

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 08/14/2014
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NAME OF PROVIDER OR SUPPLIER RESIDENCES AT DEER CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST US 30 SCHERERVILLE, IN 46375
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R000000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00153744.</p> <p>Complaint IN00153744-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 13 & 14, 2014</p> <p>Facility number: 013069 Provider number: 013069 AIM number: N/A</p> <p>Survey team: Lara Richards, RN-TC Cynthia Stramel, RN Yolanda Love, RN</p> <p>Census bed type: Residential: 80 Total: 80</p> <p>Census payor type: Other: 80 Total: 80</p> <p>Sample: 11</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p>Residencesat Deer Creek (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissibleby any third party in any civil or criminal action against the Provider or anyemployee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right tochallenge the findings of this survey if at any time the Provider determinesthat the disputed findings: (1) are relied upon to adversely influence or serveas a basis, in any way, for the selection and/or imposition of future remedies,or for any increase in future remedies, whether such remedies are imposed bythe state of Indiana or any other entity; or (2) serve, in any way, tofacilitate or promote action by any third party against the Provider. Any changes to Provider policy or proceduresshould be considered to be subsequent remedial measures as that concept isemployed in Rule 407 of the Federal Rules of Evidence and should beinadmissible in any proceeding on that basis.</p>	
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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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R000090	<p>Quality review completed on August 19, 2014, by Janelyn Kulik, RN.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time</p>			

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	<p>worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure the State Agency was notified of inappropriate behaviors between two residents who resided on the Memory Care Unit on two separate occasions. (Residents #3 and #11)</p> <p>Findings include:</p> <p>The record for Resident #3 was reviewed on 8/13/14 at 1:25 p.m. The resident's diagnoses included, but were not limited to, organic brain syndrome, dementia with behaviors, anxiety and agitation.</p> <p>An entry in the Nursing progress notes dated 6/14/14 at 7:45 p.m., indicated the Nurse was called to the resident's apartment. Upon entering the apartment,</p>	R000090	Both Residents #11 and #3 were assessed by staff following each instance. Staff documented no distress, concern or harm to either resident. Neither resident voiced any concern of what is being referred to as "inappropriate behavior". At the time of both instances, neither resident requested help or assistance from staff even when questioned by staff. At no point did the facility determine that either resident experienced an occurrence that directly threatened their welfare, safety, or health. Both residents were able to verbalize what they were doing and their desire to engage in companionship with the other. Both residents were also seen by psych services following the instances and both residents were determined to be capable of expressing their opinions and	09/09/2014

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	<p>the Nurse witnessed the resident in the bathroom, closing the door. Resident #11 was in the living area of the apartment. Both residents had their tops off and the CNA's indicated that Resident #11 was standing in the room with Resident #3 when they entered, they did not see any contact between the residents. Resident #11 was assisted with putting her top back on. When asked if she was okay, she immediately stated, "oh ya." Resident #11 was then assisted back to her room. When Resident #3 came out of the bathroom, he indicated that he and Resident #11 were "only kissing and touching." The Director of Nursing was notified, and she indicated to the Nurse to put both residents on 15 minute checks. The residents' families were notified. They both refused Emergency Room visits for the residents but indicated they felt a Psychiatric evaluation was necessary for both residents.</p> <p>Documentation in the Nursing progress notes on 6/21/14 at 8:45 p.m., indicated the writer was informed by a CNA that after dinner that evening, Resident #11 was observed in Resident #3's room sitting on the couch without her shirt and bra on. The CNA indicated the resident had her pants on but her brief was lying on Resident #3's bed. The CNA indicated Resident #3 had no clothes on</p>		<p>desires and able to verbalize dissatisfaction or complaints when they don't like something. Residents were deemed to have the ability to express consent in the moment and to engage in companionship with the other resident. A chart audit will be completed to identify other residents who may have a tendency to express "inappropriate behavior" and if required, report to the State Agency. Staff inservices will be held to discuss sexuality amongst seniors. The Resident Services Director/designee will review the 24 hour report 5 days per week to review for charting of any unusual occurrences that need to be reported to the State Agency.</p> <p>The process will be reviewed through Quality Assurance for three months. If after the three month period it is determined that all unusual occurrences are timely and appropriately reported to the State Agency, the review process through the Quality Assurance program will stop. The Facility is disputing that it failed to ensure the State Agency was notified of unusual occurrences that directly threaten the welfare, safety or health of a resident. Inappropriate behaviors alleged by the surveyors are inconsistent with the responses of the residents who consented to the relationship. At no time was either resident's health, safety or welfare at risk for harm.</p>	

