

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2014
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NAME OF PROVIDER OR SUPPLIER RIDGEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 181 CAMPUS DR LAWRENCEBURG, IN 47025
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F000000	<p>This visit was for the Investigation of Complaint # IN00148924 and # Complaint IN00148977.</p> <p>Complaint IN00148924 -- Substantiated. State deficiency is cited at R349.</p> <p>Complaint IN00148977 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F249, F250 and F514.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: May 15, 16, 19 and 20, 2014.</p> <p>Facility number: 012523 Provider number: 155789 AIM number: 201027870</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 56 Residential: 55 Total: 111</p> <p>Census Payor type: Medicare: 13 Medicaid: 23 Other: 75</p>	F000000	<p>This plan of correction is prepared and executed because it is required by the provision of the State and Federal law and not because RidgeWood Health Campus agrees with the allegations and citations. RidgeWood Health Campus maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This plan of correction shall also operate as the facility's written credible allegation of 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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F000249 SS=D	<p>Total: 111</p> <p>Sample: 3 Residential: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 28, 2014 by Cheryl Fielden, RN.</p> <p>483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL</p> <p>The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.</p> <p>Based on interview and record review, the facility failed to ensure the appropriate facility staff were actively</p>	F000249	ED inserviced management team regarding SSD being point of contact for discharge planning on 4/28/2014. ED/designee will	06/13/2014			

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	<p>involved in the transfer/discharge process for 1 of 3 residents reviewed for discharge planning in a sample of 3, resulting in an unexpected arrival of a resident for an admission at the receiving facility. (Resident #J)</p> <p>Findings include:</p> <p>Resident #J's clinical record was reviewed on 5-15-14 at 10:30 a.m. Resident #J was admitted to the facility on 3-3-14 and discharged to another facility on 4-25-14. Her diagnoses were, but not limited to, altered mental status, urinary tract infection, osteoarthritis and congestive heart failure.</p> <p>An interview with the Social Services Director (SSD) on 5-15-14 at 1:40 p.m., indicated she spoke with the SSD at the receiving facility and he indicated he was waiting to hear from the family of Resident #J and waiting on paperwork. The transfer was set up for 4-25-14 at 10:00 a.m. The SSD at the sending facility indicated she had sent out a routine email to facility departments on 4-24-14 to inform them of the planned discharge of Resident #J on 4-25-14. On 4-25-14 at 10:30 a.m., the resident had not been picked up by the other facility, so she contacted there SSD. She indicated he told her he was still waiting</p>		<p>in service staff regarding SSD being point of contact for discharge planning by 6/9/2014. ED/designee will audit residents discharging to another facility weekly x4 to ensure proper documentation and communication with receiving facility. The results of the audit will be presented to the QA committee and the need for continued audits will be determined.</p>				

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	<p>to speak with Resident #J's family as he had been unable to reach her. The sending facility SSD indicated she attempted 3 times unsuccessfully to reach the resident's sister. The SSD left the facility for the day at 2:30 p.m. and was unsure what happened after that time. The sending facility SSD did not indicate she relayed any of this information to other staff in regards to the delay in the discharge/transfer of Resident #J prior to leaving for the day.</p> <p>A review of the documentation in the clinical record, related to discharge planning indicated on 4-25-14, a handwritten note by the SSD indicated the resident would discharge on 4-25-14 to another area extended care facility. The resident was looking forward to "getting out" and the resident's sister was aware of this. There was no documentation noted regarding the delay related to the receiving facility awaiting to speak to the resident's family or attempted phone calls to the resident's family.</p> <p>In an interview with the Executive Director (ED) on 5-15-14 at 2:03 p.m., it was indicated during the week in which Resident #J was discharged to another facility, she and the Director of Nursing (DoN) were out of state at a conference.</p>			

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	<p>The ED indicated there seemed to be a miscommunication between their facility and the receiving facility in regard to the transfer of Resident #J on 4-25-14. On 4-25-14 at approximately 6:40 p.m., the ED spoke with the Administrator of the receiving facility who indicated to her the receiving facility was not expecting Resident #J that evening.</p> <p>The ED indicated from what she understood, the SSD's from both facilities had spoken several times in the process of making arrangements for the transfer/discharge. She indicated she understood the other facility's SSD said the resident could not sign for herself. The sending facility's SSD left at 2:30 p.m., on that Friday for the day. Around 4:00 p.m., the receiving facility's SSD spoke by phone with the Activities Director (AD) and informed her he had been in contact with Resident #J's sister. Some of the facility staff then transported Resident #J to the other facility. The transporting staff provided Resident #J's paperwork to an LPN.</p> <p>The ED indicated, "I realize the Activities Director should not have been the one to take [name of the other facility's SSD]'s phone call, it should have been the SSD. The Social Services person is always available by phone or</p>						

