

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00139344.</p> <p>Complaint IN00139344 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: December 2, 3, 4, 5, 6, 10, 11, 12, and 13, 2013</p> <p>Facility number: 001133 Provider number: 155593 AIM number: 200090430</p> <p>Survey team: Patti Allen, SW-TC Marcy Smith, RN Susan Worsham, RN (December 4 and 5, 2013) Diana Zgonc, RN (December 12, 2013)</p> <p>Census bed type: SNF: 12 SNF/NF: 112 Residential: 99 Total: 223</p> <p>Census payor source: Medicare: 12 Medicaid: 84</p>	F000000	<p>The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc. (The "Facility") that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 16/17 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of stature only. We are respectfully requesting the granting of paper compliance due to the low scope and serverity of the survey findings.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Other: 127 Total: 223</p> <p>Residential Sample: 08</p> <p>These deficiencies reflect residential state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 20, 2013; by Kimberly Perigo, RN.</p>				

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F000170 SS=C	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>Based on interview and record review, the facility failed to promptly send and deliver mail on Saturday. This had the potential to affect 124 of 124 residents who reside in the facility.</p> <p>Finding Include:</p> <p>1.) During interview on 12-12-13 at 11:15 a.m., with resident #45 (BIMS score of 15 on a annual Minimum Data Set (MDS) assessment dated 10-7-13) she indicated she was not sure if the facility delivered mail on Saturday, but thought they did.</p> <p>2.) Interview 12-13-13 at 10:00 a.m., with the Activity Director who indicated the facility staff did not provide Saturday delivery or pick up of mail. We used to deliver and send mail on Saturday, but the old Administrator stopped the facility staff from providing the service, before he left. She is not sure when he stopped the Saturday mail delivery, but he left in January 2013. The Activity Director provided a policy on Resident Mail</p>	F000170	The policy (Attachment F0170-1) was reviewed and it was deemed appropriate. 1. All residents in Comprehensive care were negatively affected by no mail being passed on Saturdays. 2. All residents have the potential to be negatively affected. The policy indicates that the mail would be sorted by the mail room and be given to the Activity Director (staff) working on Saturday's and the Activity Staff would be sure the mail would be passed. It shall be the policy of the Indiana Masonic Home to provide resident mail delivery and mail pick up in a timely manner. 3. Activity Coordinators will pick up residents' mail from the reception office after it has been sorted. Mail will be delivered unopened unless written permission to forward or open/read mail is obtained from the resident or responsible party. Mail will be delivered six (6) days weekly, excluding holidays. 4. This will be monitored (Attachment F0170-2) by Nurse managers on each unit weekly to make sure mail is being passed on Saturdays and the Director of Nursing, or designee will report continued compliance at the CQI quarterly meetings for	01/10/2014

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	<p>(revised May 30,2007) and indicated this was the policy in effect. Review of the policy indicated:</p> <p>"Delivery/Medical Center:</p> <p>Mail will be delivered to the resident within 24 hours of being received. Mail will be delivered six (6) days weekly, excluding holiday.</p> <p>When an Activity Coordinator is absent from work, delivery will be made by another person in the activity department by early afternoon. by</p> <p>Saturday mail will be sorted by the Activity Coordinator and delivered to the individual nurses stations. Nursing Staff will disperse mail to resident.</p> <p>Outgoing Mail:</p> <p>A locked box will be provided at each nurse's station on 1D and 1E units for residents' outgoing mail. Activity staff for the secure units will deliver outgoing mail to the the Medical Center Receptionist. The Medical Center Receptionist will be responsible for pick up of all outgoing mail from each unit other than the secure units.</p>		two quarters and then the Activity Director will ask the question (Attachment F0170-3) regarding mail delivery at each resident council meeting. Mailroom and Activity Staff are to be educated on the policy.				

