STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(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
F000000	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on April 23, 2013. This visit was in conjunction to the Investigation of Complaints IN00129606 and IN00128531. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00127162 completed on April 23, 2013. Survey Dates: June 5, 6, and 7, 2013 Facility number: 000220 Provider number: 155327 AIM number: 100267650 Survey team: Leia Alley, RN-TC Patten Allen, SW Marcy Smith, RN, (6/7/13) Dinah Jones, RN Census bed type: SNF: 29 SNF/NF: 133 TOTAL: 162	F000000	This plan of correction is to serve as University Heights Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census payor type: MEDICARE: 30 MEDICAID: 100 OTHER: 32 TOTAL: 162 Sample: 11 This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality Review completed on June 11, 2013; by Kimberly Perigo, RN.			

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F000282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on interview and record review, the facility failed to ensure residents received medications as prescribed by the medical doctor for 2 of 5 residents reviewed for medication administration. This resulted in hospitalization of one resident. (Resident's, #B, and #E.) Findings Include: 1) The clinical record for Resident #B was reviewed on 6/6/13 at 10:00 a.m. Diagnoses for Resident #B included but were not limited to hypothyroidism (inadequate levels of thyroid hormone in the body), and thyroidectomy (removal of thyroid gland). Resident #B had a physicians order to take "levothyroxine [thyroid hormone replacement medication], 137 mcg [micrograms/dosage], 1 tablet oral (by mouth), once a morning at 5:00 a.m." A Minimum Data Set [MDS] assessment completed on 3/15/13	F000282	**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** I. Resident #B and #E are no longer residing at the facility. Residents #C, & D are receiving medications as prescribed by the medical doctor. II. All residents were reviewed for receiving medications as prescribed by the medical doctor. Any concerns were addressed.III. The systemic change includes:· The computerized Medication Administration Compliance Report is reviewed daily by the DON or her designee. Any missed doses of medications are then audited for physician notification per the facility policy and the physician is notified at that time if not already noted in the electronic medical record. The DON or her designee will interview the resident in an attempt to determine reason for non-compliance. If possible, the MD will be notified and the plan of care altered to accommodate the reason for refusal. · All new admissions are reviewed for receipt of prescribed medications by the Unit Manager or designee on the day of admission. A phone call is placed to the	06/26/2013

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	indicated Resident #B had a Brief Interview for Mental Status score of 3/15, which indicated severe cognitive impairment. The MDS also indicated Resident #B required extensive assistance from staff to perform activities of daily living such as transferring, moving in the bed, eating, tilting and personal hygiene. An Electronic Medication Administration Record was reviewed and indicated Resident #B missed the medication on the dates of: 5/8/13 4:32 a.m., Not Administered: Refused [nurses notes indicated resident refused medication] 5/9/13 4:22 a.m., Not Administered: Refused 5/10/13 4:22 a.m., Not Administered: Refused 5/12/13 4:23 a.m., Not Administered: Refused to open mouth 5/15/13 4:19 a.m., Not Administered: Refused to open mouth 5/18/13 4:19 a.m., Not Administered: Refused A nurses note dated 5/21/13 and timed 11:29 a.m., indicated "Received call from _____ [name of caller] at Dr. _____ [name] office. _____ [Name of caller] stated that IV [intra-venous] Levothyroxine needed		pharmacy by the admitting nurse or Manager for a timeline of when the medications will arrive and the physician is notified if there will be any delay in medication administration. Education will be provided to Nursing Administration and licensed nurses regarding the systemic change and attempting to determine reason for resident medication refusal.IV.The Director of Nursing or designee will audit the computerized Medication Administration Compliance Report daily for missed doses of medications and documentation of physician notification per the facility policy. Any concerns will be addressed and attempts made to determine reason for medication refusal, notifying the physician and altering the plan of care to facilitate compliance. This audit will continue daily for 30 days, then weekly thereafter for a total of 12 months of monitoring. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if less than 100% compliance achieved..Date of completion: June 26, 201	