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	<p>text. Everything was up in the air until [name of the AD] spoke with [name of the other facility's SSD] around 4:00 p.m. Her understanding was [name of the other facility] would accept [name of Resident #J] that afternoon." The ED indicated she did conduct an investigation and an inservice on discharge planning and communication in regard to this.</p> <p>In an interview with the AD on 5-15-14 at 3:45 p.m., she accepted a phone call on 4-25-14 from the receiving facility's SSD. The department heads were in their daily afternoon meeting and it would have occurred between 3:45 p.m., and 4:00 p.m. The previous day, the SSD had sent a routine email in regard to the pending transfer/discharge of Resident #J on 4-25-14, so she was aware of Resident #J was to transfer/discharge. On the morning of 4-25-14, the SSD had contacted her to see if the facility's car was available to transport Resident #J to the other facility. She indicated she had not heard anything back from the SSD. She was aware the SSD had left early that day.</p> <p>She indicated in her conversation with the SSD from the receiving facility, he indicated to her, "Everything was good on his end." The SSD from the receiving</p>						

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	<p>facility indicated that facility could accept the resident then or wait until Monday (4-28-14). "He [the SSD from the other facility] did not specifically say to bring her on over or to wait. I did not specifically ask. I had to leave, so I told the others what [name of the SSD from the other facility] said and left...It made sense about going ahead with the transfer."</p> <p>In an interview with the Memory Care Unit Director on 5-15-14 at 3:30 p.m., she indicated the department heads were in the daily afternoon meeting when the AD accepted a phone call from the facility in which Resident #J was transferring to. The department heads had received a routine email the previous day from the SSD to inform them of Resident #J's planned transfer on 4-25-14. The AD informed those at the meeting the facility "had gotten the okay for her [Resident #J] to transfer to [name of receiving facility]." "So it certainly made sense to go ahead with the transfer, " as they had received the email the day before from the SSD and the AD had spoken with a staff person from the receiving facility. She indicated after the meeting, she and another staff member gathered Resident #J's belongings and her paperwork and transported her to the other facility. A staff member from the</p>						

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	<p>receiving facility provided a wheelchair for the resident and assisted them with a cart for the resident's belongings. She provided all of Resident #J's discharge paperwork to a dark-haired female with a nametag indicating she was an LPN. Resident #J seemed very excited about the move, did not appear to be in any pain and gave the other staff member a hug before they departed the other facility.</p> <p>On 5-16-14 at 11:15 a.m., the Corporate Nurse provided a copy of a job description titled "Director of Social Services." This job description indicated this position includes participating in discharge planning.</p> <p>On 5-16-14 at 11:15 a.m., the Corporate Nurse provided a copy of a job description titled "Life Enrichment Director," which was clarified by the Corporate Nurse to be equivalent to an Activities Director. The job description did not indicate discharge planning was a part of the expectations for this position.</p> <p>On 5-15-14 at 2:35 p.m., the ED provided a copy of an inservice conducted in regard to her investigation related to this event. It indicated, "Point of Contact for all discharge planning questions or concerns is [name of SSD],</p>			

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F000250 SS=D	<p>Social Services Director. She can be reached by phone if necessary & needed. Point of contact if DHS [Director of Health Services] or/and [sic] is out of building or unavailable is ADHS [Assistant Director of Health Services], [name of ADHS]. Communication regarding discharge planning is imperative."</p> <p>This Federal tag relates to Complaint IN00148977.</p> <p>3.1-33(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure social services staff routinely documented and effectively communicated with staff of the transferring and receiving facilities in order to achieve an orderly transfer, resulting in an unexpected arrival of a resident for admission at the receiving facility for 1 of 3 residents reviewed for discharge planning in a sample of 3. (Resident #J)</p>	F000250	ED inservice management team regarding SSD being point of contact for discharge planning on 4/28/2014. ED/designee will inservice staff regarding SSD being point of contact for discharge planning by 6/9/2014. ED/designee will audit residents discharging to another facility weekly x4 to ensure proper documentation and communication with receiving facility. The results of the audit will be presented to the QA committee and the need for	06/13/2014

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	<p>Findings include:</p> <p>Resident #J's clinical record was reviewed on 5-15-14 at 10:30 a.m. She was admitted to the facility on 3-3-14 and discharged to another facility on 4-25-14. Her diagnoses included, but were not limited to, altered mental status, urinary tract infection, osteoarthritis and congestive heart failure.</p> <p>In an interview with the Social Services Director (SSD) on 5-15-14 at 1:40 p.m., she indicated she had conducted an initial discharge planning with Resident #J with the initial assessment at which time the resident was uncertain of her plans for discharge. The SSD met with the resident and her sister on 4-22-14 to discuss possible options regarding discharge and addressing concerns for safety regarding returning home. The resident indicated she would like the SSD to inquire about a possible transfer to 2 other nursing homes with Medicaid beds. The SSD indicated one facility declined due to a lack of Medicaid beds and the other facility did have availability.</p> <p>The SSD indicated she spoke with the SSD at the facility with availability and he indicated he was waiting to hear from the family of Resident #J and waiting on paperwork. The transfer was set up for</p>		continued audits will be determined.		

