site. Director of Health Services (DHS) and or designee to monitor blood glucose on five diabetic residents three times per week for results outside of physician parameters for MD notification. DHS or designee will monitor all new admissions/readmissions for parameters for physician notification orders. 4) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for six months or till 100% compliance is obtained.</p>	08/16/2014

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	<p>In an interview on 7-17-2014 at 10:36 AM, LPN #1 indicated the MAR had an "N" marked in the area of MD notification. LPN#1 further indicated the "N" usually meant the physician had not been notified.</p> <p>A review of Nurse's notes for Resident #X did not indicate a note had been completed for the date of 7-3-2014. Additionally, the Nurse's note dated 7-13-2014 indicated Resident #X had bed and chair alarms discontinued, and the patient walked with walker. There was no note about Resident #X's blood sugar intervention or if the physician had been notified.</p> <p>A skilled Charting Evaluation dated 7-3-2014 did not include the results of the before supper blood sugar, nor the actions taken for the before supper blood sugar of 51.</p> <p>A current policy titled Guidelines for hyper/hypoglycemia dated 11-8-2010, provided by the Director of Health Services on 7-16-2014 at 10:59 AM indicated the following: under the section titled "Blood Glucose 50-69 MG/dL, If the resident does not have a specific order for treatment, the following procedure will be followed: When the</p>			

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	<p>resident exhibits hypoglycemia evidenced by a blood glucose level of 50-69 MG/dL, the following procedure will be followed:.....Notify the resident's primary care physician of condition and what has been done."</p> <p>2. A physician's order dated 6-25-2014 indicated Resident #X's physician should be notified for a blood sugar above 500. There was no indication of the call parameters for a low blood sugar.</p> <p>A review of Resident X's Medication Administration Record (MAR) dated 7-2014 indicated to call the physician if the blood sugar was above 500, and handwritten on the MAR was the instruction or < (less than) 70. The handwritten portion was not dated.</p> <p>A physician's order dated 7-16-2014 indicated to call Resident #X's physician if the blood sugar was less than 70.</p> <p>In an interview on 7-17-2014 at 9:48 AM, LPN #2 indicated the facility should have had low blood sugar call parameters ordered by the physician for each resident on sliding scale insulin, and the physician should have been notified to clarify the call orders.</p> <p>3. Resident #Y's record was reviewed</p>			

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	<p>7-17-2014 at 9:43 AM. Resident #Y's diagnoses included, but were not limited to diabetes, high blood pressure, and anemia.</p> <p>A review of physician's orders dated 5-21-2014 indicated Resident #Y's physician should be notified for a blood sugar over 500. There was no indication of the call parameters for a low blood sugar.</p> <p>A review of Resident Y's Medication Administration Record (MAR) dated 7-2014 indicated to call the physician if the blood sugar was above 500, and handwritten on the MAR was the instruction or < (less than) 70. The handwritten portion was not dated.</p> <p>A physician's order dated 7-16-2014 indicated to call Resident #Y's physician if the blood sugar was less than 70. There was no written physician's order for notification of low blood sugars prior to 7/16/14.</p> <p>This Federal tag relates to Complaint IN00151974</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 interview and record review, the facility failed to follow the care plan interventions for administering insulin as ordered for 2 of 3 residents reviewed who received insulin in a sample of 4. (Resident #X and Resident #Y)</p> <p>Findings include:</p> <p>1. Resident #X's record was reviewed 7-17-2014 at 8:50 AM. Resident #X's diagnoses included, but were not limited to, diabetes, high blood pressure, and anemia.</p> <p>Resident #X's care plan dated 7-17-2014 provided by the Director of Health Services on 7-17-2014 at 10:23 AM indicated under the area "Vitals... Administer my insulin as ordered- see my current orders"</p>	F000282	<p>1) Resident X and Y have been discharged. 2) Current insulin dependent Diabetics MAR's have been reviewed for past 30 days for correctly documented insulin dosages. 3) Nursing staff will be re-inserviced in regards proper diabetic orders, MD call parameters, proper insulin dosing, and documentation of injection site. DHS and or designee to monitor blood glucose on five diabetic residents three times per week for correct dosage administration. 4) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for six months or till 100% compliance is obtained.</p>	08/16/2014	