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	<p>Monitoring of Mail:</p> <p>The Administrator and the Activity Director will be responsible for the monitoring of mail delivery."</p> <p>3.) Review on 12/12/13 at 3:00 p.m., of Resident Council Minutes dated 8/7/13, 9/4/13, 10/2/13, and 11/6/13; indicated mailed is delivered unopened, but not on Saturdays."</p> <p>3.1-3(s)(1)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure laboratory blood specimens were drawn according to physician's orders for 1 of 5 residents reviewed for adequate monitoring of medications. (Resident #163)</p> <p>Findings include:</p> <p>The clinical record of Resident #163 was reviewed on 12/10/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #163 included, but were not limited to, congestive heart failure, chronic edema in bilateral lower extremities, high blood pressure, and diabetes mellitus.</p> <p>A physician's order, dated 11/25/13, indicated Resident #163 was to have a basic metabolic panel (BMP) and magnesium lab tests drawn on 12/2/13. No results of these labs were found in the resident's record.</p> <p>During an interview with Licensed</p>	F000282	<p>F282 It shall be the policy of Indiana Masonic Home, Inc. to ensure all services are provided by qualified persons in accordance with each resident's written plan of care.</p> <p>1. No residents were negatively affected. We did draw the lab and the results were reported to the physician. 2. All residents who have physician's lab orders have the potential to be affected. All laboratory blood specimens will be drawn in accordance with physician's orders. We did audit the labs for the previous 30 days and found no other deficiencies.</p> <p>3. All applicable nursing staff will be educated on the "Laboratory and Diagnostic Testing Follow Up" policy and will be educated on the correct way to write a lab order and complete the lab requisition form. Laboratory blood specimen orders will be randomly assessed to ensure that all lab orders are tracked in the electronic MAR for completion.</p> <p>4. Random assessment of laboratory orders will be conducted on ten charts on each unit on a weekly basis for 30 days, then monthly thereafter. Staff education will be provided should deviation of policy be</p>	01/10/2014			

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	<p>Practical Nurse #1 on 12/10/13 at 9:50 a.m., she indicated the labs had not been drawn. She indicated the order had not been written correctly. She indicated she would call the physician to see if he still wanted the labs drawn. A physician's order, dated 12/11/13, indicated the physician still wanted a BMP and magnesium drawn.</p> <p>During an interview on 12/10/13 at 12:20 p.m., with the Unit Manager on the secured unit; she indicated what "should" have happened was the nurse who took the order would put it on the Medication Administration Record on the day the lab results would be back, so the nurse on that day could be aware and watch for results. Also, she indicated at that time, the night nurse was supposed to check all the physicians' orders taken that day to make sure the orders had been processed correctly. She indicated, "Obviously these things didn't happen."</p> <p>3.1-35(g)(2)</p>		discovered. Monitored by: Director of Nursing Staff Education Coordinator and Unit Managers.As a means of quality assurance results of the monitoring and any corrective action taken shall be reported to the CQI committee on a quarterly basis.		

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to ensure that the resident environment was free of accident hazards in that a resident was observed under a hair dryer with oxygen (O 2) on. This had the potentially to affect 124 residents who resided in the facility. (resident # 50)</p> <p>Findings Include:</p> <p>On 12/4/13 at approximately 11:30 a.m., resident # 50 was observed in the facility's beauty salon wearing oxygen (O2) while under an operating hair dryer. A portable oxygen tank was observed to be located on the back of the resident's wheelchair. Interview with the beautician at that time, indicated she had been told that the Kwik Dri professional hair dryer could be used safely with the resident wearing oxygen.</p> <p>On 12/4/13 at 12:00 p.m., the facility Administrator provided a copy of the Kwik Dri Professional hair dryer</p>	F000323	<p>1. No residents were negatively affected. 2. All residents on oxygen who use the beauty shop services have the potential to be affected. When this deficiency was discovered and brought to the Administrator's attention, he immediately closed down the beauty shops until he could ascertain the breadth of training received by all beauty operators. The Indiana Masonic Home, Inc., contracts with Elan, Inc., for cosmetology services. 3. All beauty operators were inserviced and given copies of the current policy for "Oxygen use with Hair Dryers", and the policy was read to them. All nursing staff was in-serviced on Oxygen use with Hair Dryers. The current Indiana Masonic Home policy, which mirrors the directive found in Issue #09-36, dated November 30, 2009, of ISDH's Long Term Care Newsletter, states that the "oxygen use should be at least five feet from hair dryers." Therefore lines of demarcation were taped off on the floor of the beauty shops to keep residents who may enter the shop with oxygen on at least 5 feet away from any hair dryer(s). 4. In</p>	01/10/2014			