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	<p>4-25-14 at 10:00 a.m. She indicated she had sent out a routine email to facility departments on 4-24-14 to inform them of the planned discharge of Resident #J on 4-25-14. On 4-25-14 at 10:30 a.m., the resident had not been picked up by the other facility, so she contacted their SSD. She indicated he told her he was still waiting to speak with Resident #J's family as he had been unable to reach her. She attempted 3 times unsuccessfully to reach the resident's sister. The SSD left the facility for the day at 2:30 p.m. and was unsure what happened after that time. She did not indicate she relayed any of this information to other staff in regards to the delay in the discharge/transfer of Resident #J prior to leaving for the day.</p> <p>Review of the documentation in the clinical record, related to discharge planning indicated on 3-13-14, "Determination not made" in relationship to discharge planning at that time. A handwritten notation indicated the resident had no specific goals at that time and the Social Services Designee (SSD) would follow up with the resident's family for more information. On 4-2-14, a handwritten notation by the SSD indicated the resident desired to go home despite the resident's sister and therapy did not think this was safe. The SSD</p>						

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	<p>would follow up with the resident and sister in regards to discharge plans and safety concerns. On 4-25-14, a handwritten note by the SSD indicated the resident would discharge on 4-25-14 to an area extended care facility. The resident was looking forward to "getting out" and the resident's sister was aware of this. The notation indicated on 4-22-14 the SSD had assisted the sister in applying for and faxing a Medicaid application for the resident. It indicated the SSD was aware of the resident falling early the morning of 4-25-14. The resident stated she was "fine," but indicated the resident seemed confused in regard to the details of the fall. There was no documentation noted regarding the delay related to the receiving facility awaiting to speak to the resident's family or attempted phone calls to the resident's family.</p> <p>In interview with the Executive Director (ED) on 5-15-14 at 2:03 p.m., she indicated during the week in which Resident #J was discharged to another facility, she and the Director of Nursing were out of state at a conference. She indicated there seemed to be a miscommunication between their facility and the receiving facility in regard to the transfer of Resident #J on 4-25-14. On 4-25-14 at approximately 6:40 p.m., she</p>						

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	<p>spoke with the Administrator of the receiving facility who indicated to her the receiving facility was not expecting Resident #J that evening.</p> <p>The ED indicated from what she understood, the SSD's from both facilities had spoken several times in the process of making arrangements for the transfer/discharge. She understood the other facility's SSD said the resident could not sign for herself. She indicated this facility's SSD left at 2:30 p.m. on that Friday for the day. She indicated around 4:00 p.m., the other facility's SSD spoke by phone with the Activities Director (AD) and informed her he had been in contact with Resident #J's sister. Some of the facility staff then transported Resident #J to the other facility. The transporting staff provided Resident #J's paperwork to an LPN.</p> <p>The ED indicated, "I realize the Activities Director should not have been the one to take [name of the other facility's SSD]'s phone call, it should have been the SSD. The Social Services person is always available by phone or text. Everything was up in the air until [name of the AD] spoke with [name of the other facility's SSD] around 4:00 p.m. Her understanding was [name of the other facility] would accept [name of</p>						

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	<p>Resident #J] that afternoon." The ED indicated she did conduct an investigation and an inservice on discharge planning and communication in regard to this.</p> <p>In interview with the AD on 5-15-14 at 3:45 p.m., she indicated on 4-25-14, she accepted a phone call from the SSD at the facility in which Resident #J was to transfer. The department heads were in their daily afternoon meeting and it would have occurred between 3:45 p.m. and 4:00 p.m. She indicated the previous day, the SSD had sent a routine email in regard to the pending transfer/discharge of Resident #J on 4-25-14, so she was aware of Resident #J was to transfer/discharge. On the morning of 4-25-14, the SSD had contacted her to see if the facility's car was available to transport Resident #J to the other facility. She indicated she had not heard anything back from the SSD. She was aware the SSD had left early that day.</p> <p>She indicated in her conversation with the SSD from the other facility, he indicated to her, "Everything was good on his end." The SSD from the other facility indicated that facility could accept the resident then or wait until Monday (4-28-14). She indicated, "He [the SSD from the other facility] did not</p>				