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	<p>Resident #X's physician orders for sliding scale insulin dated 5-21-2014 were as follows: Novolog flex pen Less than 150=0 units, 150-200=4 units, 201-250=6 units, 251-300=8 units, 301-350= 10 units, 351-400= 12 units, 401-500=15 units, greater than 500= call MD.</p> <p>A review of Resident #X's Medication Administration Record (MAR) indicated the following: on 7-7-2014 at bedtime, Resident #X's blood sugar was recorded as 201 MG/dL. Under the amount of insulin coverage category, the number "5" was recorded. The amount of units ordered for this blood sugar was 6. Additionally, on 7-10-2014 at bedtime, Resident #X's blood sugar was recorded as 215 MG/dL. Under the amount category, the number "4" had been recorded. The amount of units ordered for this blood sugar was 6</p> <p>2. Resident #Y's record was reviewed 7-17-2014 at 9:43 AM. Resident #Y's diagnoses included, but were not limited to diabetes, high blood pressure, and anemia.</p> <p>Resident #Y's care plan dated 7-17-2014 provided by the Director of Health Services on 7-17-2014 at 10:23 AM indicated under the area "Vitals... Administer my insulin as ordered- see my</p>			

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	<p>current orders"</p> <p>Resident #Y's physician orders for sliding scale insulin dated 5-21-2014 were as follows: Novolog flex pen Less than 150=0 units, 150-200=4 units, 201-250=6 units, 251-300=8 units, 301-350= 10 units, 351-400= 12 units, 401-500=15 units, greater than 500= call MD.</p> <p>A review of Resident #Y's MAR dated 7-2014 indicated on 7-8-2014, before lunch, Resident #Y's blood sugar was recorded as 220 MG/ dL. Under the insulin coverage category amount, the number "8" was recorded. The amount of units ordered for this blood sugar was 6. Additionally, on 7-11-2014, before lunch, Resident #Y's blood sugar was recorded as 213 MG/dL. Under the category amount, the number"0" was recorded. The amount of units ordered for this blood sugar was 6.</p> <p>In an interview on 7-17-2014 at 2:24 PM, LPN #4 indicated the numbers under the amount category indicated the number of units of insulin a resident had been given. LPN #4 further indicated the number of units should correspond with the number ordered on the sliding scale.</p> <p>This Federal tag relates to Complaint IN00151974.</p>						

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F000309 SS=D	<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.</p> <p>Based on interview and record review, the facility failed to follow physician's orders for administering insulin as ordered for 2 of 3 residents reviewed who received insulin in a sample of 4. (Resident #X and Resident #Y) The facility further failed to monitor low blood sugars per facility policy for 1 of 3 residents reviewed for low blood sugar monitoring in a sample of 4. (Resident #X)</p> <p>Findings include:</p> <p>1. Resident #X's record was reviewed 7-17-2014 at 8:50 AM. Resident #X's diagnoses included, but were not limited to, diabetes, high blood pressure, and anemia.</p> <p>Resident #X's care plan dated 7-17-2014</p>	F000309	<p>1) Resident X and Y have been discharged.</p> <p>2) Current insulin dependent Diabetics MAR's have been reviewed for past 30 days for correct insulin dosages and MD notification related to blood glucose outside of normal parameters.</p> <p>3) Nursing staff will be re- inserviced in regards proper diabetic orders, MD call parameters, proper insulin dosing, and documentation of injection site. DHS and or designee to monitor blood glucose on five diabetic residents three times per week for dosage accuracy and results outside of physician parameters for MD notification.</p> <p>4) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus</p>	08/16/2014

