

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00181877, IN00182301, and IN00181484.</p> <p>Complaint IN00181877- Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00182301 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00181484- Substantiated. Federal/State deficiencies are cited at F 203, F279, F282, and F 333.</p> <p>Survey dates: September 17 and 18, 2015</p> <p>Facility number: 000513 Provider number: 155426 AIM number: 100275360</p> <p>Census bed type: SNF/NF: 163 Total: 163</p> <p>Census payor type: Medicare: 24 Medicaid: 111 Other: 28 Total: 163</p>	F 0000	The facility requests that this plan of correction be considered its credible allegation of compliance Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of correction is prepared solely because of federal and state law	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
F 0203 SS=D Bldg. 00	<p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 9/23/15 by 29479.</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure written notification of a facility discharge for 1 of 1 resident reviewed for discharge notification (Resident B).</p> <p>Finding Includes:</p> <p>Resident B's record was reviewed on 9/18/15 at 9:45 a.m. The record indicated Resident B was admitted to the</p>	F 0203	<p>1. Resident B was transferred to the ER for evaluation and treatment on 8/26/15; changes could not be made fro this resident 2. Residents in facility have the potential to be affected. The Notice of Transfer or discharge (state form 49669) have been included in the Hospital Discharge packets by Medical Records, as of 10/02/15.</p> <p>3. Systematic changes made to ensure deficient practice does not</p>	10/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>facility on 8/25/15 at 7:00 p.m. An admission nursing note, dated 8/25/15, indicated Resident B was alert and oriented to person, place, and time, but had some difficulty with short term memory. The admission note indicated, "...orders verified per [name of physician]...." Diagnosis included, but was not limited to diabetes mellitus.</p> <p>Hospital discharge orders, dated 8/25/15 at 4:30 p.m., indicated, "...34 UNITS HUMULIN R U500 PTS [patient's] OWN MED [medication] TAKES IN AM AND AT LUNCH. HUMULIN R U500 25 UNITS AT SUPPER. HUMULIN R U500 SLIDE SCALE IS BS [blood sugar] &gt; [greater than] 150 SUBTRACT 100 FROM BS THEN DIVIDE THAT BY 20 TO GET DOSE, IF BS&lt; [less than] 70 TAKE 7 UNITS OFF SCHEDULED DOSE...."</p> <p>A nurses' note, dated 8/26/15 at 12:00 p.m., indicated Resident B's blood sugar was 300 and indicated the endocrinologist (diabetes specialist) was contacted at 10:45 a.m. regarding changing the prescribed insulin. The noted indicated the endocrinologist did not want the insulin changed due to irregularity of the resident's blood sugars. The record did not indicate the facility administered the prescribed HumuLIN R</p>		<p>recur: 1) Transfer or Discharge form (state form 49669) has been added to the facility transfer/discharge packet by Medical Records, as of 10/02/15. 2) Licensed Nurses will be educated by SDC, until 100% compliance is achieved regarding completing and providing The Notice of Transfer/Discharge at the time of transfer/discharge from the facility. 3) A copy of the completed form will be maintained in the medical record. 4) When upcoming discharges are discussed in the morning meeting, Social Service or designee will review the medical record to ensure an appropriate discharge notice has been issued within 30 days of discharge. If the discharge notice has not been issued, the facility will meet with the resident and/or responsible party and begin the 30 day discharge process. 4. The IDT will validate 5 times per week x 2 weeks; then weekly x 4 weeks to ensure a copy of the Transfer or Discharge form is in place in the medical record for any resident transferred/discharged from the facility during morning Department Head meeting. Audit findings will be reviewed monthly x 3 by the DON during the QAPI (Quality Assurance Performance Improvement meetings or until the QAPI members have determined substantial compliance has been achieved. 5. The DON will be responsible to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>U-500. The nurses' note indicated the primary care physician was notified at 12:28 p.m. and order was received to send the resident to a facility that could give the prescribed insulin.</p> <p>A nurses' note, dated 8//26/15 at 3:00 p.m., indicated the primary care physician ordered Novolog 10 units subcutaneously (under the skin) stat (immediately). The record indicated the resident refused the alternate insulin.</p> <p>A nurses' note, dated 8/26/15 at 6:00 p.m., and identified as a "Late entry," indicated, "...Unit Manager called [name of physician] et [and] received order to discharge resident to [name of hospital]."