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R000241	<p>and grabbed a towel to cover himself up. The CNA assisted Resident #11 with getting her clothes on and escorted her out of the room. The CNA asked Resident #3 what they were doing, and he indicated that "we were just talking. That's all."</p> <p>Review of the facility reportable's to the State Agency for the past 6 months, indicated the above two incidents had not been reported.</p> <p>Interview with the Director of Nursing (DoN) on 8/14/14 at 11:00 a.m., indicated the above incidents between Residents #3 and #11 had not been reported due to there being no negative outcome and Resident #11 indicated she enjoyed Resident #3's company. The DoN, also indicated an action plan was put into place after the incidents.</p> <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. Based on record review and interview, the facility failed to ensure Physician</p>	R000241	Resident #5 experienced no adverse effects as a result of this finding. The clinical record	09/09/2014

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	<p>orders were followed as written related to providing treatment for low blood sugar and documenting the amount of insulin administered per sliding scale for 1 of 8 records reviewed. (Resident #5)</p> <p>Findings include: The record for Resident #5 was reviewed on 8/13/14 at 11:00 a.m. The resident's diagnoses included, but were not limited to, dementia and type 2 diabetes. A Physician's order dated 4/15/14, indicated the resident was to receive Humalog insulin injections twice daily, A.M. and P.M., per sliding scale based on the results of the blood sugar test. The sliding scale was as follows: 150-200, 2 units; 201-250, 4 units; 251-300, 6 units; 301-350, 8 units; and 351-400, 10 units. Review of the Medication Administration Record for July and August 2014, indicated many of the blood sugar results were above 150, which would have required sliding scale insulin, however, there was no documentation of how much insulin was given. The following dates did not have sliding scale insulin documented for the corresponding blood sugar level: 7/1 p.m. 174; 7/2 p.m. 150; 7/3 p.m. 164; 7/5 p.m. 217; 7/6 p.m.</p>		<p>contained documentation that the sliding scale insulin was given by the nurse. As documented in the medical record, the resident was given cranberry juice on 8/4/2014 which had a positive effect on the resident's blood sugar level as evidenced by a later blood sugar level check. All sliding scale orders have been reviewed and the electronic medical records have been updated so that the sliding scale dosage is required as a part of the medication administration record. Licensed staff will print missed medication report at the end of each shift to make certain insulin is given and documented per sliding scale order. All licensed nurses will be re-inserviced on medication administration and sliding scale orders. The Director of Resident Services/designee will review missed medication report weekly. The process will be reviewed through Quality Assurance for three months. If the review process finds that all insulin is given and documented per sliding scale as ordered, the monitoring will stop at the end of the three month period The Facility disputes that it failed to administer medications and treatment for low blood sugar for resident #5. As documented in the chart, staff administered the medications and provided the treatment</p>				

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	<p>207; 7/7 p.m. 256; 7/9 p.m. 183; 7/11 p.m. 241; 7/13 p.m. 359; 7/14 a.m. 193, p.m. 310; 7/15 p.m. 390; 7/16 p.m. 327; 7/17 p.m. 420; 7/18 p.m. 236; 7/19 a.m. 243, p.m. 178; 7/20 p.m. 189; 7/21 p.m. 271; 7/22 p.m. 241; 7/23 p.m. 211; 7/25 p.m. 162; 7/26 p.m. 204; 7/27 p.m. 213; 7/28 a.m. 198; 7/29 p.m. 214; 7/30 p.m. 188; 7/31 a.m. 180, p.m. 241; 8/2 p.m. 318; 8/3 p.m. 201; 8/4 p.m. 214; 8/5 p.m. 250; 8/7 p.m. 168; 8/8 p.m. 261; 8/9 p.m. 189; 8/10 p.m. 197; 8/11 p.m. 304; and 8/12 p.m. 312.</p> <p>A Physician's order dated 7/30/14, indicated the resident was to receive Glutose 15, 40% dextrose (a sugar based solution) solution to be given orally if the resident's blood sugar was less than 60.</p> <p>On 8/4/14, the Medication Administration Record indicated the resident's blood sugar was 55 in the a.m. There was no indication that Glutose 15 had been given. The Nursing notes dated 8/4/14 at 5:35 a.m. indicated, "Resident alert and verbally responsive, given 120 ml of cranberry juice for low blood sugar".</p> <p>Interview with the Director of Nursing on 8/13/14 at 2:10 p.m., indicated the amount of insulin given should be documented in the resident's record. She</p>			

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R000273	<p>also indicated the Physician's order for Glucose 15 was not followed on 8/4/14 as ordered.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure food was stored in a sanitary manner related to uncovered food, undated food, boxes of food stored on the floor and improper holding temperatures for cold food items. This had the potential to</p>	R000273	<p>On the date of this finding the items in the walk inrefrigerator and the parfait cups in the main dining room refrigerated displaywere covered. The items in the walk in refrigeratorand walk in freezer were dated. The boxes on the floor under the shelf were placed on shelves. Staff will be</p>	09/09/2014

