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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E209 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 09/10/2012 | |
| NAME OF PROVIDER OR SUPPLIER SUMMIT CONVALESCENT CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 701 S MAIN ST SUMMITVILLE, IN 46070 | | | |
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| F0000 | <p>This visit was for the recertification and state licensure survey.</p> <p>Survey dates: September 4, 5, 6, 7, and 10, 2012</p> <p>Facility number: 000373 Provider number: 15E209 AIM number: 100288730</p> <p>Survey team: Tammy Alley RN TC (September 4, 5, 6, and 10, 2012) Donna M. Smith RN Ginger McNamee RN</p> <p>Census bed type: NF: 31 Total: 31</p> <p>Census payor type: Medicaid: 19 Other: 12 Total: 31</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/11/12 Cathy Emswiller RN</p> | | | F0000 | <p>Submission of this plan of correction shall not constitute or be construed as an admission by Summit Convalescent Center that the allegations contained in this survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Convalescent Center. The facility requests the following plan of correction be considered its allegation of compliance. The facility also requests paper compliance due to the low scope and severity of the tags written.</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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| F0157 SS=D | <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 the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician as ordered when blood sugar levels were greater than 200 for 1 of 10 residents reviewed for</p> | F0157 | The Nurse Practitioner responsible for Resident # 13's care was informed on 9/10/12 of the occasions of the resident's blood sugars being over 200 and the MD or NP was not contacted. | 10/10/2012 |

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| | <p>unnecessary medications. [Resident #15]</p> <p>Findings include:</p> <p>Resident #15's clinical record was reviewed on 9/6/12 at 8:21 a.m. The resident's diagnoses included, but were not limited to, non-insulin dependent diabetes mellitus.</p> <p>The resident's Physician's Orders were sign by the physician on 8/23/12, and included an order for blood sugar checks to be done at 4:00 p.m. on Mondays, Wednesdays, and Fridays and the physician was to be notified of blood sugars greater than 200. This order was originally initiated on 4/14/10.</p> <p>Review of the resident's clinical record lacked an indication of the physician being notified of the following 4:00 p.m. blood sugars: 234 on 8/27/12 275 on 8/22/12 237 on 8/20/12 270 on 7/30/12 201 on 7/20/12 249 on 7/6/12 298 on 7/4/12 225 on 6/18/12.</p> <p>During an interview with the</p> | | <p>No new orders were received at that time. All other residents that receive accu-checks and have call order parameters treatment records were reviewed and the MD or NP had been notified as ordered for accu-checks outside of the written parameters. The Director of Nursing/Designee will review all resident documentation of accu-checks with call parameters and MD/NP notification as indicated twice a week for 1 month, then weekly for 5 months. Results of the monitoring will be discussed at the next 3 QAA meetings and provided MD/NP notification is occurring on a consistent basis the QAA team may determine the audits can stop or the QAA team will determine the need for continued monitoring. All licensed nurses were in-serviced regarding the importance of notifying the MD or NP of any accu-check results outside of the ordered parameters. POC: 10/10/12</p> | | | | |

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| | <p>Administrator on 9/7/12 at 10:10 a.m., she indicated the blood sugars had not been reported to the physician as ordered.</p> <p>3.1-5(a)(2)</p> | | | | |

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| F0241 SS=E | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure resident's personal dignity was maintained for 3 of 4 dining room observations. (Resident # 13, #33, # 16 and # 9)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 9/5/12 at 11:53 a.m., CNA # 1 brought Resident # 13 into the dining room in her wheelchair. CNA #1 bumped the residents foot on the table leg and the said to the resident "sorry baby." On 9/6/12 at 7:49 a.m., Resident # 33 was in the dining room in his wheelchair. He was wearing a gown and the gown's back was open, exposing his back. On 9/6/12 at 7:49 a.m., Resident # 16 was sitting in her wheelchair in the dining room. She was wearing a gown and the gown's back was open exposing most of her back. At 7:55 a.m., the Director of Nursing came into the dining room and pulled the | F0241 | <p>It is the practice of Summit Convalescent Center to treat residents in a dignified manner. No residents appeared to suffer any adverse effects from the facilities lack of dignity provided to them. Resident # 13 was interviewed on 9/21/12 regarding the situation in the dining room where CNA # 1 stated, "sorry baby" Resident # 33 was discharged to home on 9/8/12Resident # 13 exhibited no adverse effects related to her alleged lack of dignity in the dining room.Resident # 9 was interviewed on 9/12/12 regarding her feeling regarding being pushed on her rolling walker backwards when she it too fatigued to continue to ambulate. The resident indicated during the interview that she is not upset by this and she feels safer as someone is in front of her should she lean forward. The physical therapist was interviewed on 9/18/12 and indicated this method of transportation is an acceptable and safe mode of transportation for residents with a rolling walker with a seat. The resident's daughter who is POA was contacted regarding rolling walker</p> | 10/10/2012 | | | |