</p> <p>A physician order, dated 8/26/15 at 6:00 p.m., indicated Resident B was to be discharged from facility and sent to the hospital emergency room.</p> <p>A nurses' note, dated 8/26/15 at 6:35 p.m., indicated an order to send Resident B to the hospital emergency department due to unable to accept resident and administer HumuLIN R 500. The record indicated the resident left the facility with his girlfriend to go to the hospital and indicated, "...Report sent to [name of hospital]...." The record did not indicate the facility had additional communication</p>		ensure compliance by 10/12/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>with the hospital regarding the resident's health or discharge coordination. The record did not indicate a written notice of discharge had been provided to the resident.</p> <p>During an interview on 9/18/15 at 10:15 a.m., the hospital Director of Medical Records and Chief Nursing Officer indicated there was no documentation indicating Resident B was assessed or treated in their emergency department on 8/26/15.</p> <p>During an interview on 9/18/15 at 11:15 a.m., LPN (Licensed Practical Nurse) #1 indicated a report was called to the hospital emergency department on 8/26/15 informing the hospital Resident B was in route from the facility. The LPN indicated Resident B was discharged from the facility.</p> <p>During a confidential interview on 9/18/15 at 12:07 p.m., the caller indicated hospital emergency department staff indicated Resident B would not be admitted to the hospital, and the resident left without being assessed by medical staff. The caller indicated the resident did not return to the nursing facility because he had been discharged and indicated the resident was staying in the home of a friend.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
F 0279 SS=D Bldg. 00	<p>During an interview on 9/18/15 at 11:45 a.m., RN #2 indicated a discharge summary which included all disciplines of the resident's care team should have been completed for any resident discharged from the facility. and included all disciplines of resident's care team. The RN indicated discharge planning had not been completed for Resident B.</p> <p>A policy titled, "Facility Bedhold and Discharge Notices", requested on 9/18/15 and received on 9/21/15 at 12:27 p.m. from Administrator, included but was not limited to, "Policy Statement", ... The facility will also notify the resident/responsible party in writing of the reason for transfer/discharge to another legally responsible institutional setting and about the resident's right to appeal transfer/discharge...."</p> <p>3.1-12(6)(A)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop an immediate plan of care to ensure diabetes management for 1 of 6 residents reviewed for care plans (Resident B).</p> <p>Finding Includes:</p> <p>Resident B's record was reviewed on 9/18/15 at 9:45 a.m. The record indicated Resident B was admitted to the facility on 8/25/15 at 7:00 p.m. An admission nursing note, dated 8/25/15, indicated Resident B was alert and oriented to person, place, and time, but had some difficulty with short term memory. The admission note indicated, "...orders verified per [name of physician]...." Diagnosis included, but was not limited to diabetes mellitus.</p>	F 0279	<p>We are requesting an IDR because an Interim Care plan was completed at the time of admission and potential complications as a result of diabetes mellitus was included. Regulation required comprehensive care plan to be in place, by the 21st day of the resident stay. (Resident was in facility less than 24 hours). 1 Resident B was transferred to the ER for evaluation and treatment on 8/26/15; changes could not be made for this resident 2. New admissions are potentially affected therefore, Interim Care plans are placed in the Admission packet and are validated as complete during the morning clinical meeting following admission. 3. Systematic changes include 1) Education of licensed nurses by the SDC until 100% compliance achieved</p>	10/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>Hospital discharge orders accompanying resident on admission to the facility, dated 8/25/15 at 4:30 p.m., indicated, "...34 UNITS HUMULIN R U-500 [used in treatment of insulin-resistant patients with diabetes requiring daily doses of more than 200 units, since a large dose may be administered subcutaneously in a reasonable volume] PTS [patient's] OWN MED [medication] TAKES IN AM AND AT LUNCH. HUMULIN R U-500 25 UNITS AT SUPPER. HUMULIN R U-500 SLIDE SCALE IS BS [blood sugar] &gt; [greater than] 150 SUBTRACT 100 FROM BS THEN DIVIDE THAT BY 20 TO GET DOSE, IF BS&lt; [less than] 70 TAKE 7 UNITS OFF SCHEDULED DOSE...."