STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155570	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW LODGE	7476 W LANE RD MC CORDSVILLE, IN 46055

(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 Recertification and State Licensure Survey. Survey Dates: December 3-11, 2013 Facility number: 000477 Provider number: 155570 AIM number: 100290860 Survey Team: Beth Walsh, RN, TC Courtney Mujic, RN Karina Gates, Generalist Tom Stauss, RN Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 2 Medicaid: 28 Other: 5 Total: 35 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on December 16, 2013, by Janelyn Kulik, RN.	F000000	December 27, 2013 Kim Rhoades, DirectorLong Term Care Dear Kim Rhoades, Please accept our Plan of Correction as our creditable allegation of compliance. If you have any questions please feel free to call me at 317-335-2159. Sincerely,Colleen McCreary-WarnickAdministratorPleasant View Lodge	

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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F000159 SS=A	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on interview and record review, the facility failed to provide quarterly financial statements to a guardian of a resident with severe cognitive impairment, for 1 of 3 residents reviewed for personal funds (Resident #1). Findings include: During a family interview, on 12/4/13 at 1:37 p.m., Family Member #2 indicated they have not received any personal funds account statements from the facility. The clinical record for Resident #1 was reviewed on 12/9/13 at 1:00 p.m. The diagnoses for Resident #1 included, but were not limited to: mental retardation, seizure disorder, and dementia with delusions related to psychosis. A review of the Annual MDS (Minimum Data Set), dated 9/10/13, indicated Resident #1 had a BIMS	F000159	1. Corrective Action:We mailed a copy of resident #1's quarterly accounting of their resident funds to their legal representative.2. Identification of Other Residents:We reviewed all residents who have a resident's fund account within the facility. We mailed a copy of all residents quarterly accounting statement of their resident's funds to their legal representative and requested a signed acknowledgement of receipt of the quarterly resident fund statement.3. Measure to Prevent Reoccurrence:We developed a new policy on Quarterly Accounting of Resident's Funds. (See exhibit #1) An in-service training was conducted with the business office personnel on December 27, 2013. (See exhibit #2)4. Continued Monitoring: The Business Office Manager and another office employee will monitor that the resident account statement has been mailed and returned by their legal representative every quarter. (See exhibit #3) Audits will be reviewed quarterly at the facility QA meetings until 100%	01/10/2014

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	(Brief Interview of Mental Status) of 5, which was indicative of severe cognitive impairment. A review of a document titled, In the Matter of the Guardianship of (Name of Resident #1), Incapacitated Adult, dated 2/25/08, it indicated Family Member #2 was the guardian of Resident #1. During an interview with Bookeeper #4, on 12/9/13 at 2:38 p.m., she indicated she was in charge of the personal funds account statements. She indicated she gives the resident a copy of their personal funds account statement to sign on a quarterly basis and to family, if requested. A copy of the personal funds account statement, for Resident #1 dated 9/30/13, was provided by Bookeeper #4 on 12/9/13 at 2:55 p.m. It indicated Resident #1 refused to sign the document. On 12/10/13 at 10:30 a.m., the Social Services Director (SSD) indicated a resident would have a POA (Power of Attorney) or Guardian if the Resident was unable to fully comprehend what was being explained to them and/or if they were unable to make decisions		compliancy is met within a 9 month period.5. Completion date:January 10, 2014	

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	for themselves. The SSD indicated this was why Resident #1 had a guardian. She also indicated she was unsure why a personal funds account statement was given to Resident #1, instead of the guardian, when Resident #1 was not always able to comprehend explanations. At 11:15 a.m., on 12/10/13, Bookeeper #4 indicated it has always been the facility's policy to give the personal funds account statements to the residents, no matter what their cognition was or if they had a POA or guardian. She also indicated a resident would have a POA/guardian if they were not able fully comprehend what was explained to them and/or if they were unable to make decisions for themselves. Bookeeper #4 also indicated Resident #1 sometimes understands what was explained to her, but not always. She indicated the facility was now looking into possibly revising their policy/practice of only providing quarterly personal funds account statements to Residents. During an interview with the Administrator, on 12/10/13 at 2:45 p.m., she indicated the facility might revise their policy on distributing personal funds account statements to			

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	only just the residents, since it made sense to distribute the statement to a POA/guardian of a cognitively impaired resident. During the final exit conference, 12/11/13 at 1:30 p.m., the Administrator and Bookeeper #4 indicated the facility was going to revise their policy on distribution of quarterly personal funds account statements. 3.1-6(b)			