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	<p>provided by the Director of Health Services on 7-17-2014 at 10:23 AM indicated under the area "Vitals... Administer my insulin as ordered- see my current orders"</p> <p>Resident #X's physician orders for sliding scale insulin dated 5-21-2014 were as follows: Novolog flex pen Less than 150=0 units, 150-200=4 units, 201-250=6 units, 251-300=8 units, 301-350= 10 units, 351-400= 12 units, 401-500=15 units, greater than 500= call MD.</p> <p>A review of Resident #X's Medication Administration Record (MAR) indicated the following: on 7-7-2014 at bedtime, Resident #X's blood sugar was recorded as 201 MG/dL. Under the amount category, the number "5" was recorded. The amount of units ordered for this blood sugar was 6. Resident #X's blood sugar before breakfast on 7-8-2014 was recorded as 89. Additionally, on 7-10-2014 at bedtime, Resident #X's blood sugar was recorded as 215 MG/dL. Under the amount category, the number "4" had been recorded. The amount of units ordered for this blood sugar was 6. Resident #X's blood sugar before breakfast on 7-11-2014 was recorded as 120.</p> <p>2. Resident #Y's record was reviewed</p>		Quality Assurance Committee for six months or till 100% compliance is obtained.				

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	<p>7-17-2014 at 9:43 AM. Resident #Y's diagnoses included, but were not limited to diabetes, high blood pressure, and anemia.</p> <p>Resident #Y's care plan dated 7-17-2014 provided by the Director of Health Services on 7-17-2014 at 10:23 AM indicated under the area "Vitals... Administer my insulin as ordered- see my current orders"</p> <p>Resident #Y's physician orders for sliding scale insulin dated 5-21-2014 were as follows: Novolog flex pen Less than 150=0 units, 150-200=4 units, 201-250=6 units, 251-300=8 units, 301-350= 10 units, 351-400= 12 units, 401-500=15 units, greater than 500= call MD.</p> <p>A review of Resident #Y's MAR dated 7-2014 indicated on 7-8-2014, before lunch, Resident #Y's blood sugar was recorded as 220 MG/ dL. Under the category amount, the number "8" was recorded. The amount of units ordered for this blood sugar was 6. Resident #Y's blood sugar before supper on 7-8-2014 was recorded as 160. Additionally, on 7-11-2014, before lunch, Resident #Y's blood sugar was recorded as 213 MG/dL. Under the category amount, the number"0" was recorded. The amount of units ordered for this blood sugar was 6.</p>						

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	<p>Resident #Y's blood sugar before supper on 7-11-2014 was recorded as 180.</p> <p>In an interview on 7-17-2014 at 2:24 PM, LPN #4 indicated the numbers under the amount category indicated the number of units of insulin a resident had been given. LPN #4 further indicated the number of units should correspond with the number ordered on the sliding scale. Additionally, LPN #4 indicated the residents should be given medications as ordered by the physician.</p> <p>3. A review of Resident #X's MAR dated 7-2014 indicated Resident #X had a blood sugar of 51 on 7-3-2014, before supper. The MAR indicated Resident #X received Orange juice. Additionally, on 7-13-2014, before breakfast, the MAR indicated Resident #X had a blood sugar of 60. The MAR did not indicate Resident #X had any intervention.</p> <p>A review of Nurse's notes for Resident #X did not indicate a note had been completed for the date of 7-3-2014. Additionally, the Nurse's note dated 7-13-2014 indicated Resident #X had bed and chair alarms discontinued, and the patient walked with walker. There was no note about Resident #X's blood sugar interventions.</p>			