</p> <p>A nurses' note, dated 8/26/15 at 12:00 p.m., indicated Resident B's blood sugar was 300 and indicated the endocrinologist (diabetes specialist) was contacted at 10:45 a.m. regarding changing the prescribed insulin. The noted indicated the endocrinologist did not want the insulin changed due to irregularity of the resident's blood sugars. The record did not indicate the facility administered the prescribed HumuLIN R U-500. The nurses' note indicated the primary care physician was notified at 12:28 p.m. and order was received to send the resident to a facility that could</p>		<p>regarding the completion of pertinent interim care plans. 2) New admission charts will be reviewed during morning clinical meeting by the Unit Managers, and they will validate completion and appropriateness of interventions. 4. Monitoring of new admission interim care plan audit will be completed by Unit Managers and findings reported by the DON to the QAPI committee meeting monthly x 3 and then quarterly thereafter until QAPI team members decide substantial compliance has been achieved. 5. DON will ensure compliance by 10/12/15.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>give the prescribed insulin.</p> <p>A physician order, dated 8/26/15 at 6:00 p.m., indicated Resident B was to be discharged from facility and sent to the hospital emergency room.</p> <p>A nurses' note, dated 8/26/15 at 6:35 p.m., indicated an order to send Resident B to the hospital emergency department due to unable to accept resident and administer HumuLIN R U-500.</p> <p>During an interview on 9/17/15 at 2:25 p.m., the Director of Nursing (DON) indicated the Marketing and Admissions Director accepted Resident B to the facility. The DON indicated the Marketing and Admissions Director was unaware the facility was unwilling to administer HumuLIN R U-500 insulin and indicated Resident B refused alternative insulin not prescribed by his endocrinologist. The DON indicated the facility was not able to provide the recommended medication and transferred the resident to the hospital. The DON indicated the facility did not have a written policy regarding refusal of care to residents receiving HumuLIN R U-500 insulin.</p> <p>During an interview on 9/18/15 at 11:15 a.m., LPN #1 indicated Resident B was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
F 0282 SS=D Bldg. 00	<p>transferred to the hospital emergency department because the facility could not give him the prescribed insulin and the resident refused an alternate insulin.</p> <p>3.1-35(a)</p> <p>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 record review and interview, the facility failed to ensure prescribed insulin was administered as ordered by the physician for 1 of 6 residents reviewed for following plan of care (Resident B).</p> <p>Finding Includes:</p> <p>Resident B's record was reviewed on 9/18/15 at 9:45 a.m. The record indicated Resident B was admitted to the facility on 8/25/15 at 7:00 p.m. An admission nursing note, dated 8/25/15, indicated Resident B was alert and oriented to person, place, and time, but had some difficulty with short term memory. The admission note indicated, "...orders verified per [name of physician]...." Diagnosis included, but</p>	F 0282	<p>1 Resident B was transferred to the ER for evaluation and treatment on 8/26/15; changes could not be made for this Resident 2 New admissions have the potential to be affected. New admission inquiries will have physician orders reviewed by a clinician prior to admission to prevent future reoccurrence. 3 Marketing Director/Admissions have been educated by the DON regarding the facility policy not to accept those residents on U500 insulin due to degree of risk associated with the medication, side effects and dosing calculations Facility policy has been reviewed and revised by the facility Medical Director on 9/29/15 Nurse Management will review new orders and/or new admission documents daily (M-F) during the morning clinical meeting Orders will be modified</p>	10/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>was not limited to diabetes mellitus.</p> <p>Hospital discharge orders, dated 8/25/15 at 4:30 p.m., indicated, "...34 UNITS HUMULIN R U-500 PTS [patient's] OWN MED [medication] TAKES IN AM AND AT LUNCH. HUMULIN R U-500 25 UNITS AT SUPPER. HUMULIN R U-500 SLIDE SCALE IS BS [blood sugar] &gt; [greater than] 150 SUBTRACT 100 FROM BS THEN DIVIDE THAT BY 20 TO GET DOSE, IF BS&lt; [less than] 70 TAKE 7 UNITS OFF SCHEDULED DOSE...."</p> <p>A nurses' note, dated 8/26/15 at 12:00 p.m., indicated Resident B's blood sugar was 300 and indicated the endocrinologist (diabetes specialist) was contacted at 10:45 a.m. regarding changing the prescribed insulin. The noted indicated the endocrinologist did not want the insulin changed due to irregularity of the resident's blood sugars. The record did not indicate the facility administered the prescribed HumuLIN R U-500. The nurses' note indicated the primary care physician was notified at 12:28 p.m. and order was received to send the resident to a facility that could give the prescribed insulin.