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| 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 09/24/2013 |
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| NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814 |
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| R000000 | <p>This visit was for the Investigation of Complaints IN00136220, IN00136275, and IN00136406.</p> <p>Complaint IN 00136220 Substantiated. State deficiencies related to the allegations are cited at R0217.</p> <p>Complaint IN 00136275 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN 00136406 Substantiated. State deficiencies related to the allegations are cited at R0036, R0241, R0297, and R0305.</p> <p>Survey dates: September 23, and 24, 2013</p> <p>Facility number: 011804 Provider number: 011804 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: Residential: 110 Total: 110</p> | R000000 | This plan of correction is submitted as required by law. It is not an admission of noncompliance; rather, it serves as the facility's credible allegation of compliance. Due to the low severity of the deficiencies cited, the facility respectfully requests approval by desk review. | |

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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| | <p>Census payor type: Other: 110 Total: 110</p> <p>Sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 26, 2013 by Randy Fry RN.</p> | | | |

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| R000036 | <p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on interview and record review the facility failed to notify the physician of a change in continence and behaviors for 1 of 3 residents reviewed for physician notification in a sample of 10. (Resident #Y)</p> <p>Findings include:</p> <p>Resident #Y's record was reviewed 9-24-2013 at 10:54 AM. Resident #Y's diagnoses included but were not limited to Parkinson's disease, high blood pressure, and heart disease.</p> <p>A review of Service plan dated 5-12-2013 indicated Resident #Y was rarely incontinent of bladder, and was continent of bowel.</p> <p>A review of Nurse's notes indicated the following: On 5-31-2013, Resident #Y was</p> | R000036 | Resident Y has been re-admitted to Geri-psych hospital, family has given 30 day notice to the Hearth therefore the resident will seek alternate placement from the hospital. The Hearth's pertinent charting and 24 hr report sheets have been reviewed by the Wellness Directors and no other residents were identified as having a significant decline in the resident's physical, mental or psychosocial status. In-servicing has been completed with nursing staff by Wellness Directors on October 2nd and October 3rd, 2013 on proper physician notification on change in conditions including continence and behaviors. Resident right were reviewed as well during these in-servicing sessions. (see attachment A) Wellness Directors will monitor 24hr report and pertinent charting form for change of conditions, the Wellness Directors will conduct random audits to ensure physicians have been notified of any change of | 10/11/2013 | | | |

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| | <p>incontinent. There was no indication the incontinence was bowel or bladder. There was no time noted on the nursing notes.</p> <p>On 6-4, 2013, Resident #Y was incontinent of bowel and bladder in the hallway. There was no time noted on the nursing notes.</p> <p>On 6-29-2013 at 1:45 PM, Resident #Y was urinating in the dining room.</p> <p>On 7-8-2013 at 2 PM, Resident #Y was noted to have increased confusion and was incontinent of bowel in the shower room.</p> <p>On 7-9-2013 at 9 PM, Resident #Y urinated in the hallway and became agitated and combative with evening care.</p> <p>There are no further Nurse's notes until 8-5-2013.</p> <p>On 8-5-2013 at 9 PM, Resident #Y punched a staff member during care. The nurse's notes further indicated Resident #Y was physically aggressive with staff during the following times:</p> <p>On 8-6 at 9 PM, 8-9 at 9 PM, 8-10 at 9 PM, 8-11 during AM care, with no time indicated on the note, and 8-13-2013 at 12:25 PM.</p> <p>On 8-13-2013 at 3:30 PM, Nurse's notes indicated Resident #Y's physician was notified of his behavior escalation. Depakote Sprinkles 125</p> | | <p>condition, weekly for 4 weeks, then every other week for 4 weeks and then monthly for 4 months. Results of the audit will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly. Systemic changes will be completed by October 11, 2013.</p> | | | | |

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| | <p>milligrams (MG) three times per day, Haldol 1 mg every 8 hours as needed for aggression, and a urinalysis were ordered.</p> <p>There were no notations in the nursing notes the physician had been notified of the change in continence for Resident #Y from 6-4-2013 until 8-13-2013.</p> <p>There were no notations in the nursing notes the physician had been notified of a change in behavior from 7-9-2013 through 8-13-2013.</p> <p>On 9-24-2013 at 3:32 PM, LPN #1 provided a fax to the physician dated 8-7-2013. The fax indicated the physician had been notified of a skin tear received when Resident #Y was very combative with his shower. The note did not indicate this was new behavior and there was no indication the physician had been notified of Resident #Y's change in continence.</p> <p>In an interview on 9-23-2013 at 1:25 PM, the Administrator indicated behaviors are tracked through the 24 hour report, the unit manager follows up with the case manager and the physician. The Administrator further indicated there was no behavior policy.</p> | | | | | | |