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	<p>specifically say to bring her on over or to wait. I did not specifically ask. I had to leave, so I told the others what [name of the SSD from the other facility] said and left...It made sense about going ahead with the transfer."</p> <p>In interview with the Memory Care Unit Director on 5-15-14 at 3:30 p.m., she indicated the department heads were in the daily afternoon meeting when the AD accepted a phone call from the facility in which Resident #J was transferring to. She indicated the department heads had received a routine email the previous day from the SSD to inform them of Resident #J's planned transfer on 4-25-14. She indicated the AD informed those at the meeting the facility "had gotten the okay for her [Resident #J] to transfer to [name of receiving facility]." She indicated, "So it certainly made sense to go ahead with the transfer, " as they had received the email the day before from the SSD and the AD had spoken with a staff person from the receiving facility. After the meeting, she and another staff member gathered Resident #J's belongings and her paperwork and transported her to the other facility. A staff member from the receiving facility provided a wheelchair for the resident and assisted them with a cart for the resident's belongings. She provided all of Resident #J's discharge</p>			

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	<p>paperwork to a dark-haired female with a nametag indicating she was an LPN. Resident #J seemed very excited about the move, did not appear to be in any pain and gave the other staff member a hug before they departed the other facility.</p> <p>In interview with the Administrator of the receiving facility on 5-16-14 at 9:30 a.m., she indicated in her conversation with the ED on 4-25-14 around 6:40 p.m., she was told the last conversation she had with her facility that date was Resident #J would be admitting to her facility on 4-28-14 due to no family contact.</p> <p>On 5-16-14 at 11:15 a.m., the Corporate Nurse provided a copy of a job description for the "Director of Social Services." This job description indicated this position includes participating in discharge planning.</p> <p>On 5-15-14 at 2:35 p.m., the ED provided a copy of an inservice conducted in regard to her investigation related to this event. It indicated, "Point of Contact for all discharge planning questions or concerns is [name of SSD], Social Services Director. She can be reached by phone if necessary & needed. Point of contact if DHS [Director of Health Services] or/and [sic] is out of</p>			

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F000425 SS=E	<p>building or unavailable is ADHS [Assistant Director of Health Services], [name of ADHS]. Communication regarding discharge planning is imperative."</p> <p>This Federal tag relates to Complaint IN00148977.</p> <p>3.1-34(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review,</p>	F000425	DHS/Designee immediately began verbally inservicing nursing	06/13/2014	

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	<p>the facility failed to implement a written policy for tracking the return of unused medications to the pharmacy upon transfer or discharge of a resident or the sending of medications with a resident upon transfer or discharge for 2 of 3 residents reviewed for transfer/discharge in a sample of 3. (Resident #J and Resident #K)</p> <p>Findings include:</p> <p>1. Resident #J's clinical record was reviewed on 5-15-14 at 10:30 a.m. It indicated she was admitted to the facility on 3-3-14 and discharged to another facility on 4-25-14. Her diagnoses included, but were not limited to, altered mental status, urinary tract infection, osteoarthritis and congestive heart failure.</p> <p>Review of Resident #J's "Discharge Instructions", dated 4-25-14, indicated a blank column where the number of each medication which was sent with the resident.</p> <p>2. Resident #K's clinical record was reviewed on 5-20-14 at 9:40 a.m. His diagnoses included, but were not limited to, vascular dementia, diabetes, hypertension, gouty arthritis, history of deep vein thrombosis with anticoagulant</p>		<p>staff regarding ensuring the number of medications sent with a resident upon transfer or discharge was documented on the discharge instruction form. A medication reconciliation form will be implemented for tracking unused medications returned to the pharmacy. DHS/Designee will inservice nursing staff on ensuring the number of medications send with a resident upon transfer or discharge is documented on the discharge instruction form by 6/9/2014. DHS/Designee will inservice nursing staff on use of the reconciliation form for tracking unused medications returned to the pharmacy by 6/9/2014. DHS/designee will audit discharge instruction form to ensure documentation of number of medications sent with resident upon transfer or discharge weekly x4. DHS/designee will audit medication reconciliation form for proper documentation of unused medications sent back to pharmacy weekly x4. The results of the audits will be presented to the QA committee and the need for continued audits will be determined by the QA committee.</p>				

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	<p>therapy, atrial fibrillation and history of falls. He was admitted to the facility on 11-18-11 and discharged on 4-22-14.</p> <p>Review of Resident #K's "Discharge Instructions", dated 4-22-14, indicated a blank column where the number of each medication which was sent with the resident.</p> <p>Review of Resident #K's "Discharge Summary" did not indicate if medications were sent with the resident and did not indicate if prescriptions were provided for medications.</p> <p>In interview with the Director of Health Services (DHS) on 5-19-14 at 10:35 a.m., she indicated the nurse who discharged Resident #K failed to send his medications with him to the receiving facility and should have done so. She learned of this via a text message from the Assistant Director of Health Services. The facility is in the process of changing the manner in which medications are documented when medications are sent with a resident or returned to the pharmacy for credit.</p> <p>In interview with the DHS on 5-16-14 at 2:15 p.m., she indicated the nursing staff should fill out the number of pills or doses of medications sent with the</p>			