</p> <p>A nurses' note, dated 8//26/15 at 3:00 p.m., indicated the primary care physician</p>		<p>as needed Licensed Nurses will be retrained regarding not accepting residents with U500 Insulin. A nurse manager will review each residents care plan when admission orders/new orders are received and develop or revise the care plan to include all impertinent care needs and interventions, including but not limited to physician orders. Nurse management will run an Omission Report daily (M-F) to ensure medications have been administered as ordered. Nurse management or designee will review the electronic medication record during the daily clinical meeting (M-F) to ensure all orders and/or parameters have been properly placed in the medication record Nurse management will run an Omission Report at a minimum of daily (M-F) to ensure medications have been administered as ordered. 4 The Marketing Director has been informed that we are unable to accept admissions with orders for Humulin R U-500 The measure that was put into place to ensure that the same issue does not recur is a written policy The Marketing Director has been provided a copy of the written policy for future reference The Marketing Director will review medications and treatments with a member of the nursing management team prior to accepting a new admission Nurse management will review</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>ordered Novolog 10 units subcutaneously (under the skin) stat (immediately). The record indicated the resident refused the alternate insulin.</p> <p>A nurses' note, dated 8/26/15 at 6:00 p.m., and identified as a "Late entry," indicated, "...Unit Manager called [name of physician] et [and] received order to discharge resident to [name of hospital]."</p> <p>A physician order, dated 8/26/15 at 6:00 p.m., indicated Resident B was to be discharged from facility and sent to the hospital emergency room.</p> <p>A nurses' note, dated 8/26/15 at 6:35 p.m., indicated an order to send Resident B to the hospital emergency department due to unable to accept resident and administer HumuLIN R U-500.</p> <p>During an interview on 9/17/15 at 2:25 p.m., the Director of Nursing (DON) indicated the Marketing and Admissions Director accepted Resident B to the facility. The DON indicated the Marketing and Admissions Director was unaware the facility was unwilling to administer HumuLIN R U-500 insulin and indicated Resident B refused alternative insulin not prescribed by his endocrinologist. The DON indicated the facility was not able to provide the</p>		<p>new orders and/or new admission documents daily (M-F) during the morning clinical meeting. Orders will be modified as needed.</p> <p>DON will monitor new admissions orders weekly x 4 and then monthly x 3 and report findings to the QAPI committee. Monitoring will continue until the QAPI committee decides that substantial compliance has been achieved. 5 DON will ensure compliance by 9/29/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
F 0333 SS=G Bldg. 00	<p>recommended medication and transferred the resident to the hospital. The DON indicated the facility did not have a written policy regarding refusal of care to residents receiving HumuLIN R U-500 insulin.</p> <p>During an interview on 9/18/15 at 11:15 a.m., LPN #1 indicated Resident B was transferred to the hospital emergency department because the facility could not give him the prescribed insulin and the resident refused an alternate insulin.</p> <p>3.1-35(g)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a prescribed medication was obtained and administered to prevent significant medication errors. This resulted in an untreated blood sugar of 300 and the resident was discharged from the facility without receipt of medication prescribed for management of diabetes for 1 of 5 residents reviewed for medication errors (Resident B).</p>	F 0333	We are requesting an IDR because: Resident B was not admitted until 1900 on 8/25/15 with an Insulin dose due at 2000 Residents B's admission orders included Levemir 100 Units at bedtime Resident B refused the Levemir insulin because he wanted to take it with Humulin R U-500 Resident B's blood glucose was 133 at 0700 on 8/26/15 He did not require coverage A call was placed to the Endocrinologist to alert him of our policy not to administer U-500 due to the risks	10/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>Finding includes:</p> <p>Resident B's record was reviewed on 9/18/15 at 9:45 a.m. The record indicated Resident B was admitted to the facility on 8/25/15 at 7:00 p.m. An admission nursing note, dated 8/25/15, indicated Resident B was alert and oriented to person, place, and time, but had some difficulty with short term memory. The admission note indicated, "...orders verified per [name of physician]...." Diagnosis included, but was not limited to diabetes mellitus.