

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 03/15/2012	
NAME OF PROVIDER OR SUPPLIER  BLISS HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3008 SHAWNEE DR S BEDFORD, IN 47421			
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 14 and 15, 2012</p> <p>Facility number: 004011 Provider number: 004011 AIM number: NA</p> <p>Survey team: Sharon Whiteman RN TC Susan Worsham RN</p> <p>Census bed type: Residential: 44 Total: 44</p> <p>Census payor type: Residential: 44 Total: 44</p> <p>Sample: 11</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 3/18/12 by Jennie Bartelt, RN.</p>			R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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R0243	<p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:</p> <p>(A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.</p> <p>Based on interview and record review, the facility failed to ensure nursing staff signed medication out when given for 2 of 11 sampled residents reviewed for medications. (Resident #1 and Resident #5)</p> <p>Findings include:</p> <p>1. Review of Resident #1's clinical record on 03/14/12 at 12:05 p.m. indicated the following:</p> <p>Resident #1 had diagnoses which included, but were not limited to, severe rheumatoid arthritis, osteoporosis, and lung cancer.</p> <p>A physician's re-write order for February 2012 listed medication orders which included, but were not limited to, Hydrocodone-Apap (narcotic pain medication) 5-500 milligrams (2) tablets to be given 4 times daily as needed for pain. This medication order was dated</p>	R0243	<p>We respectfully disagree with the below citation and would like to introduce for your review the attached documentation. This is provided for you review by way of the Informal Dispute Resolution in effort to overturn this ruling. Citation #1 410 IAC 16.2-5-4 (e)(3)Health Services(1) What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #1 and Resident #5's Medication Administration Record was reviewed and was noted to include the date, time, initial of nurse administering, and the effectiveness of the medication administration. Although not documented on the back of the Medication Administration Record it was found to exist within the resident's clinical record.(2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found</p>	04/20/2012			

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	<p>11/14/11.</p> <p>A PRN (as needed) medication record for December 2011 indicated Resident #1 received the Hydrocodone 5-500 milligrams on 12/02/11 at 5:00 p.m. and 9:30 p.m., on 12/08/12 at 9:00 a.m. and 8:00 p.m., on 12/12/11 at 7:50 a.m., on 12/13/11 at 7:00 p.m., on 12/15/11 at 9:00 p.m., and on 12/29/11 at 8:00 p.m. The December 2011 medication entries lacked documentation supporting who had given the medication to Resident #1.</p> <p>A PRN medication record for January 2012 indicated Resident #1 received Hydrocodone 5-500 milligrams on 01/01/12 at 7:00 p.m.; on 01/05/12, on 01/12/12 at 7:00 p.m.; on 01/08/12 at 10:00 a.m.; on 01/09/12 at 5:00 p.m.; on 01/10/12 at 6:00 p.m.; on 01/13/12 at 6:00 p.m.; on 01/17/12 at 10:00 a.m. and 9:00 p.m.; on 01/19/12 at 6:00 p.m.; on 01/21/12 at 10:00 a.m. and 9:00 p.m.; and on 01/22/12 at 9:00 p.m. The January 2012 medication record lacked documentation supporting who had given the Hydrocodone to Resident #1.</p> <p>2. Review of Resident #5's clinical record on 03/14/12 at 12:00 p.m. indicated Resident #5 had diagnoses which included, but were not limited to, hypertension, dementia, bradycardia (slow</p>		<p><b>to be affected. (3) What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b>The Residence Director, Wellness Director, and licensed staff were re-educated to our policy and procedure regarding documentation in the resident's clinical record. The Wellness Director and/or Designee will be responsible to ensure continued compliance with documentation in the resident's clinical record upon a change of condition per our policy and procedure.(4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Wellness Director and/or Designee will perform a random weekly review of resident's clinical record upon experiencing a change of condition to ensure continued compliance with our policy and procedure. Findings will be reviewed during a scheduled Bliss House QA meeting at the end of the quarter to determine the need for the ongoing monitoring plan. Finding resulting in compliance will result in cessation of monitoring plan.</p>				

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	<p>heart rate), and syncope (dizziness).</p> <p>A physician's re-write order for February 2012 listed orders which included, but were not limited to, Hydrocodone-Apap 5-500 milligrams to be given every 6 hours as needed for pain. This order was dated 06/09/11.</p> <p>A PRN medication record for February 2012 indicated Resident #5 received Hydrocodone 5-500 milligrams on 01/12/12 at 6:00 p.m., on 01/14/12 at 1:00 p.m., on 01/17/12 at 8:00 p.m., and on 01/19/12 at 6:00 p.m. The medication record lacked documentation supporting who had given the Hydrocodone to the resident.</p> <p>Interview of the Wellness Director on 03/14/12 at 1:15 p.m., indicated she could tell by the handwriting who the nurse was who had given the Hydrocodone. The Wellness Director indicated nursing staff should always initial after giving medications to residents.</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 ensure clinical records were completely and thoroughly documented to include the reason why a resident was sent out to a Behavioral Unit and the reason for administration of pain medication. This affected 2 of 11 sampled residents reviewed for charting in clinical records. (Resident #4 and Resident #8)</p> <p>Findings include:</p> <p>1. During initial observation tour of the facility on 03/15/12 at 9:40 a.m. with the Wellness Director present, Resident #4 was described as being out to a Behavioral Unit due to refusing to take her medications.</p> <p>Review of Resident #4's clinical record on 03/15/12 at 2:00 p.m., indicated the following:</p>	R0349	<p><b>We respectfully disagree with the Citation #2 R 349410 IAC 16.2-5-8.1 (a) (1-4)Clinical Records (1) What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? below citation and would like to introduce for your review the attached documentation. This is provided for you review by way of the Informal Dispute Resolution in effort to overturn this ruling.</b></p> <p>Resident #4 had documentation as to several episodes of behavioral disturbance documented prior to transfer onto the geri psyche for evaluation and possible treatment. Resident #1 had documentation regarding the date, time, initial of nurse administering, and the effectiveness of the medication that was administered. Although not documented on the back of</p>	04/20/2012			