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F000514 SS=E	<p>resident on the "Discharge Instruction" form. She did not think that information was located anywhere else in the clinical record. She indicated, "We do not have a tracking mechanism for those meds we send back to the pharmacy for credit. We just send them back. It's not like anything I've ever seen."</p> <p>On 5-16-14 at 11:55 a.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for LOA/Discharge Instructions." This policy indicated, "Reconciliation of all medications regardless of payor source should be on individual resident disposition and/or pharmacy credit form within 7 days or state specified guidelines."</p> <p>3.1-25(s)(5)</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 ensure complete and accurate discharge/transfer documentation for 3 of 3 residents reviewed for transfer/discharge in a sample of 3. (Resident #J, #K and #L)</p> <p>Findings include:</p> <p>1. Resident #J's clinical record was reviewed on 5-15-14 at 10:30 a.m. Resident #J was admitted to the facility on 3-3-14 and discharged to another facility on 4-25-14. Her diagnoses included, but were not limited to, altered mental status, urinary tract infection, osteoarthritis and congestive heart failure.</p> <p>In interview with the Social Services Director (SSD) on 5-15-14 at 1:40 p.m., she indicated she spoke with the SSD at the facility to which Resident #J was transferring and he indicated he was waiting to hear from the family of Resident #J and waiting on paperwork. The transfer was set up for 4-25-14 at 10:00 a.m. She indicated she had sent out a routine email to facility departments on 4-24-14 to inform them of the planned discharge of Resident #J on 4-25-14. She indicated on 4-25-14 at 10:30 a.m., the</p>	F000514	ED/designee immediately inserviced SSD to ensure complete and accurate discharge/transfer documentation on the Discharge Instructions and Discharge Summary forms. ED/designee will audit discharge instruction and discharge summary forms on discharging/tranferring residents weekly x4. The results of the audit will be presented to the QA committee and the need for continued audits will be determined.	06/13/2014

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	<p>resident had not been picked up by the other facility, so she contacted their SSD. He told her he was still waiting to speak with Resident #J's family as he had been unable to reach her. She attempted 3 times unsuccessfully to reach the resident's sister. She indicated she left the facility for the day at 2:30 p.m. and was unsure what happened after that time. She did not indicate she relayed any of this information to other staff in regards to the delay in the discharge/transfer of Resident #J prior to leaving for the day. There was no documentation noted regarding the delay related to the receiving facility awaiting to speak to the resident's family or attempted phone calls to the resident's family.</p> <p>Review of Resident #J's "Discharge Instructions", dated 4-25-14, indicated the following:</p> <ul style="list-style-type: none"> - a blank column where the number of each medication which was sent with the resident. - a blank entry for diet. - a blank entry for activity level. - a blank entry for precautions. - a blank entry for follow up appointments. <p>Review of Resident #J's "Discharge Summary" indicated a blank entry for</p>				

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	<p>diagnoses.</p> <p>2. Resident #K's clinical record was reviewed on 5-20-14 at 9:40 a.m. His diagnoses included, but were not limited to, vascular dementia, diabetes, hypertension, gouty arthritis, history of deep vein thrombosis with anticoagulant therapy, atrial fibrillation and history of falls. He was admitted to the facility on 11-18-11 and discharged on 4-22-14.</p> <p>Review of Resident #K's "Discharge Instructions", dated 4-22-14, indicated the following:</p> <ul style="list-style-type: none"> - a blank column where the number of each medication which was sent with the resident. - a blank entry for activity level. - a blank entry for precautions. - a blank entry for follow up appointments. - a blank entry for discharge needs/arrangements. <p>Review of Resident #K's "Discharge Summary" indicated the following:</p> <ul style="list-style-type: none"> - a blank entry for diagnoses. - did not indicate if medications were sent with the resident. - did not indicate if prescriptions were provided for medications. <p>3. Resident #L's clinical record was</p>				

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	<p>reviewed on 5-19-14 at 2:30 p.m. Her diagnoses included, but were not limited to urinary tract infection, abdominal pain, chronic back pain and deep vein thrombosis. She was admitted to the facility on 9-4-13 and discharged on 11-29-13.</p> <p>Review of Resident #L's "Discharge Instructions", dated 11-29-13 indicated the following:</p> <ul style="list-style-type: none"> - a blank entry for diet. - a blank entry for activity level. - a blank entry for precautions. - a blank entry for follow up appointments. <p>Review of Resident #L's "Discharge Summary", dated 11-27-13, indicated a blank entry for diagnoses.</p> <p>In interview with the Director of Health Services (DHS) on 5-16-14 at 2:15 p.m., she indicated the nursing staff should fill out the number of pills or doses of medications sent with the resident on the "Discharge Instruction" form. She did not think that information was located anywhere else in the clinical record.</p> <p>On 5-16-14 at 11:55 a.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for LOA/Discharge Instructions." This policy indicated, "The</p>			