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	<p>Model No. 515 Owner Instruction Manual. A review of the owner instruction manual indicated no clearance for usage while in the presence of a portable oxygen tank.</p> <p>On 12/4/13 at 12:04 p.m., a call was made to Pibbs industry costumer service. A costumer service representative indicated that in no way would they recommend the use of a portable oxygen tank while under the Kwik Dri Professional Hair Dryer Model No. 515.</p> <p>An interview with the beautician on 12/4/13 at approximately 2:00 p.m., indicated she had been told that the hair dryers were safe for the residents to use while wearing oxygen, but she could not recall who informed her of this. She, at that time, showed an apparatus that she used before she was told that the Hair dryers were safe. The apparatus was a hat that was to fit over the residents head with a 2-2 1/2 ft long accordion hose that a handheld hair dryer was to be attached to. She also indicated she was unsure of the time when she made the switch from the apparatus to the currently used hair dryers.</p> <p>On 12/4/13 at 1:45 p.m., the Administrator provided a policy on</p>		<p>the future all beauty operators will be given a copy of the current policy on "Oxygen use with hair drayers" at orientation. The beauty operator will also log each resident who comes into the baeauty shop, indicating whether or not they have oxygen, and checking to be sure they are not in the restricted aread. (Attachment F0323-4). The beauty shops will be radomly monitored once a week when the shop is operating. Should non-compliance be observed immediate action shall be taken. This will be monitored by Director of Nursing Administrator or their designee. (Attachment F0323-1). Continued compliance shall be reorted to the CQI committee on a quarterly basis.</p>		

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	<p>Oxygen use with hair dryers (original date 9-2-09) and indicated that this was the policy in effect. Current policy indicated:</p> <p><u>"Oxygen Use with Hair Dryers</u></p> <p>Policy Statement: The use of oxygen with a hair dryer could create a potentially hazardous environment. In order to mitigate the threat, the Indiana Masonic Home, Inc. will practice the following procedure.</p> <p>Procedures:</p> <p>2. The Beauty shop and nursing staff will be trained/ oriented upon hire and annually thereafter on the following.</p> <ul style="list-style-type: none"> - Keeping the Oxygen tank 5 feet away from the dryers at all times; -The need for residents Oxygen to be supervised -Proper placement and removal of portable oxygen <p>3. Residents who are receiving Oxygen therapy and routinely receive Beauty Shop services and/ or use a hand held hair dryer may be evaluated to see if they can go without oxygen while receiving services. If appropriate a physicians order to remove Oxygen prior to going to the Beauty Shop and/ or using a handheld hair dryer will be obtained. "</p>						

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	<p>On 12/12/13 at 3:30 p.m., review of resident #50's clinical record indicated that an encapsulated physician's order with an original date of 09-17-09 indicated that resident was to receive O2 at 2 liters per minute continuously.</p> <p>On 12/13/13 Administrator indicated The model no. 505 hair dryers in the Beauty Shop were installed in 2005. No where in the hair dryer manual does it list oxygen use as a warning in their list of "General Warnings" concerning the hair dryers.</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a gradual dose reduction was considered or attempted and laboratory specimens were drawn according to a physician's order for 2 of 5 residents reviewed for unnecessary medications. (Residents #23 and #163))</p> <p>Findings include:</p>	F000329	F329 It shall be the policy of Indiana Masonic Home, Inc. to ensure each resident's drug regimen is free from unnecessary drugs. 1. No residents were negatively affected. Resident #23 has been reviewed for GDR and has been found not to be appropriate at this time. 2. All residents receiving antipsychotic medications have the potential to be negatively affected. All residents receiving antipsychotic medications will be reviewed for a GDR. 3. Per facility policy, a gradual dose reduction will be	01/10/2014			

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	<p>1. The clinical record of Resident #23 was reviewed on 12/11/13 at 9:45 a.m.</p> <p>Diagnoses for Resident #23 included, but were not limited to, mental disorder, cerebral palsy, and senile depressive disorder. She was admitted to the facility on 11/14/1977.</p> <p>A physician's order, dated 10/12/12, indicated Resident #23 was to receive Zyprexa 7.5 mg. (milligrams) every day at 4:00 p.m. The indication for this medication was, "behavioral disturbance." Zyprexa is an anti-psychotic medication.</p> <p>There was no information in Resident #23's record, which indicated a Gradual Dose Reduction (GDR) had been considered or attempted since 10/12/12.</p> <p>During an interview with the Unit Manager of the East Hall on 12/11/13 at 11:00 a.m., she indicated she was unable to find any documentation regarding a GDR for Resident #23's Zyprexa since 10/12/12.</p> <p>During an interview with the Director of Nursing on 12/12/13 at 2:45 p.m., she indicated she was aware a GDR had not been considered or</p>		<p>considered or attempted for every resident that receives an antipsychotic medication. All residents that are admitted on an antipsychotic medication, or after the facility has initiated an antipsychotic medication, will have an attempted gradual dose reduction attempted in two separate quarters, unless clinically contraindicated. After the first year, a gradual dose reduction will be attempted annually, unless clinically contraindicated. The date of the last considered or attempted reduction will be recorded on the side effect monitoring form. All laboratory blood specimens will be drawn in accordance with physician's orders. All applicable nursing staff will be educated on the "Medication Monitoring – Medication Management" and the "Laboratory and Diagnostic Testing Follow Up" policies and will be educated on the correct way to write a lab order and complete the lab requisition form. Gradual dose reduction consideration or attempts will be made every 6 months for applicable residents. Laboratory blood specimen orders will be randomly assessed to ensure that all lab orders are tracked in the electronic MAR for completion. Gradual dose reduction consideration or attempts will be monitored by the Behavior Management Committee on a monthly basis. 4. Random</p>		