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F000250 SS=D	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 follow-up to ensure audiology visits were done according to family wishes for 1 of 1 resident reviewed for Preadmission Screen and Resident Review (PASRR) (Resident #15). Findings include: The clinical record for Resident #15 was reviewed on 12/9/13 at 11:00 a.m. The diagnoses for Resident #15 included, but were not limited to: hydrocephalus, severe mental retardation, and seizure disorder. A review of the current PASRR recommendations, dated 1/4/13, indicated, "...5. (Name of Resident) continues to benefit from routine medical, dental, audio and vision evaluations as needed for his overall general health needs." During a review of the clinical record, an audiology evaluation was not located in the clinical record and was requested on 12/9/13 at 12:30 p.m.,	F000250	1. Corrective Action:On resident #15 the resident's family has updated their consent form and has declined services for audiology, vision and dental.2. Identification of Other Residents:The facility reviewed all residents under Preadmission Screening and Residents Review and all ancillary services were completed as consented and recommended.3. Measure to Prevent Reoccurrence:The facility created a new audit form to monitor all services provided and recommendations as ordered by PASSAR. (See exhibit #4)4. Continued Monitoring:The DON or designee will monitor that all services recommended through PASSAR is completed monthly. Audits will be reviewed during the facility quarterly Quality Assurance meeting. If 100 % has been met for 9 months then the QA team will reevaluate for continued monitoring.5. Completion Date: January 10, 2014	01/10/2014

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	from the Social Services Director. The evaluation was requested again on 12/9/13 at 4:00 p.m. from the Director of Nursing. A review of a Social Service Progress Note, dated 10/22/12, indicated, "Writer called (name of ancillary company) in regards to resident being seen by audiology. Rep of (name of ancillary company) stated that audiology was denied on the consent form. Writer called (name of Family Member #1) who had called earlier but left a message for her to resign another consent form so the resident could be seen." During an interview with the Social Services Director (SSD), on 12/10/13 at 10:30 a.m., she indicated she was unable to locate an audiology evaluation for this year. She also indicated she called Resident #15's family member (Family Member #1) on the previous day, after she was unable to locate the audiology evaluation. Family Member #1 indicated, during the phone call, they did initially want an audiology visit this year as previously discussed above, but just changed her mind and will sign the waiver on audiology evaluations the next time she visits Resident #15.			

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	A review of a Social Services Progress Note, dated 12/9/13, indicated, "Per verbal report from residents [sic] P.O.A (Power of Attorney) his sister (name of family member) in regards to residents [sic] receiving [sic] audiology and optometry care [sic] she had sign [sic] a consent form due to updates of outside services (Family Member #1 signed a consent for evaluations to be done this year for services listed) but rethought the fact that resident would be unable to correctly report an accurate reading of either services [sic]." On 12/10/13 at 10:40 a.m., the SSD indicated she was unsure why the facility did not follow up on the audiology evaluation, as Family Member #1 initially desired, until it was requested. The SSD also indicated it probably was a lapse on her part since Resident #15 had a routine medical, vision, and podiatry evaluations this year as previously requested with the 2012 updates. At 11:30 a.m., on 12/11/3, the SSD indicated the above PASRR recommendations were the current recommendations for Resident #15.			

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	3.1-34(a)			

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F000279 SS=D	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. The facility must develop a comprehensive 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. 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).			
	Based on interview and record review, the facility failed to ensure a resident had a care plan to address her daily use of an antidepressant medication for 1 of 19 residents reviewed for care plans. (Resident #16) Findings include: The clinical record for Resident #16 was reviewed on 12/4/13 at 1:37 p.m. The diagnoses for Resident #16 included, but were not limited to,	F000279	1. Corrective Action:Resident #16 was immediately assessed and a care plan for the antidepressant was developed including measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs as identified in the assessment.2. Identification of Other Residents:A full house audit of resident care plans has been accomplished to ensure residents have comprehensive care plans that come from assessment to include measurable objectives and timetables to meet the resident's	01/10/2014