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	<p>discharge instructions should include:</p> <ol style="list-style-type: none"> 1. a. Listing of medications/dose, time, amount and route to administer. b. Activity level. c. Diet d. Precautions. e. Follow up appointments... i. Any other special information... <p>6. c. "Reconciliation of all medications regardless of payor source should be on individual resident disposition and/or pharmacy credit form within 7 days or state specified guidelines."</p> <p>On 5-20-14 at 2:05 p.m., the Executive Director provided a copy of a policy entitled, "EXECUTIVE SUMMARY Clinical Documentation Systems." This policy indicated, "...Staff will document their service delivery and assessment of mental and physical functioning...The DHS or designee will review the documentation or documentation reports to evaluate compliance with documentation requirements..."</p> <p>This Federal tag relates to Complaint IN00148977.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						

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R000298	<p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on interview and record review, the facility failed to implement a written policy for tracking the return of unused medications to the pharmacy upon transfer or discharge of a resident or the sending of medications with a resident upon transfer or discharge for 3 of 3 residents reviewed for transfer/discharge in a sample of 3. (Resident #G, #H and #I)</p> <p>Findings include:</p> <p>1. Resident #G's clinical record was reviewed on 5-19-14 at 1:45 p.m. Resident #G was admitted to the facility on 6-15-13 and discharged to another facility on 4-18-14. Her diagnoses included, but were not limited to,</p>	R000298	DHS/Designee immediately began verbally inservice nursing staff regarding ensuring the number of medications sent with a resident upon transfer or discharge was documented on the discharge instruction form. A medication reconciliation form will be implemented for tracking unused medications returned to the pharmacy. DHS/Designee will inservice nursing staff on ensuring the number of medications send with a resident upon transfer or discharge is documented on the discharge instruction form by 6/9/2014. DHS/Designee will inservice nursing staff on use of the reconciliation form for tracking unused medications returned to the pharmacy by 6/9/2014. DHS/designee will audit discharge instruction form to ensure	06/13/2014			

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	<p>dementia, diabetes, hypertension, and anxiety.</p> <p>Review of Resident #G's "Discharge Summary," dated 4-16-14 indicated no listing of the resident's diagnoses. It did indicate, "Medications sent with resident/responsible party."</p> <p>The clinical record indicated an absence of the "Discharge Instructions" form which includes a listing of the resident's physician-ordered medications with administration instructions and how much of each medication was sent with the resident, as well as instructions for diet, activity level, precautions, follow up appointments, discharge needs/arrangements and any special instructions or comments regarding the resident.</p> <p>In interview with the Director of Health Services (DHS) on 5-19-14 at 2:15 p.m., she indicated, "I will be very honest with you, when I reviewed this chart, I did not find some of the discharge information I expected." She spoke with the discharging nurse who told her she had not filled out some of the discharge paperwork. She indicated some of the paperwork not included was Resident #G's MAR (Medication Administration Record) or the physician's orders. The</p>		documentation of number of medications sent with resident upon transfer or discharge weekly x4. DHS/designee will audit medication reconciliation form for proper documentation of unused medications sent back to pharmacy weekly x4. The results of the audits will be presented to the QA committee and the need for continued audits will be determined by the QA committee.				

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	<p>DHS indicated the nurse chose not to include this information, "Because she was going to another facility [and] she didn't think she would need to forward all the information you would send if someone was going home." This was not consistent with the facility's discharge policies. She indicated, "It looks like I have a lot of educating to do with discharges."</p> <p>2. Resident #H's clinical record was reviewed on 5-15-14 at 3:15 p.m. Her diagnoses included, but were not limited to, hallucinations, diabetes, hypertension, and atrial fibrillation. She was admitted to the facility on 4-30-13 and discharged on 4-28-14.</p> <p>Review of Resident #H's "Discharge Instructions", dated 4-22-14, indicated a blank column where the number of each medication which was sent with the resident.</p> <p>3. Resident #I's clinical record was reviewed on 5-19-14 at 3:20 p.m. Her diagnoses included, but were not limited to, chronic low back pain and osteoarthritis. She was admitted for a respite stay from 4-11-14 to 4-20-14.</p> <p>The clinical record indicated an absence of the "Discharge Instructions" form</p>						

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	<p>which includes a listing of the resident's physician-ordered medications with administration instructions and how much of each medication was sent with the resident, as well as instructions for diet, activity level, precautions, follow up appointments, discharge needs/arrangements and any special instructions or comments regarding the resident.</p> <p>The clinical record indicated an absence of the "Discharge Summary" form which includes the resident's diagnoses, destination of discharge/transfer, reason for transfer, services provided by the facility at the time of discharge and recapitulation of the resident's stay by discipline.</p> <p>In an interview with the Executive Director on 5-20-14 at 2:05 p.m., she indicated the paperwork for all residents, including respite stay residents, was the same related to admission, care and discharge.</p> <p>In an interview with the DHS on 5-16-14 at 2:15 p.m., she indicated the nursing staff should fill out the number of pills or doses of medications sent with the resident on the "Discharge Instruction" form. She did not think that information was located anywhere else in the clinical</p>			