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	<p>attempted for Resident #23's Zyprexa dose. She indicated she had spoken with her pharmacist, who should have been aware a GDR was due. She indicated the process was the pharmacist would send a report to the DON with recommendations, including GDR's. She indicated this was not done.</p> <p>A facility policy, dated 2007, titled, "Medication Monitoring Medication Management, received from the DON on 12/10/13 at 11:30 a.m., indicated, "Tapering of a medication dose/gradual dose reduction [GDR]: Within the first year in which a resident is admitted on an antipsychotic medication or after the nursing care center has initiated an antipsychotic medication, the nursing care center must attempt a GDR in two separate quarters [with at least one month between attempts] unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated."</p> <p>2. The clinical record of Resident #163 was reviewed on 12/10/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #163 included, but were not limited to,</p>		<p>assessment of laboratory orders on ten charts per unit will be conducted on a weekly basis for 30 days, then monthly thereafter. Staff education will be provided should deviation of policy be discovered. Continued compliance with monitoring of GDR's to insure each resident's drug regiment is free from unnecessary drugs shall be reported to the CQI committee on a quarterly basis. (Attachment F-0329-1) Monitored by: Director of Nursing Social Services Consultant Pharmacist Unit Managers Staff Educator</p>		

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	<p>congestive heart failure, chronic edema in bilateral lower extremities, high blood pressure, and diabetes mellitus.</p> <p>Resident #163 was receiving 2 diuretic medications. (Lasix and spironolactone) A physician's order, dated 11/25/13, indicated Resident #163 was to have a basic metabolic panel (BMP) and magnesium lab tests drawn on 12/2/13. No results of these labs were found in the resident's record. A BMP is a blood test consisting of a panel of 8 tests providing information about the current status of kidney function, blood glucose level and electrolytes, and is frequently ordered periodically for residents receiving diuretics. A magnesium blood test measures the level of magnesium in the blood.</p> <p>During an interview with Licensed Practical Nurse #1 on 12/10/13 at 9:50 a.m., she indicated the labs had not been drawn. She indicated the order had not been written correctly. She indicated she would call the physician to see if he still wanted the labs drawn. A physician's order, dated 12/11/13, indicated the physician still wanted a BMP and magnesium drawn.</p>			

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	<p>During an interview with the Unit Manager on the secured unit, on 12/10/13 at 12:20 p.m., she indicated what "should" have happened was the nurse who took the order would put it on the Medication Administration Record on the day the lab results would be back, so the nurse on that day could be aware and watch for results. Also, she indicated at that time, the night nurse was supposed to check all the physicians' orders taken that day to make sure the orders had been processed correctly. She indicated, "Obviously these things didn't happen."</p> <p>3.1-48(a)(3) 3.1-48(b)(2)</p>			

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F000499 SS=D	<p>483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on interview and record review, the facility failed to ensure a nurse's professional license was current in that RN #1 had been working with an expired nursing license dated October 31, 2013. (RN #1)</p> <p>Findings include:</p> <p>Review of facility employees records on 12/4/13 at 1:30 p.m., indicated RN #1 had been working on an expired license dated 10/31/13. During an interview with Director of Nursing (DON) on 12/5/13 at 10:05 a.m., she indicated RN #1, after general orientation on 11/05/13, proceeded to start orienting on the floor on 11/16/13, then proceeded to work on their own as of 11/23/13, working the 2:00 p.m. to 10:00 p.m. shift. In an interview with the DON on 12/5/13 at 10:05 a.m., she indicated RN #1 was removed from the schedule as of 12/4/13.</p>	F000499	<p>1. No resident was negatively affected. 2. All residents have the potential to be affected. 3. The Human Resource Department will check the Professional licensing registry for each Nurse, CNA, QMA, and other licensed individuals prior to hire, and will check the individual's license on the first day of orientation (first day that staff work) and enter the expiration date on the orientation check list. We have added that to the orientation check list (Attachment F0499-1). They will then enter that information on the spreadsheet and create a calendar in outlook that will remind them one month before a license expires so that letters can go out reminding persons to renew (Attachment F0499-2) All renewals will be entered onto the spreadsheet prior to the expiration date to make sure everyone's license is current. Human Resources will send a list of anyone not renewed by the expiration date to the scheduler so those persons are not scheduled to work. 4. By</p>	01/10/2014	