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	<p>effect all 80 of the residents that received food prepared in the kitchen.</p> <p>Findings include:</p> <p>On 8/13/14 at 9:05 a.m., the following observations were made in the kitchen during the initial tour with the Sous Chef:</p> <ol style="list-style-type: none"> In the walk in refrigerator, there was a pan of brownies on a rack, they were uncovered. The Sous Chef indicated they had been put there to cool at 6:15 a.m. There were 5 parfait cups uncovered on the rack. There was a large bin of red grapes with no cover on them. A bag of fresh spinach was opened and not closed. In the main dining room refrigerated display, there were 4 parfait cups uncovered. The Sous Chef indicated the items should be covered. In the walk in refrigerator, there were no dates on the boxes containing blueberries, strawberries, lemons, peppers, cucumbers, tomatoes or apples. In the walk in freezer, there were no dates on 3 bags of precooked chicken. The Sous Chef indicated there were no dates on the above items. In the walk in freezer, there were two boxes on the floor under a freezer shelf. The Sous Chef indicated one box was 		<p>re-inserviced on the policy related to Food Production and Guidelines. Random inspections by the Executive Chef or Designee of walk-in refrigerator, walk-in freezer and dining room refrigerated display as well as review of the temperature log will be made at least weekly to ensure ongoing compliance with this requirement. Results of the inspections will be reviewed in Quality Assurance meetings for three months. If after the three month period, no additional non-compliance is found relating to this issue, the monitoring will discontinue</p>				

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	<p>pizza dough and the other was bread.</p> <p>On 8/13/14 at 11:30 a.m., the Food Holding Temperature Log was reviewed with the Chef. The August 2014 log for Lunch service indicated on 8/4/14 the egg salad was 42 degrees. On 8/6/14 the salad was 42 degrees. On 8/7/14 the cold wrap was 45 degrees. The Food Holding Temperature Log indicated at the bottom of the page, "Cold Food Holding Standards: Hold cold food at 41 F or below", if the food was not at 41 or below, there were actions to take. The log did not have documentation that any action had been taken for the food that was held above 41 degrees.</p> <p>The policy Food Production and Guidelines was provided by the Chef on 8/13/14 at 11:00 a.m. The policy indicated, "Food prepared in advance must be covered, labeled, dated and refrigerated." The policy also indicated, "Food is served as soon after preparation as possible and is held at the following temperatures: Hot 135 (degrees) or above; Cold 41 (degrees) or below".</p>			

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R000349	<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. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of obtaining stool and urine samples for 2 of 8 records reviewed. (Residents #1 and #2)</p> <p>Findings include:</p> <p>1. The record for Resident #1 was reviewed on 8/13/14 at 11:10 a.m. A Physician's order dated 8/9/14, indicated a stool sample was to be obtained and checked for white blood cells, culture and sensitivity, and clostridium difficile rapid toxin.</p> <p>Review of the Nursing progress notes for the dates of 8/9-8/13/14, indicated there was no documentation to indicate if the stool specimen had been collected.</p> <p>Review of the 24 hour report sheet on</p>	R000349	Specimens were obtained and picked up for residents #1 and #2. The lab orders were tracked in the 24 hour daily report which is a part of the electronic health record system that is also reviewed by the nurses. Results were phoned to physicians. A review of existing lab orders was conducted to ensure orders were carried out and results communicated to the physicians. When a lab order is obtained the order will be entered into the resident's electronic medical record and licensed staff will notify lab of order. All licensed nurses will be re-inserviced on the protocol of notifying lab of new orders. The Director of Resident Services/designee will review missed medication and treatment report weekly to ensure orders are followed up on a timely basis. The process will be reviewed through Quality Assurance for three months. If after the three month period, all orders are followed up on a timely basis, the ongoing monitoring will	09/09/2014			

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	<p>8/14/14 at 11:15 a.m., which was provided by LPN #1, indicated the resident's stool specimen had been collected on 8/10/14. The LPN indicated the stool sample should have been picked up by the lab on 8/13/14. She indicated they kept trying to call the lab to come out and pick up the sample. This was not documented in the Nursing progress notes. Continued interview at the time with LPN #1 indicated documentation should have been completed in the Nursing progress notes related to obtaining the stool sample and the attempts to contact the laboratory.</p> <p>2. The record for Resident #2 was reviewed on 8/14/14 at 8:35 a.m. A Physician's order dated 7/7/14, indicated the resident was having increased confusion and an order was obtained for a urinalysis with culture and sensitivity and to start Cipro (an antibiotic) 500 milligrams (mg) by mouth twice a day. Documentation in the Nursing progress notes on 7/7/14 at 9:28 p.m., indicated a plastic device to collect urine was placed on the toilet and staff were aware of need for urine sample. The resident stated, "I just got done using the bathroom before you came in." Documentation in the Nursing progress notes on 7/11/14, indicated the resident's urine sample had been obtained. There</p>		end				

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NAME OF PROVIDER OR SUPPLIER RESIDENCES AT DEER CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST US 30 SCHERERVILLE, IN 46375			
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	<p>was no documentation of attempts to collect the urine sample between 7/8 and 7/10/14.</p> <p>Interview with the Director of Nursing on 8/14/14 at 11:30 a.m., indicated documentation should have been completed related to attempts to collect the resident's urine.</p>						