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| | <p>gown together to cover Resident # 16's back.</p> <p>During interview on 9/10/12 at 1:34 p.m., the Administrator indicated had been informed by the Director of Nursing that Resident # 16's back had been exposed during breakfast time in the dining room.</p> | | <p>transportation and she is in agreement that this is an acceptable/safe mode of transportation for resident # 9. Resident # 9's health care plan was updated with this information, and will be assessed with resident and daughter during each MDS assessment period. Since all residents have the potential to be affected by this alleged deficient practice the Director of Nursing (DON)/ Designee will complete resident rounds for dignity three times a week for 1 month, then 2 times a week for 3 months, then weekly for 2 months. Additionally DON/Social Service Designee/Designee will interview a minimum of 3 residents weekly for 1 month, the 2 residents weekly for 5 months to determine if they have any concerns regarding dignity. During the monthly resident council meetings the meeting facilitator will address those in attendance if they have any concerns regarding dignity. The results of monitoring and interviews will be discussed at the next 3 QAA meeting. The QAA committee will determine the frequency for continued monitoring. Provided there are no concerns regarding resident dignity, and the residents upon interview are not having concerns with their dignity the QAA team may determine the audit rounds and interviews can be stopped. All staff in-services were held on</p> | |

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| | <p>4. On 9/4/12 at 11:50 a.m. during lunch observation, CNA #1 was observed to be bringing Resident #9 down the hallway to the dining room. Resident #9 was observed sitting in her walker seat being rolled backwards down the hallway. As she continued down the hallway, CNA #1 instructed Student Nurse's Aide (SNA) #2 to take Resident #9 into the dining room. As SNA #2 continued to push this resident in the same manner down the hallway and was entering the dining room, LPN #3 stopped Student SNA #2 and instructed her to turn the resident around to face her forward. At this same time during an interview, Student SNA #2 indicated she was unaware she should not be transporting the resident backwards to the dining room.</p> <p>3.1-3(t)</p> | | 9/25 and 9/26 and included topic of resident dignity.POC Date: 10/10/12 | | |

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| F0246 SS=D | <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observations, record review, and interview, the facility failed to ensure a resident was positioned at a dining room table in a manner conducive for consumption of one's meal for 1 of 10 residents observed being assisted/fed during 3 of 3 meal observations. (Resident #26)</p> <p>Findings include:</p> <p>On 9/4/12 at 12:10 p.m. during lunch observation, Resident #26 was observed sitting at one of the 3 assist/feeding tables with a total of 10 residents observed at these tables. Resident #26 was sitting in a dining room chair with her chin observed to be at the same level as the table height.</p> <p>On 9/6/12 at 12:25 p.m. during lunch observation, Resident #26 was again observed sitting at the same table in a dining room chair. She was positioned with her chin level to the</p> | F0246 | The Dining Room Feeding table where Resident # 20 sits for meals was lowered to better accommodate her positioning at meals. Additionally, resident # 20 is sitting on a cushion at meal time. New orders were obtained for OT positioning on 9/18/12. All other residents with possible positioning concerns will be screened by Occupational Therapy and the therapist will determine if MD/NP orders need obtained to start the resident on therapy case load for positioning. The Director of Nursing (DON)/Designee will observe 3 times a week for 1 month, then 2 times a week for 3 months, then weekly for 2 months during dining room and other various times for proper resident positioning. Any identified concerns will be referred to MD/NP for orders for OT for positioning. The results of the positioning rounds will be discussed at the next 3 QAA meeting, and the QAA team will determine the need/frequency for continued monitoring. Provided all residents are positioned properly on the positioning rounds the | 10/10/2012 | |