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	<p>A skilled Charting Evaluation dated 7-3-2014 did not include the results of the before supper blood sugar, nor the actions taken for the before supper blood sugar of 51.</p> <p>A Skilled Charting Evaluation dated 7-13-2014 did not include the results of the before breakfast blood sugar, nor the actions taken for the before breakfast blood sugar of 60.</p> <p>In an interview on 7-17-2014 at 9:10 AM, LPN #2 indicated if the blood sugar was below 70, juice should be given and the physician called for further guidance.</p> <p>A current policy titled Guidelines for hyper/hypoglycemia dated 11-8-2010, provided by the Director of Health Services on 7-16-2014 at 10:59 AM indicated the following: under the section titled "Blood Glucose 50-69 MG/dL, If the resident does not have a specific order for treatment, the following procedure will be followed: When the resident exhibits hypoglycemia evidenced by a blood glucose level of 50-69 MG/dL, the following procedure will be followed: Give a 15 gram carbohydrate oral feeding of one of the following: 1 tube of glucose gel; 4 ounces of any juice without adding sugar; 4 ounces of regular soda pop; 8 ounces of low-fat or nonfat</p>						

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F000514 SS=D	<p>milk. Wait 15 minutes and recheck blood sugar, If resident continues to have hypoglycemic symptoms or blood sugar less than 70, repeat the 15 gram carbohydrate oral feeding. Recheck blood sugar every 15 minutes and repeat to above 15 gram carbohydrate feeding until symptoms are resolved or blood sugar is greater than 70. "</p> <p>This Federal tag relates to Complaint IN00151974.</p> <p>3.1-37(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of</p>						

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	<p>any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to consistently document the site of insulin administration for 2 of 3 residents reviewed for insulin administration documentation in a sample of 4 (Resident #X an Resident #Y)</p> <p>Findings include:</p> <p>1. Resident #X's record was reviewed 7-17-2014 at 8:50 AM. Resident #X's diagnoses included, but were not limited to, diabetes, high blood pressure, and anemia.</p> <p>A review of Resident #X's Medication Administration Record (MAR) dated 7-2014 indicated under sliding scale insulin administration an area to record site of administration. There was no documentation of the site of Resident #X's sliding scale insulin administration for the following times:</p> <p>7-2 before supper 7-6 before supper 7-8 before supper 7-9 before supper 7-13 before supper and 7-14 before supper.</p>	F000514	<p>1) Resident X and Y have been discharged. 2) Current insulin dependent Diabetics MAR's have been reviewed for past 30 days for injection site documentation. 3) Nursing staff will be re-inserviced in regards proper diabetic orders, MD call parameters, proper insulin dosing, and documentation of injection site. DHS and or designee to monitor injection site documentation on five diabetic residents three times per week. 4) The results of the audit and or observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for six months or till 100% compliance is obtained.</p>	08/16/2014

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	<p>2. Resident #Y's record was reviewed 7-17-2014 at 9:43 AM. Resident #Y's diagnoses included, but were not limited to diabetes, high blood pressure, and anemia.</p> <p>A review of Resident #Y's MAR dated 7-2014 indicated under sliding scale insulin administration an area to record site of administration. There was no documentation of the site of Resident #Y's sliding scale insulin administration for the following times:</p> <p>7-1 before supper 7-2 before supper 7-3 before supper 7-4 at bedtime 7-5 at bedtime 7-6 before lunch, and at bedtime 7-7 before supper 7-8 before lunch, before supper and at bedtime 7-9 at bedtime 7-10 before supper 7-11 before breakfast, and before supper 7-12 at bedtime 7-13 before lunch, and at bedtime 7-14 before supper, and at bedtime 7-16 before lunch, and before supper.</p> <p>In an interivew on 7-16-2014 at 1:59 PM, LPN #3 indicated site of insulin administration should have been documented on the MAR.</p>			

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	<p>A current Policy dated 2-1-2010 titled Medication Administration- General guidelines provided by the Director of Health Services on 7-16-2014 at 12:07 PM indicated "at the end of each medication pass, the person administering the medications reviews the MAR to ensure the necessary doses were administered and documented." There was no indication to document the site of an injectable administration.</p> <p>This Federal tag relates to Complaint IN00151974.</p> <p>3.1-50(a)(1)</p>			