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| | In an interview on 9-23-2013 at 3:03 PM, the Wellness Director indicated the physician was to be notified within 24 hours of a change in behavior or condition which necessitated a change in treatment. | | | |

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| R000217 | <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 appropriately revise the service plan after assessment for 2 of 7 residents reviewed for appropriate service plans in a sample of 10. (Resident #R, and Resident #T)</p> | R000217 | Resident R has been discharged from the Hearth community. Resident T's fall risk and service plan was updated on September 24, 2013 to correctly reflect fall risk. Resident Records were audited by the Wellness Directors to ensure service plans reflect residents current fall risk as scored on fall risk | 10/11/2013 |

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| | <p>Findings include:</p> <p>1. Resident #R's record was reviewed 9-23-2013 at 1:25 PM. Resident #R's diagnoses included but were not limited to Alzheimer's dementia with delusions, COPD, and depression.</p> <p>A review of Resident #R's nurse's notes indicated Resident #R had fallen the following times: 8-24 next to her bed, 8-25 while taking her brief off in the hallway, 8-27 in room, 8-27 when getting up from couch, 8-28, foot tangled in wheelchair, and on 8-29-2013 in her room.</p> <p>An undated fall risk evaluation indicated Resident #R was a high risk. The evaluation was not totaled, scores on the assessment were as follows: Mental status=2, history of falls was blank, Elimination status=4, vision status=0, gait, balance, ambulation=1, no blood pressure was indicated, Medications=2, and predisposing conditions =2. The total score was blank. Adding the scores from above, the total would have been 11. The area by total score indicated 10+ was high risk.</p> <p>A preadmission service plan for</p> | | <p>assessment. In-servicing was completed with nursing staff on fall risk assessment policy and procedure by Wellness Director on October 2nd and 3rd, 2013. (see attachment B) Resident records will be randomly audited to ensure continued compliance by the Wellness Directors, weekly for 4 weeks, then every other week for 4 weeks and then monthly for 4 months. Results of the audit will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly. Systemic changes will be completed by October 11, 2013.</p> | | | | |

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| | <p>Resident #R dated 8-20-2013 indicated under mobility fall risk was medium.</p> <p>In an interview on 9-24-2013 at 3:48 PM, LPN #1 indicated the service plan should have been updated to reflect the fall assessment. LPN #1 further indicated the service plan had not been updated because Resident #R had not been in the building 30 days.</p> <p>2. Resident #T's record was reviewed 9-23-2013 at 2:42 PM. Resident #T's diagnoses included but were not limited to; bursitis, diabetes, and high blood pressure.</p> <p>A review of Resident #T's nurse's notes indicated Resident #T had fallen on 9-6-2013.</p> <p>A fall risk evaluation dated 8-3-2013 indicated Resident #T was a high risk. The evaluation was not totaled, scores on the assessment were as follows: Mental status=0, history of falls=2, Elimination status=4, vision status=0, gait, balance, ambulation=2, blood pressure=0, Medications=2, and predisposing conditions =2. The total score was blank. Adding the scores from above, the total would have been 12. The</p> | | | |

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| | <p>area by total score indicated 10+ was high risk.</p> <p>Resident #T's service plan dated 8-20-2013 indicated under mobility fall risk was medium.</p> <p>In an interview on 9-23-2013 at 3:10 PM, the Wellness Director indicated the service plan should reflect the assessment.</p> | | | |

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| R000241 | <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.</p> <p>Based on interview and record review the facility failed to administer medication as ordered by the physician for 1 of 3 residents reviewed for medication administration in a sample of 10 (Resident #T)</p> <p>Findings include:</p> <p>Resident #T's record was reviewed 9-23-2013 at 2:42 PM. Resident #T's diagnoses included but were not limited to; bursitis, diabetes, and high blood pressure.</p> <p>A physician's order for Resident #T dated 9-4-2013 indicated to start Lexapro 10 milligrams (mg) every morning.</p> <p>Resident #T's Medication Administration Record dated 9-2013 indicated Lexapro was circled on 9-5,</p> | R000241 | <p>Resident T had been restarted on antidepressant and has been administered as ordered by the physician since September 12, 2013. Resident medications records (MAR's) were audited by the Wellness Directors and no other residents were identified. The Wellness Directors completed In-servicing on October 2nd and 3rd, 2013 to The Hearth's Licensed Nursing staff and QMA's on the procedure to follow if medications are unavailable to administer to a resident. (see attachment C) Wellness Directors will audit Medication Administration Records weekly for 4 weeks, then every other week for 4 weeks, then monthly and monthly for 4 months.. Results of the audit will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly. Systemic changes will be completed by October 11, 2013.</p> | 10/11/2013 | | | |