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| | <p>table height. As the resident indicated she was finished eating and was being transferred to her merry walker, she was observed to have a blue deflated cushion in the dining room chair.</p> <p>On 9/7/12 at 12:15 p.m. during lunch observation, Resident #26 was observed at the same dining room table. She was observed sitting on a deflated cushion which positioned her at chin level to the height of the table. At this same time during an interview, LPN #3 indicated the resident was sitting too low at the table, and she should be sitting on a cushion. When LPN #3 checked her cushion, she indicated she was sitting on a cushion, which was not fully inflated, and she needed to get her a new one.</p> <p>On 9/10/12 at 8:42 a.m. during an interview, the Director of Nursing indicated a cushion in the dining room chair for Resident #26 worked well for her when eating in the dining room.</p> <p>Resident #26's record was reviewed on 9/7/12 at 9:49 a.m. The resident's diagnoses included, but were not limited to, osteoporosis, scoliosis, Alzheimer's Disease, expressive dysphagia disorder, and chronic pain.</p> | | <p>QAA team may determine the continued documentation of the rounds can be stopped. All staff was in-serviced regarding importance of proper resident positioning. Information included in this inservice was to report to the charge nurse or DON if any have staff have any concerns with resident positioning. POC Date: 10/10/12</p> | | | | |

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| | 3.1-3(v)(1) | | | |

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| F0329 SS=D | <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 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 record review and interview, the facility failed to ensure a laboratory test to monitor blood coagulation was completed as ordered for 1 of 10 residents reviewed for unnecessary medications. (Resident #20)</p> <p>Findings include:</p> <p>Resident #20's record was reviewed on 9/5/12 at 3:45 p.m. The resident's diagnoses included, but were not</p> | F0329 | The Nurse Practitioner responsible for Resident # 20's care was notified that the PT/INR lab ordered for 8/28/12 was not obtained as ordered. An order was given to obtain a Stat PT/INR for resident # 20. All other residents on Coumadin therapy charts were reviewed. All the residents have orders for PT/INR and they have been obtained as ordered. The Director of Nursing (DON)/Designee will review PT/INR labs on a weekly basis for 6 months. The results of the monitoring will be discussed at | 10/10/2012 |

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| | <p>limited to, history of Cerebral Vascular Accident (CVA-stroke), aphasia, and coronary artery disease. The medications resident's included, but were not limited to, Coumadin 4.5 mg (milligrams) (blood thinner) by mouth on Monday, Wednesday and Friday and Coumadin 4.0 mg on Tuesday, Thursday, Saturday, and Sunday with Coumadin therapy for history of CVA.</p> <p>The physician order, dated 8/23/12, was no change to Coumadin and to repeat the PT/INR in 1 week (8/28 was indicated).</p> <p>The laboratory studies were as follows: The PT/INR (Prothrombin Time/International Normalized Ratio) results, dated 8/21/12, were PT of 22.5 (normal was 10.6-14.5 seconds [sec]) and INR of 2.2 (INR: 2.0-3.0 conventional anticoagulation; INR: 2.5-3.5 intensive anticoagulation). The PT/INR results, dated 9/6/12, were PT of 19.3 (normal was 10.6-14.5 seconds [sec]) and INR of 1.8 (INR: 2.0-3.0 conventional anticoagulation; INR: 2.5-3.5 intensive anticoagulation).</p> <p>On 9/7/12 at 8:00 a.m. during an interview, LPN #3 indicated the</p> | | <p>the next 3 QAA meeting and depending on the results of the monitoring the QAA committee will determine the need/frequency of continued monitoring. Provided all the PT/INR labs are obtained as ordered the QAA team may determine the weekly monitoring can be stopped. A new form was initiated for all residents on Coumadin therapy to track the dosage and orders for laboratory testing. The DON/designee is responsible to monitor this form as well on a weekly basis. All licensed staff was in-serviced regarding importance of obtaining PT/INR as ordered and the Coumadin tracking forms. POC Date: 10/10/12</p> | | | | |