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	3.1-14(s)		1/10/2014 the Human Resource Department will do an audit to assure every licensed person is current with their licensure. Human Resources Department will report quarterly at our CQI meetings on the renewal of all licenses.		

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F000502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure labs were drawn according to physician's orders for 1 of 5 residents reviewed laboratory monitoring of medication. (Resident #163)</p> <p>Findings include:</p> <p>The clinical record of Resident #163 was reviewed on 12/10/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #163 included, but were not limited to, congestive heart failure, chronic edema in bilateral lower extremities, high blood pressure, and diabetes mellitus.</p> <p>A physician's order, dated 11/25/13, indicated Resident #163 was to have a basic metabolic panel (BMP) and magnesium lab tests drawn on 12/2/13. No results of these labs were found in the resident's record.</p> <p>During an interview with Licensed Practical Nurse #1 on 12/10/13 at</p>	F000502	<p>F502 It is the policy of Indiana Masonic Home, Inc. to provide laboratory services to meet the needs of our residents. 1. No residents were negatively affected. The lab for resident #163 was obtained and results reported to the physician. 2. All residents needing laboratory blood specimens and diagnostic testing follow up have the potential to be affected. We audited charts and not other labs were missed in the prior 30 days. 3. All laboratory blood specimens will be drawn in accordance with physician's orders. All applicable nursing staff will be educated on the "Laboratory and Diagnostic Testing Follow Up" policy and will be educated on the correct way to write a lab order and complete the lab requisition form. Laboratory blood specimen orders will be randomly assessed to ensure that all lab orders are tracked in the electronic MAR for completion. 4. Random assessment of laboratory orders on ten charts per unit will be conducted on a weekly basis for 30 days, then monthly thereafter. Staff education will be provided should deviation of policy be discovered. (Attachment</p>	01/10/2014

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	<p>9:50 a.m., she indicated the labs had not been drawn. She indicated the order had not been written correctly. She indicated she would call the physician to see if he still wanted the labs drawn. A physician's order, dated 12/11/13, indicated the physician still wanted a BMP and magnesium drawn.</p> <p>During an interview with the Unit Manager on the secured unit, on 12/10/13 at 12:20 p.m., she indicated what "should" have happened was the nurse who took the order would put it on the Medication Administration Record on the day the lab results would be back, so the nurse on that day could be aware and watch for results. Also, she indicated at that time, the night nurse was supposed to check all the physicians' orders taken that day to make sure the orders had been processed correctly. She indicated, "Obviously these things didn't happen."</p> <p>3.1-49(a)</p>		F0502-1) Continued compliance and any corrective actions will be reported to the CQI committee on a quarterly basis. Monitored by: Director of Nursing Staff Education Coordinator Unit Managers		

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F000514 SS=D	<p>483.75(I)(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 any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure clinical records contained pertinent information regarding follow up of laboratory blood draws for 2 of 5 residents reviewed for medication monitoring and follow up of lab results. (Residents #163 and #151)</p> <p>Findings include:</p> <p>A facility policy, titled Lab and Diagnostic Testing Follow Up, dated 7/29/10, received from the DON on 12/11/13, indicated, "Laboratory Test 1. Receive Physician's order for lab test. 2. Complete the lab requisition and schedule the date lab is to be drawn. 3. Using the Paperless System [the facility's Medication Administration Record (MAR) on the</p>	F000514	F514 1. No residents were negatively affected. The labs were drawn on resident #163 and the results were reported to the physician. We contacted the hospital regarding the lab that was drawn on 11/27/13 and obtained the results for physician review. 2. All residents have the potential to be affected. It is the policy of Indiana Masonic Home, Inc. to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. We audited charts and no other labs were missed in the prior 30 days. 3. All laboratory blood specimens will be drawn in accordance with physician's orders. All applicable nursing staff will be educated on the "Laboratory and Diagnostic	01/10/2014			