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R000306	<p>record.</p> <p>On 5-16-14 at 11:55 a.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for LOA/Discharge Instructions." This policy indicated, "Reconciliation of all medications regardless of payor source should be on individual resident disposition and/or pharmacy credit form within 7 days or state specified guidelines."</p> <p>5.6(c)(2)(c)</p> <p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review,</p>	R000306	DHS/Designee immediately began verbally inservicing nursing	06/13/2014

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	<p>the facility failed to implement a written policy for tracking the return of unused medications to the pharmacy upon transfer or discharge of a resident or the sending of medications with a resident upon transfer or discharge for 3 of 3 residents reviewed for transfer/discharge in a sample of 3. (Resident #G, #H and #I)</p> <p>Findings include:</p> <p>1. Resident #G's clinical record was reviewed on 5-19-14 at 1:45 p.m. REsident #G was admitted to the facility on 6-15-13 and discharged to another facility on 4-18-14. Her diagnoses included, but were not limited to, dementia, diabetes, hypertension, and anxiety.</p> <p>Review of Resident #G's "Discharge Summary," dated 4-16-14 indicated, "Medications sent with resident/responsible party."</p> <p>The clinical record indicated an absence of the "Discharge Instructions" form which includes a listing of the resident's physician-ordered medications with administration instructions and how much of each medication was sent with the resident, as well as instructions for diet, activity level, precautions, follow up</p>		<p>staff regarding ensuring the number of medications sent with a resident upon transfer or discharge was documented on the discharge instruction form. A medication reconciliation form will be implemented for tracking unused medications returned to the pharmacy. DHS/Designee will inservice nursing staff on ensuring the number of medications send with a resident upon transfer or discharge is documented on the discharge instruction form by 6/9/2014. DHS/Designee will inservice nursing staff on use of the reconciliation form for tracking unused medications returned to the pharmacy by 6/9/2014. DHS/designee will audit discharge instruction form to ensure documentation of number of medications sent with resident upon transfer or discharge weekly x4. DHS/designee will audit medication reconciliation form for proper documentation of unused medications sent back to pharmacy weekly x4. The results of the audits will be presented to the QA committee and the need for continued audits will be determined by the QA committee.</p>		

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	<p>appointments, discharge needs/arrangements and any special instructions or comments regarding the resident.</p> <p>In interview with the Director of Health Services (DHS) on 5-19-14 at 2:15 p.m., she indicated, "I will be very honest with you, when I reviewed this chart, I did not find some of the discharge information I expected." She spoke with the discharging nurse who told her she had not filled out some of the discharge paperwork. She indicated some of the paperwork not included was Resident #G's MAR (Medication Administration Record) or the physician's orders. The DHS indicated the nurse chose not to include this information, "Because she was going to another facility [and] she didn't think she would need to forward all the information you would send if someone was going home." This was not consistent with the facility's discharge policies. She indicated, "It looks like I have a lot of educating to do with discharges."</p> <p>2. Resident #H's clinical record was reviewed on 5-15-14 at 3:15 p.m. Her diagnoses included, but were not limited to, hallucinations, diabetes, hypertension, and atrial fibrillation. She was admitted to the facility on 4-30-13 and discharged</p>						

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	<p>on 4-28-14.</p> <p>Review of Resident #H's "Discharge Instructions", dated 4-28-14, indicated a blank column where the number of each medication which was sent with the resident.</p> <p>3. Resident #I's clinical record was reviewed on 5-19-14 at 3:20 p.m. It indicated her diagnoses included, but were not limited to, chronic low back pain and osteoarthritis. She was admitted for a respite stay from 4-11-14 to 4-20-14.</p> <p>The clinical record indicated an absence of the "Discharge Instructions" form which includes a listing of the resident's physician-ordered medications with administration instructions and how much of each medication was sent with the resident, as well as instructions for diet, activity level, precautions, follow up appointments, discharge needs/arrangements and any special instructions or comments regarding the resident.</p> <p>The clinical record indicated an absence of the "Discharge Summary" form which includes the resident's diagnoses, destination of discharge/transfer, reason for transfer, services provided by the</p>				

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	<p>facility at the time of discharge and recapitulation of the resident's stay by discipline.</p> <p>In interview with the Executive Director on 5-20-14 at 2:05 p.m., the paperwork for all residents, including respite stay residents, was the same related to admission, care and discharge.</p> <p>In interview with the DHS on 5-16-14 at 2:15 p.m., she indicated the nursing staff should fill out the number of pills or doses of medications sent with the resident on the "Discharge Instruction" form. She did not think that information was located anywhere else in the clinical record.</p> <p>On 5-16-14 at 11:55 a.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for LOA/Discharge Instructions." This policy indicated, "Reconciliation of all medications regardless of payor source should be on individual resident disposition and/or pharmacy credit form within 7 days or state specified guidelines."</p> <p>5.6(g)(2) 5.6(g)(4) 5.6(g)(5) 5.6(g)(6) 5.6(g)(7)</p>				