</p> <p>Hospital discharge orders, dated 8/25/15 at 4:30 p.m., indicated, "...34 UNITS HUMULIN R U-500 PTS [patient's] OWN MED [medication] TAKES IN AM AND AT LUNCH. HUMULIN R U-500 25 UNITS AT SUPPER. HUMULIN R U-500 SLIDE SCALE IS BS [blood sugar] &gt; [greater than] 150 SUBTRACT 100 FROM BS THEN DIVIDE THAT BY 20 TO GET DOSE, IF BS&lt; [less than] 70 TAKE 7 UNITS OFF SCHEDULED DOSE...."</p> <p>The Medication Administration Record (MAR), dated August 2015, indicated sliding scale HumuLIN R U-500 insulin was held on 8/25/15 at 8:00 p.m. "due to MD [Medical Doctor]." The MAR did not indicate the resident's blood sugar</p>		<p>associated with the dose. The Endocrinologist returned our call 8/26/15 at 1045 The Endocrinologist would not give the charge nurse alternative insulin orders to treat Resident B The charge nurse left messages for the Primary Care Physician Resident B's blood glucose was 300 at 1130 am Resident B's Primary Care Physician was notified three times. The Primary Care Physician returned our calls 10/26/15 at 1228. The PCP was notified that we were unable to administer Humulin R U-500 in our facility due to the high risks associated and that the Endocrinologist would not provide us with alternative insulin orders that could be administered in the facility. The PCP ordered to send the resident to a facility that would accept the prescribed Humulin R U-500. The PCP did not give us orders to treat the blood sugar of 300. Resident B was updated that his PCP gave orders to transfer to a facility that could administer Humulin R U-500. The resident was asymptomatic, stated he understood why we would not administer the Humulin R U-500 and would like to transfer to a facility that would. Social Services contacted 3 facilities as ordered by the PCP and was also desired by Resident B The 3 facilities that were contacted denied the admission based on the Humulin R U-500. The PCP was notified again at</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>level. The MAR indicated HumuLIN R U-500 insulin was not administered on 8/26/15 for the following reasons:</p> <ol style="list-style-type: none"> <li>1. Sliding scale dose not required at 7:00 a.m. The MAR did not indicate the blood sugar level.</li> <li>2. At 8:00 a.m., the MAR indicated 34 units was not given and was coded, "DOSE/TREATMENT NOT DUE." The MAR did not indicate the blood sugar level.</li> <li>3. At 11:30 a.m., the MAR indicated sliding scale insulin was not given and was coded, "DOSE/TREATMENT NOT DUE." The MAR did not indicate the blood sugar level.</li> <li>4. At 12:00 p.m., the MAR indicated 34 units was not given and was coded, "DOSE/TREATMENT NOT DUE." The MAR did not indicate the blood sugar level.</li> <li>5. At 3:00 p.m., the MAR indicated the Novolog (fast acting insulin) stat (immediately) dose ordered by the primary care physician was refused by the resident. The record indicated the blood sugar was 300 (high).</li> <li>6. At 5:00 p.m., 25 units was not given and was coded, "HELD SEE NURSES NOTES." The record did not indicate the resident's blood sugar level.</li> </ol> <p>A nurses' note, dated 8/26/15 at 10:00 a.m., indicated Resident B's blood sugar</p>		<p>1452 and new order received by the PCP 8/26/15 at 1452 to administer Novolog 10 unit stat. Resident refused the Insulin order and the PCP was notified. Three attempts by the charge nurse were made to contact the PCP to report the 3 facility denials for transfer to not avail; therefore the Medical Director was notified on 8/26/15 at 1815 and orders were received to send Resident B to the emergency room for evaluation and treatment of elevated blood glucose Resident B agreed with Medical Directors orders for transfer Resident B refused transportation offered by the facility and chose to travel by private care to the ER so he could take his electric wheelchair with him Emergency room was notified by the charge nurse and report was given Transitional Care Nurse contacted Resident B following his discharge. Resident B reports that he is "doing well" and that the physician in the emergency room "did not change anything", did not give him insulin, and sent him home with his x-wife. Facility respectfully asserts that every effort was made to treat Resident B with insulin that could safely be administered within the facility and the resident refused. Resident B stated he understood the facility's choice not to administer Humulin R U-500 because of high associated risk and he choose not to accept the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>was 133.</p> <p>A nurses' note, dated 8/26/15 at 12:00 p.m., indicated Resident B's blood sugar was 300 and indicated the endocrinologist (diabetes specialist) was contacted at 10:45 a.m. regarding changing the prescribed insulin. The noted indicated the endocrinologist did not want the insulin changed due to irregularity of the resident's blood sugars. The record did not indicate the facility administered the prescribed HumuLIN R U-500. The nurses' note indicated the primary care physician was notified at 12:28 p.m. and order was received to send the resident to a facility that could give the prescribed insulin.