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| | repeat PT/INR ordered on 8/14/12 was not done as ordered, and a repeat PT/INR was done last night (9/6/12). 3.1-48(a)(3) | | | | |

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| F0502 SS=D | <p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure a urinalysis ordered following an emergency room visit was done/followed through in a timely manner for 1 of 1 resident randomly reviewed with a laboratory order after an emergency visit. (Resident #17)</p> <p>Findings include:</p> <p>1. Resident #17's record was reviewed on 9/6/12 at 9:10 am. The resident's diagnoses included, but were not limited to, expressive language disorder, diabetic mellitus type II, and Alzheimer's disease.</p> <p>In the progress notes the following was indicated: On 4/21/12 at 5:04 p.m., the resident was observed ambulating down the hall. When she arrived at the nurse's station, she began to lean and became flaccid with no response. After she was assisted to a wheelchair and vital signs were obtained, the physician was notified</p> | F0502 | Resident # 17 was treated for her UTI in May 2012, and has not had any symptoms to warrant a urinalysis since that time. All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing (DON)/Designee will complete a laboratory audit by 9/30/12. A new laboratory tracking form was implemented to ensure all ordered laboratory tests are completed as ordered. The DON/designee will monitor the laboratory tracking form weekly for 3 months, then monthly for 3 months to ensure all laboratory testing is done timely. The results of the monitoring will be reviewed at the next 3 QAA meetings and the QAA team will determine if additional monitoring is required. All licensed staff in-serviced on 9/25 & 9/26 in regarding to new laboratory tracking forms and tracking of laboratory results. POC Date: 10/10/12 | 10/10/2012 | | | |

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| | <p>and ordered the resident to be sent to the hospital for an evaluation. Upon her return from the hospital, a urinalysis (UA) was ordered.</p> <p>On 4/22/12 at 2:00 a.m., the resident was indicated as resisting some care needs.</p> <p>No further information was indicated the resident had resisted any further care.</p> <p>On 4/24/at 10:34 a.m., the physician was notified concerning unable to obtain urine for UA. The UA was indicated as causing the resident undue distress with dementia, and she had no signs/symptoms (s/s) of infection.</p> <p>On 4/24/12 at 2:35 p.m., the physician discontinued the UA order and to watch for s/s of infection, elevated temperature, or any complaint of discomfort.</p> <p>On 5/9/12 at 2:39 p.m., the annual UA was obtained per physician's rewrite orders.</p> <p>On 5/11/12 at 6:16 p.m., the physician ordered Cipro (antibiotic) 250 mg (milligrams) by mouth 2 times a day for 7 days for urinary tract infection.</p> <p>The laboratory urine report, dated 5/9/12 and collected 5/8/12, indicated the urine contained 10 to 20 red blood cells (normal = negative), greater than</p> | | | |

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| | <p>100 white blood cells (normal 0 to 5 red blood cells), and 4 plus bacteria (normal = negative).</p> <p>2. On 9/10/12 at 8:39 am during an interview, the Director Of Nursing indicated the annual urinalysis for Resident #17 was obtained by the use of a hat (container to fit inside the toilet to collect the urine).</p> <p>3. The "Laboratory Blood Draw Procedure" policy was provided by the Administrator on 9/10/12 at 1:30 p.m. This current policy indicated the following:</p> <p>"PROCEDURE: ...2. AFTER THE ORDER IS RECEIVED AND NOTED, THE LAB ORDER IS TO BE FAXED TO PRN PHARMACY, THE CHA LAB (FACILITY'S LABORATORY SERVICE) AND NOTED ON THE MAR/TAR (MEDICATION ADMINISTRATION RECORD/TREATMENT ADMISSION RECORD). THE ORDER IS TO BE DOCUMENTED ON THE LAB CLIPBOARD, AND THE 24 HR (HOUR) REPORT SHEET FOR THE DON (DIRECTOR OF NURSING) TO REVIEW.</p> <p>3. THE NURSE WHO TAKES THE</p> | | | |

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| | <p>ORDER IS RESPONSIBLE TO FOLLOW THROUGH WITH THE LAB ORDERS BY FAXING TO THE CHA LAB, PRN PHARMACY, PLACING IT ON THE CLIPBOARD...."</p> <p>3.1-49(a)</p> | | | |