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	<p>The resident had diagnoses which included, but were not limited to depression, sleeplessness, and history of hypertension, and stroke.</p> <p>A hospital report, dated 11/19/11, indicated, "...Chief Complaint: Dementia with behavioral issues. History of present illness: The patient (Resident #4)...was brought to the (Psych Unit) with delusions. She hears her son crying at night (according to Resident #4's clinical record her son is in a group home), talks to him. Everything is in codes. Coast is clear. She is having severe paranoia and problems with other residents."</p> <p>A "Resident Services Notes" entry, dated 02/28/12 at 4:30 p.m., indicated, "CNA states resident vomited a small amount. BP (blood pressure) 134/98 - (heart rate) 116 - (respiratory rate - 22 - temperature - 99.2. Resident states feels better. Resident states wants to eat dinner. States feels fine now."</p> <p>The clinical record lacked any further "Resident Services Notes" documentation until 03/08/12.</p> <p>A "Resident Services Notes" entry, dated 03/08/12 at 10:45 a.m., indicated, "To (local hospital) via ambulance transportation for evaluation per</p>		<p>the Medication Administration Record it was found to exist within the resident's clinical record.</p> <p><b>(2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> No other residents were found to be affected.</p> <p><b>(3) What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</b> The Residence Director, Wellness Director, and licensed staff were re-educated to our policy and procedure regarding documentation in the resident's clinical record. The Wellness Director and/or Designee will be responsible to ensure continued compliance with documentation in the resident's clinical record upon a change of condition per our policy and procedure.</p> <p><b>(4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Wellness Director and/or Designee will perform a random weekly review of resident's clinical record upon experiencing a change of condition to ensure continued compliance with our policy and procedure. Findings will be reviewed during a</p>				

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	<p>(physicians name). Signs et symptoms of psychosis."</p> <p>A "Resident Services Notes"entry, dated 03/09/12 (no time documented), indicated, "RD (Resident Director) spoke with ER doctor last evening regarding (Resident #4) - ER doctor stated resident needed to be sent to (local psychiatric hospital) for psych stay to be stabilized. We discussed the requirement of (psych hospital) to sign a form stating we would take her (Resident #4) back. We wanted to make sure we could have a nurse assess the resident before we could say we could take her back due to being Assisted Living. We need to make sure we can meet her needs. (Physician's name) stated she (Resident #4) was paranoid and she (the physician) was trying to help us get her (Resident #4) to a geri-psych (hospital) for stabilized (stabilization)."</p> <p>Interview of the Wellness Director on 03/14/12 at 11:00 a.m., indicated the facility policy was to chart "by exception."</p> <p>The Wellness Director was interviewed regarding Resident #4's behavior symptoms and reason for the resident being sent to the psychiatric hospital. The Wellness Director did not respond nor answer the question.</p>		<p>scheduled Bliss House QA meeting at the end of the quarter to determine the need for the ongoing monitoring plan. Finding resulting in compliance will result in cessation of monitoring plan.</p>				

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	<p>2. Resident #8's clinical record was reviewed on 3/15/12 at 2:00 p.m. Current physician's orders, dated 2/24/12 , included an order for Lortab 5/500 (narcotic pain medication),give one orally every 6 hours as needed for breakthrough pain.</p> <p>The Medication Administration Record for March 2012 showed that Lortab 5/500 was given at the following times: 2/24/12 at 7:00 p.m., 2/25/12, at 7:30 p.m. and 3/3/12 with no time given when administered. The March 2012 medication administration record did not document any relief from the medication.</p> <p>The policy and procedure for Documentation, provided by the Administrator on 3/15/12 at 7:00 p.m., indicated: "Resident Service notes- ... it is essential that staff document observations and occurrences accurately and as soon as possible after they occur.... staff document only non routine observations and occurrences.... Medications - document all medications on the medication assistance record...document prn (as needed) medications in the Resident Service Notes.</p>	R0349	<p><b>We respectfully disagree with the Citation #2 R 349410 IAC 16.2-5-8.1 (a) (1-4)Clinical Records (1) What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</b></p> <p><b>below citation and would like to introduce for your review the attached documentation. This is provided for you review by way of the Informal Dispute Resolution in effort to overturn this ruling.</b></p> <p>Resident #4 had documentation as to several episodes of behavioral disturbance documented prior to transfer onto the geri psyche for evaluation and possible treatment. Resident #1 had documentation regarding the date, time, initial of nurse administering, and the effectiveness of the medication that was administered. Although not documented on the back of the Medication Administration Record it was found to exist within the resident's clinical record.</p> <p><b>(2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>No other residents were found to be affected.</p>	04/20/2012			

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