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	to be started immediately or she needed to be admitted to the hospital to get it. She has a critical TSH [thyroid stimulating hormone] level of 214.5 [therapeutic or normal range is 0.3 to 5.0]. This writer found out that we don't have levothyroxine IV in the EDK [emergency drug kit] and that she would need to go to the hospital for treatment. Call placed back to _____ [name of caller] and was given orders to send through IU ER [Indiana University hospital Emergency Room] and admit to hospital. Mother and friend was here for care plan meeting and was made aware of condition. Call placed to seals for transport to hospital. Report called to IU ER. Call placed to dialysis center that she would not be getting dialysis today. EMS [emergency medical services] here to transport and mother accompanied them." A physicians "Final Report" from Indiana University hospital, dated 5/15/13 "From a thyroid perspective, she is getting 137 mcg of levothyroxine, but this is being sprinkled onto applesauce according to the mother who brought the patient today. We therefore need to check a TSH and free T4 (blood level), I think they may have to find an alternative way of giving her levothyroxine, if			

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	necessarily intramuscularly since its absorption will not be good with any kind of food ... Plan: Our plan is to check her TSH and free T4 today and based on the results we will recommend alterative delivery mechanisms to the nursing home if they cannot get the levothyroxine given to her on an empty stomach." The clinical record lacked documentation of any interventions or alternate means of medication administration, put into place to assist Resident #B to get required medications. The record also lacked documentation the physician providing care for Resident #B, while in the nursing facility, was aware of the missed medications. During an interview with the Director of Nursing (DON) on 6/6/13 at 12:00 p.m., further information was requested in regard to alternate means of medication administration, facility plan of care for a resident #B receiving thyroid medication, and physician notification of missed medications. During an interview with the Nurse Consultant and DON on 6/6/13 at 3:30 p.m., no information could be found in regard to alternate means of			

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	medication administration, facility plan of care for a resident #B receiving thyroid medication, or physician notification of missed medications. The DON indicated at that time the facility Nurse Practitioner would be in on 6/7/13 and would discuss the acknowledgement of missed medications with the survey team. During an interview with the DON on 6/7/13 at 9:00 a.m., the DON indicated the Nurse Practitioner did not feel comfortable to give a statement indicating she was aware Resident #B had missed any medications. The DON at that time indicated as of 6/6/13, the facility had reviewed and placed an update in the Electronic Administration Record for each resident in the facility that was taking the medication levothyroxine [Synthroid], and if a dose was missed, the doctor would be notified. A facility policy, undated provided by the Nurse Consultant on June 7, 2013 at 11:30 a.m., and titled WITHHOLDING OR REFUSAL OF MEDICATION OR TREATMENT, indicated, "The physician will be notified when a medication or treatment has been refused by the resident OR held by the nurse for a resident-related reason for 24 hours			

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	AND the resident's condition is medically STABLE (not presenting signs or symptoms). ... The physician will be notified AFTER THE FIRST MISSED DOSE when a drug from the following classes has been refused by the resident OR held for a medically related reason: ANTIBIOTICS ANTIDIABETICS ANTICOAGULANTS ANTICONVULSANTS BRONCHIODILATORS CARDIOACTIVES... The nurse may determine per professional discretion to notify the physician sooner than above parameters if such notification is necessary in order to provide appropriate resident care." 2) On 6/5/13 at 1:30 p.m., Resident #E was observed lying in his bed with his right leg in a CPM [Continuous Passive Motion] machine. He was observed to have a bandage covering his right knee that had a date of 6/5/13 and a time of 10:30 a.m. In an interview, the resident indicated he had admitted to the facility on Saturday, June 1, 2013 at 2:50 p.m. A review of the resident's clinical record on 6/5/13 at 2:00 p.m.,			