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	depression and osteoarthritis pain. The December, 2013 MAR (medication administration record) for Resident #16 indicated she received one 30 mg capsule of Cymbalta (antidepressant medication) daily at 9:00 a.m. During review of Resident #16's care plans, no care plan addressing her use of Cymbalta was found. During an interview with the ADON (Assistant Director of Nursing) on 12/10/13 at 12:13 p.m. she indicated Resident #16's use of Cymbalta should be care planned. She reviewed Resident #16's care plan folder and indicated she could not find a care plan to address her Cymbalta use. She further indicated interventions that should be care planned include "monitor for side effects, call M.D. as needed." At this time, she provided a copy of a different resident's care plan for antidepressant medication use that indicated side effects of antidepressant medication use were nausea, dry mouth, head ache, fatigue, insomnia, dizziness, diarrhea, flu like symptoms, and increased sweating. She stated, "I'm surprised she doesn't have one."		medical, nursing, and mental and psychosocial needs. (See exhibit #5) The care plans describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and where applicable the resident's right to refuse treatment.3. Measure to Prevent Reoccurrence: All resident care plans will be reviewed by the DON or designee upon completion of the MDS process. This review will include auditing the care plans to ensure all care, medications and treatment needs are addressed in a comprehensive manner. The care plans will include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs and will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and if applicable the resident's right to refuse treatment.4. Continued Monitoring:Audits will be reviewed quarterly at the facility QA meeting until 100% compliancy is met within a 9 month period.5. Completion Date:The facility will allege compliance concerning the deficiency of developing comprehensive care plans on January 10, 2013.	

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	3.1-35(a)			

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F000282 SS=D	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 observation, interview, and record review, the facility failed to ensure a care plan intervention was followed regarding providing a night light for 1 of 3 residents reviewed for falls. (Resident #20) Findings include: Resident #20's clinical record was reviewed on 12/5/13 at 10:44 a.m. It indicated Resident #20 had fallen in her room on 11/30/13. On 12/8/13 at 1:51 pm, during an observation, Resident #20 was lying in bed watching TV with call light in reach. No night light was observed plugged into any outlet in the resident's room. On 12/9/13 at 10:57 am, Resident #20 was observed in bedside chair with call light within reach and fall care plan interventions observed to be in place, but no night light was observed plugged into any outlet in the bedroom.	F000282	1. Corrective Action:Resident #20 had a night light placed in her room 12/9/2013 as written in the care plan.2. Identification of Other Residents:A full house audit of residents' care plans have been completed to ensure all care planned interventions are in place as written. (See exhibit #6)3. Measure to Prevent Reoccurrence:An audit of care planned interventions will be completed daily by the DON or designee to ensure compliancy. Missing interventions will be addressed immediately.4. Continued Monitoring:Daily audits will be reviewed weekly by the DON for compliancy and complied monthly for the QA committee. The QA committee will review quarterly until 100% compliancy is met within 9 months.5. Completion Date:The facility will allege compliance with Services by Qualified Persons/Per Care Plan on January 10, 2013.	01/10/2014

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	During an interview on, on 12/9/13 at 2:31, LPN #6 indicated she had no knowledge of any specific interventions for Resident #20 related to falls. She indicated the resident was encouraged to use call light whenever staff observed resident ambulating. She indicated not being aware of a "night light" intervention for Resident #20. Care plans reviewed on 12/9/13 indicated interventions including, but not limited to, clear aisle way, provide adequate lighting, monitor movement when up, place night light in room, raised toilet seat. A fall investigation was conducted by the interdisciplinary team and a root cause of Resident #20 needing a night light was identified. A new intervention on 11/30/13 was generated of providing Resident #20 a nightlight. On 12/10/13 at 10:59am, Resident's room was observed and no night lights were observed in any of the outlets in the room. On 12/10/13 at 11:48am, during an interview, Resident #20 indicated that the only other light she uses is the light (she pointed to a small lamp			

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NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN 46055	

(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
	across her room on a night stand). She indicated when she gets up to take herself to the bathroom at night, she will turn on a lamp on a nightstand immediately next to her bed. She then indicated that if she needed additional light, she would go across the room to the "other light" and turn it on. She indicated that she did not leave lights on at night time. She indicated that staff brought the "other light" in to provide her more light at night if she needs it. On 12/10/13 at 11:47 a.m., the DON indicated that housekeeping was to provide a night light that plugged into an outlet near Resident #20's bed. The DON indicated that there was not a nightlight in place and that there should be one. On 12/10/13 at 11:58 a.m., during an interview, the Housekeeping Supervisor indicated that she was told the lamp placed in Resident #20's room which was placed across the room from the resident's bed was for additional light for the resident at night. 3.1-35(g)(2)			

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