</p> <p>A nurses' note, dated 8//26/15 at 3:00 p.m., indicated the primary care physician ordered Novolog 10 units subcutaneously (under the skin) stat (immediately). The record indicated the resident refused the alternate insulin.</p> <p>A nurses' note, dated 8/26/15 at 6:00 p.m., and identified as a "Late entry," indicated, "...Unit Manager called [name of physician] et [and] received order to discharge resident to [name of hospital]."</p> <p>A physician order, dated 8/26/15 at 6:00 p.m., indicated Resident B was to be</p>		<p>alternative Insulin orders. Resident B requested to be transferred to a facility that could administer U-500. Resident B was made aware the 3 facilities contacted for alternative placement also had policies in place preventing the administration of Humulin R U-500 and the only facility that could administer that concentration of insulin immediately was the emergency room where he was discharged from less than 24 hour prior Resident B was asymptomatic during his stay within the facility and at the time of his transfer to the emergency room At no time did he demonstrate any signs or symptoms of physical or emotional harm Signature Healthcare respectfully requests tag to be reduced or expunged from the record 1. Resident B was transferred to the ER for evaluation and Treatment, was not treated or admitted and was discharged to his home. Resident was physically asymptomatic when he was transferred from the facility and did not voice any anxiety, worry or emotional upset with the transfer. 2 Residents with orders for Humulin R U-500 would be affected. Facility policy has been reviewed and updated with the Medical Director to exclude admission of residents using U500 insulin due to complication</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
---	--

(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
	<p>discharged from facility and sent to the hospital emergency room.</p> <p>A nurses' note, dated 8/26/15 at 6:35 p.m., indicated an order to send Resident B to the hospital emergency department due to unable to accept resident and administer HumuLIN R U-500.</p> <p>During an interview on 9/17/15 at 2:25 p.m., the Director of Nursing (DON) indicated the Marketing and Admissions Director accepted Resident B to the facility. The DON indicated the Marketing and Admissions Director was unaware the facility was unwilling to administer HumuLIN R U-500 insulin and indicated Resident B refused alternative insulin not prescribed by his endocrinologist. The DON indicated the facility was not able to provide the recommended medication and transferred the resident to the hospital. The DON indicated the facility did not have a written policy regarding refusal of care to residents receiving HumuLIN R U-500 insulin.</p> <p>During an interview on 9/18/15 at 11:15 a.m., LPN #1 indicated Resident B was transferred to the hospital emergency department because the facility could not give him the prescribed insulin and the resident refused an alternate insulin.</p>		<p>and associated risks. Marketing/Admissions Director has been updated with a copy of policy and education has been provided by the DON. Admissions going forward will have clinical review prior to acceptance. 3 Marketing Director/Admissions have been educated by the DON regarding the facility policy not to accept those residents on U500 insulin due to degree of risk associated with the medication, side effects and dosing calculations Facility policy has been reviewed and revised by the facility Medical Director on 9/29/15 Nurse management will review new orders and/or new admission documents daily (M-F) during the morning clinical meeting Orders will be modified as needed Nurse manager or designee will review the electronic medication record during the daily clinical meeting to ensure all orders and/or parameters have been properly placed in the medication record. Nurse manager will run an Omission Report daily (M-F) to ensure medications have been administered as ordered. 4 DON will monitor new admission orders weekly x 4 and then monthly x 3 and report findings to the QAPI committee Monitoring will continue until the QAPI committee decides that substantial compliance has been achieved 5 DON will ensure compliance by 10/05/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
(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	
	<p>During a confidential interview on 9/18/15 at 12:07 p.m., the caller indicated hospital emergency department staff indicated Resident B would not be admitted to the hospital, and the resident left without being assessed by medical staff. The caller indicated the resident did not return to the nursing facility because he had been discharged and indicated the resident was staying in the home of a friend.</p> <p>3.1-48(c)(2)</p>				