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	indicated diagnoses including but not limited to; chronic airway obstruction, depression, hypertension, anxiety, schizophrenia, personality disorder, post-traumatic stress syndrome, asthma, coronary artery disease, insomnia, chronic pain, and after care for knee surgery. The clinical record indicated physician's orders dated, 6/1/13 for medications including but not limited to: abilify 30 mg [milligrams] 1 po [by mouth] q [every] 5:00 p.m. aspirin 81 mg 1 po q 8:00 a.m. bumetanide 2 mg 1 po 1 8:00 a.m. chantix 0.5 mg 1 po b.i.d. [twice daily] colase 100 mg 1 po b.i.d. combivent 20-100 mcg [micrograms] dextromethoraphan-quaifenesin 10-100 mg/5 ml [milliliters] 10 ml qhs [every hour of sleep] prn [as needed] dulera inhaler 200-5 mcg 2 puffs b.i.d. at 8:00 a.m. and 5:00 p.m. hydroxyzine 50 mg 1 po b.i.d. at 8:00 a.m. and 5:00 p.m. isorbide er [extended release] 60 mg 1 po qd [every day] at 5:00 p.m. klonopin 1 mg 1 po t.i.d. [three times per day] lamictal 25 mg 2 po qd at 5 p.m. lomotil 2.5-0.025 mg 2 po q.i.d. [four times per day] prn			

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	losartin 50 mg 1 po qd at 8:00 a.m. lovenox 40 mg/0.4 ml subcutaneous [beneath the skin] qd at 8:00 a.m. metoprolol 100 mg 1 po b.i.d. at 8:00 a.m. and 5:00 p.m. multivitamin 1 po qd at 8:00 a.m. nicotine 21 mg/24 hour 1 patch transdermal [through the skin] qd at 8:00 a.m. olanzapine 15 mg 1 po qhs at 8:00 p.m. oxycodone-acetaminophen 10-325 mg 1 po q 4 hours prn requip 2 mg 1 po t.i.d. at 8:00 a.m., 1:00 p.m., and 5:00 p.m. simvastatin 10 mg 1 po qhs at 8:00 p.m. spireva 18 mcg 1 capsule with inhalation qd at 8:00 a.m. zantac 150 mg 1 po b.i.d. at 8:00 a.m. and 5:00 p.m. zoloft 100 mg 1 po with 50 mg to equal 150 mg qhs at 8:00 p.m. A review of the resident's clinical record on 6/5/13 at 2:00 p.m., indicated medications not given on 6/1/13 at 5:00 p.m. and/or 8:00 p.m. included but not limited to: abilify 30 mg 1 po at 5:00 p.m. chantix 0.5 mg 1 po b.i.d. colase 100 mg 1 po b.i.d. combivent respimat aerosol 20-100 mcg 1 puff inhaled			

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	isosorbide mononitrate 60 mg 1 po at 5:00 p.m. klonopin 1 mg 1 po t.i.d. at 5:00 p.m. lamictal 25 mg 2 po at 5:00 p.m. metoprolol tartrate 100 mg 1 po b.i.d. at 5:00 p.m. restoril 15 mg 1 po at 8:00 p.m. zantac 150 mg 1 po at 5:00 p.m. On 6/2/13, the resident did not receive medications including but not limited to: abilify 30 mg 1 po at 5:00 p.m. chantix 0.5 mg 1 po b.i.d. The 8:00 a.m. and 5:00 p.m. doses were not administered. colase 100 mg 1 po b.i.d. The 8:00 a.m. and 5:00 p.m. doses were not administered. dulera aerosol inhaler 200-5 mcg 2 puffs inhaled combivent respimat aerosol 20-100 mcg 1 puff inhaled. The 8:00 a.m. and 5:00 p.m. doses were not administered. isosorbide mononitrate 60 mg 1 po at 5:00 p.m. klonopin 1 mg 1 po t.i.d. at 8:00 a.m. or 1:00 p.m. lamictal 25 mg 2 po at 5:00 p.m. nexium 40 mg 1 po qd at 7:00 a.m. nicotine patch 24 hr 21 mg/24 hr 1 patch transdermal at 8:00 a.m. omeprazole 20 mg 2 po q 5:00 a.m.			