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| | <p>9-6, 9-7, 9-8, 9-9, and 9-10. A note on the record indicated the Lexapro was discontinued until arrival from VA pharmacy.</p> <p>A physician's order dated 9-11-2013 indicated to discontinue Resident #T's Lexapro.</p> <p>In an interview on 9-24-2013 at 11:34 AM, QMA #2 indicated Resident #T's Lexapro was not available from the VA, and so the medication was not given, but was circled.</p> <p>In an interview on 9-24-2013 at 11:58 AM, LPN #3 indicated the physician should have been notified the medication was not able to be given due to not being available and the facility should have provided the medication earlier, or had the medication discontinued.</p> | | | |

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| R000297 | <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.</p> <p>Based on interview and record review the facility failed to provide medication as ordered by the physician for 1 of 3 residents reviewed for medication administration in a sample of 10 (Resident #T)</p> <p>Findings include:</p> <p>Resident #T's record was reviewed 9-23-2013 at 2:42 PM. Resident #T's diagnoses included but were not limited to; bursitis, diabetes, and high blood pressure.</p> <p>A physician's order for Resident #T dated 9-4-2013 indicated to start Lexapro 10 milligrams (mg) every morning.</p> <p>Resident #T's Medication Administration Record dated 9-2013 indicated Lexapro was circled on 9-5, 9-6, 9-7, 9-8, 9-9, and 9-10. A note on</p> | R000297 | <p>Resident T had been restarted on antidepressant and has been administered as ordered by the physician since September 12, 2013. Resident Medication records (MAR's) were audited by the Wellness Directors and no other residents were identified. The Wellness Directors completed In-servicing on October 2nd and 3rd, 2013 to The Hearth's Licensed Nursing staff and QMA's on the procedure to follow if medications are unavailable to administer to a resident. (see attachment C) Wellness Directors will audit Medication Administration Records weekly for 4 weeks, then every other week for 4 weeks, then monthly for 4 months. Results of the audit will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly. Systemic changes will be completed by October 11, 2013.</p> | 10/11/2013 | | | |

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| | <p>the record indicated the Lexapro was discontinued until arrival from VA pharmacy.</p> <p>A physician's order dated 9-11-2013 indicated to discontinue Resident #T's Lexapro.</p> <p>In an interview on 9-24-2013 at 11:34 AM, QMA#2 indicated Resident #T's Lexapro was not available from the VA, and so the medication was not given.</p> <p>In an interview on 9-24-2013 at 11:58 AM, LPN #3 indicated the nurses frequently have to miss medication administrations because VA doesn't send medications in a timely manner. LPN #3 further indicated the medication should have been made available or discontinued earlier.</p> | | | | | | |

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| 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 09/24/2013 | |
| NAME OF PROVIDER OR SUPPLIER HEARTH AT SYCAMORE VILLAGE LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 611 W COUNTY LINE RD S FORT WAYNE, IN 46814 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| R000305 | <p>410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance (f) Residents may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens.</p> <p>Based on interview and record review the facility failed to provide medication as ordered by the physician for 1 of 3 residents reviewed for medication administration in a sample of 10 (Resident #T)</p> <p>Findings include:</p> <p>Resident #T's record was reviewed 9-23-2013 at 2:42 PM. Resident #T's diagnoses included but were not limited to; bursitis, diabetes, and high blood pressure.</p> <p>A physician's order for Resident #T dated 9-4-2013 indicated to start Lexapro 10 milligrams (mg) every morning.</p> | R000305 | The Wellness Directors are conducting an audit of resident pharmacy usage. All residents not using The Hearth's house pharmacy will be asked to contract with our house pharmacy for back up purposes for prompt delivery of medications and not to interrupt drug regimens. This procedure will be reviewed with the new resident and their representative upon move in to the Hearth Community. Wellness Directors will audit pharmacy usage weekly for 4 weeks, then every other week for 4 weeks, then monthly for 4 months. Results of the audit will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly. Systemic changes will be completed by October 31, 2013. | 10/11/2013 | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>Resident #T's Medication Administration Record dated 9-2013 indicated Lexapro was circled on 9-5, 9-6, 9-7, 9-8, 9-9, and 9-10. A note on the record indicated the Lexapro was discontinued until arrival from VA pharmacy.</p> <p>A physician's order dated 9-11-2013 indicated to discontinue Resident #T's Lexapro.</p> <p>In an interview on 9-24-2013 at 11:34 AM, QMA#2 indicated Resident #T's Lexapro was not available from the VA, and so the medication was not given.</p> <p>In an interview on 9-24-2013 at 11:58 AM, LPN #3 indicated the nurses frequently have to miss medication administrations because VA doesn't send medications in a timely manner.</p> | | | |