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R000349	<p>5.6(g)(8)</p> <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 complete and accurate documentation for 3 of 3 residents reviewed for transfer/discharge in a sample of 3. (Resident #G, #H and #I)</p> <p>Findings include:</p> <p>1. Resident #G's clinical record was reviewed on 5-19-14 at 1:45 p.m. Resident #G indicated she was admitted to the facility on 6-15-13 and discharged to another facility on 4-18-14. Her diagnoses included, but were not limited to, dementia, diabetes, hypertension, and anxiety.</p> <p>Review of Resident #G's "Discharge Summary," dated 4-16-14, did not include the resident's diagnoses. It did indicate the resident's medications were</p>	R000349	ED/designee immediately inserviced SSD to ensure complete and accurate discharge/transfer documentation on the Discharge Instructions and Discharge Summary forms. ED/designee will audit discharge instruction and discharge summary forms on discharging/transferring residents weekly x4. The results of the audit will be presented to the QA committee and the need for continued audits will be determined.	06/13/2014			

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	<p>sent with the resident/responsible party.</p> <p>The clinical record indicated an absence of the "Discharge Instructions" form which includes a listing of the resident's physician-ordered medications with administration instructions and how much of each medication was sent with the resident, as well as instructions for diet, activity level, precautions, follow up appointments, discharge needs/arrangements and any special instructions or comments regarding the resident.</p> <p>In interview with the Director of Health Services (DHS) on 5-19-14 at 2:15 p.m., she indicated, "I will be very honest with you, when I reviewed this chart, I did not find some of the discharge information I expected." She spoke with the discharging nurse who told her she had not filled out some of the discharge paperwork. Some of the paperwork not included was Resident #G's MAR (Medication Administration Record) or the physician's orders. The DHS indicated the nurse chose not to include this information, "Because she was going to another facility [and] she didn't think she would need to forward all the information you would send if someone was going home." This was not consistent with the facility's discharge</p>			

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	<p>policies. She indicated, "It looks like I have a lot of educating to do with discharges."</p> <p>2. Resident #H's clinical record was reviewed on 5-15-14 at 3:15 p.m. Her diagnoses included, but were not limited to, hallucinations, diabetes, hypertension, and atrial fibrillation. She was admitted to the facility on 4-30-13 and discharged on 4-28-14.</p> <p>Review of Resident #H's "Discharge Summary" indicated a blank entry for diagnoses.</p> <p>Review of Resident #H's "Discharge Instructions", dated 4-28-14, indicated the following:</p> <ul style="list-style-type: none"> - a blank column where the number of each medication which was sent with the resident. - a blank entry for diet. - a blank entry for activity level. - a blank entry for precautions. - a blank entry for follow up appointments. <p>3. Resident #I's clinical record was reviewed on 5-19-14 at 3:20 p.m. Her diagnoses included, but were not limited to, chronic low back pain and osteoarthritis. It indicated she was admitted for a respite stay from 4-11-14</p>				

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	<p>to 4-20-14.</p> <p>The clinical record indicated an absence of the "Discharge Summary" form which includes the resident's diagnoses, destination of discharge/transfer, reason for transfer, services provided by the facility at the time of discharge and recapitulation of the resident's stay by discipline.</p> <p>The clinical record indicated an absence of the "Discharge Instructions" form which includes a listing of the resident's physician-ordered medications with administration instructions and how much of each medication was sent with the resident, as well as instructions for diet, activity level, precautions, follow up appointments, discharge needs/arrangements and any special instructions or comments regarding the resident.</p> <p>In interview with the Executive Director on 5-20-14 at 2:05 p.m., she indicated the paperwork for all residents, including respite stay residents, was the same related to admission, care and discharge.</p> <p>In interview with the DHS on 5-16-14 at 2:15 p.m., she indicated the nursing staff should fill out the number of pills or doses of medications sent with the</p>				

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	<p>resident on the "Discharge Instruction" form. She did not think that information was located anywhere else in the clinical record.</p> <p>On 5-16-14 at 11:55 a.m., the Corporate Nurse provided a copy of a policy entitled, "Guidelines for LOA/Discharge Instructions." This policy indicated, "The discharge instructions should include:</p> <ol style="list-style-type: none"> 1. a. Listing of medications/dose, time, amount and route to administer. b. Activity level. c. Diet d. Precautions. e. Follow up appointments... i. Any other special information... <p>6. c. "Reconciliation of all medications regardless of payor source should be on individual resident disposition and/or pharmacy credit form within 7 days or state specified guidelines."</p> <p>This State tag relates to Complaint IN00148924.</p> <p>5.8-1(a)(1) 5.8-1(a)(2)</p>			