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	restoril 15 mg 1 po q 8:00 p.m. simvastatin 10 mg 1 po q 8:00 p.m. spiriva with inhalation device 18 mcg q 8:00 a.m. zoloft 100 mg 1 po q 8:00 p.m. zoloft 50 mg 1 po q 8:00 p.m. On 6/3/13 the resident did not receive medications including but not limited to: klonopin 1 mg 1 po t.i.d. at 8:00 a.m. or 1:00 p.m. omeprazole 20 mg 2 po q 5:00 a.m. restoril 15 mg 1 po q 8:00 p.m. simvastatin 10 mg 1 po q 8:00 p.m. zoloft 100 mg 1 po q 8:00 p.m. zoloft 50 mg 1 po q 8:00 p.m. A review on 6/6/13 at 1:30 p.m., of nursing progress notes dated 6/1/13, indicated, "resident had arrived to UHHLC [University Heights Health and Living Center] and none of his 5 p.m. medications were passed due to, medication was not available." A nursing progress note dated 6/3/13, at 2:18 p.m., indicated the physician was notified of the medications that were not passed 6/1/13 at 5 p.m. No new orders were received from the physician at that time. Nursing spoke with pharmacy on 6/2/13, who indicated the medications would be			

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	sent that evening [6/2/13]. During an interview on 6/6/13 at 11:20 a.m., the resident indicated he did not receive all of his medications "for a couple of days." He indicated the nurses were able to give him his pain medication and "some of his other medications that they got from other areas." The resident indicated the staff told him his medications were not available because the pharmacy had not delivered them. 3) The clinical record for Resident #D was reviewed on 6/5/13 at 1:00 p.m. Diagnoses for Resident #D included, but were not limited to hypothyroidism (inadequate levels of thyroid hormone in the body). A physicians order, dated 7/30/12, indicated Resident #D was to receive "levothyroxine [thyroid hormone replacement medication], 25 mcg [micrograms/dosage] by mouth, once a morning at 5:00 a.m." An Electronic Medication Administration Record was reviewed and indicated Resident #C missed the			

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	medication on the date of 5/25/13 at 4:55 a.m., due to "Not Administered: Refused [nurses notes indicated resident refused medication]." The clinical record lacked documentation in regard to alternate means of medication administration for Resident #D receiving thyroid medication, and physician notification of missed medications. During an interview with the Director of Nursing (DON) on 6/6/13 at 12:00 p.m., further information was requested in regard to alternate means of medication administration for Resident #D receiving thyroid medication and physician notification of missed medications. During an interview with the DON and Nurse Consultant on 6/6/13 at 1:30 p.m., they indicated no further information was available. 4) The clinical record for Resident #C was reviewed on 6/6/13 at 9:00 a.m. Diagnoses for Resident #C included, but were not limited to hypothyroidism (inadequate levels of thyroid hormone			

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	in the body). A physicians order, dated 12/5/12, indicated Resident #C was to receive "levothyroxine [thyroid hormone replacement medication], 75 mcg [microgram/dosage] by mouth, once a morning at 5:00 a.m." An Electronic Medication Administration Record was reviewed and indicated Resident #C missed the medication on the date of 5/17/13 at 4:55 a.m., due to "Not Administered: Refused [nurses notes indicated resident refused medication]." The clinical record lacked documentation in regard to alternate means of medication administration, facility plan of care for a resident #C receiving thyroid medication, and physician notification of missed medications. During an interview with the Director of Nursing (DON) on 6/6/13 at 12:00 p.m., further information was requested in regard to alternate means of medication administration, facility plan of care for a resident #C receiving thyroid medication, and physician notification of missed medications.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227	

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	A facility Care Plan dated 10/6/11, for Resident #C indicated, "Approach: medications as ordered." During an interview with the DON and Nurse Consultant on 6/6/13 at 1:30 p.m., no further information was available. This Federal tag relates to Complaint IN00129606. This deficiency was cited on April 23, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			