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	<p>computer] enter a reminder for the nurse to check for lab results for the day after the lab is to be drawn...4. If lab result is present on the unit, the nurse is to review it and notify the physician of abnormal values. 5. If lab result is not present on the unit, the nurse is to contact the Lab Tech to see if lab was drawn. If lab was not drawn, make arrangements to have the lab drawn that day. 6. If the physician's order specifically stated the date the lab was to be drawn, and it was not drawn on that date, the physician must be notified of the error..."</p> <p>1. The clinical record of Resident #163 was reviewed on 12/10/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #163 included, but were not limited to, congestive heart failure, chronic edema in bilateral lower extremities, high blood pressure, and diabetes mellitus.</p> <p>A physician's order, dated 11/25/13, indicated Resident #163 was to have a basic metabolic panel (BMP) and magnesium lab tests drawn on 12/2/13. No results of these labs were found in the resident's record.</p>		<p>Testing Follow Up" policy. III-IV. 4. Laboratory blood specimen orders from ten charts from every unit will be assessed on a weekly basis for 30 days, then monthly thereafter to insure that blood specimens are collected and results are available in accordance with the physician's order. Staff education will be provided should deviation of policy be discovered. (Attachment F0502-1) Continued compliance and any corrective actions will be reported to the CQI committee on a quarterly basis. Monitored by: Director of Nursing, Staff Education Coordinator, Unit Managers</p>		

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	<p>During an interview with LPN #1 on 12/10/13 at 9:50 a.m., she indicated the labs had not been drawn. She indicated the order had not been written correctly. She indicated she would call the physician to see if he still wanted the labs drawn. A physician's order, dated 12/11/13, indicated the physician still wanted a BMP and magnesium drawn.</p> <p>During an interview with the Unit Manager on the secured unit, on 12/10/13 at 12:20 p.m., she indicated what "should" have happened was the nurse who took the order would put it on the Medication Administration Record (MAR) on the day the lab results would be back, so the nurse on that day could be aware and watch for results. Also, she indicated at that time, the night nurse was supposed to check all the physicians' orders taken that day to make sure the orders had been processed correctly. She indicated the reminder to follow up on the results of the BMP and magnesium labs to be drawn 12/2/13 had not been put on the December, 2013 MAR. She indicated, "Obviously these things didn't happen."</p> <p>2. The clinical record of Resident #151 was reviewed on 12/11/13 at</p>				

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	<p>10:00 a.m.</p> <p>Diagnoses for Resident #151 included, but were not limited to coronary artery disease, high blood pressure, and diabetes mellitus.</p> <p>A physician's order, dated 11/20/13, indicated Resident #151 was to have a basic metabolic panel (BMP) lab drawn in 1 week. This lab was drawn 11/27/13.</p> <p>The MAR for November, 2013, did not indicate a follow up date for the BMP, which was to be drawn 11/27/13.</p> <p>During an interview with the Unit Manager of the Transitional Care Unit on 12/11/13 at 12:55 p.m., she indicated the lab reminder for Resident #151's BMP to be drawn 11/27/13 did not get put on the MAR. She indicated the nurse who took the order didn't work very often and might not have known to do it.</p> <p>3.1-50(a)(1)</p>			

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R000064	<p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on record review and interview, the facility failed to ensure missing property was reported to the Indiana State Department of Health, as indicated by their policy 1 of 1 resident reviewed for missing personal effects in a sample of 7. (Resident # 578).</p> <p>Findings include:</p> <p>The clinical record for Resident #578 was reviewed on 12/12/13 at 9:30 A.M.</p> <p>Diagnoses for Resident #578 included, but were not limited to diabetes, hypertension, hypothyroidism, anemia, and osteoporosis.</p> <p>A Service Plan dated and signed by the resident on 7/2/13, indicated the resident was independent with decision making. A nurses note dated 7/8/13, indicated the resident is independent in all care areas and can</p>	R000064	R064 Residents Rights The facility shall exercise reasonable care for the protection of resident's Property from loss and theft. The facility completed a thorough investigation of the alleged missing items. The missing property report indicated the rings were not located and a resident misappropriation report to local officials was not completed. 1. No residents were negatively affected. 2. All residents have the potential to be affected. 3. The following corrective actions have been taken: The current Resident Abuse Prevention Policy (Attachment R-0064-1) revised 2/20/12 was reviewed and observed to be appropriate. The prior policy and procedure distributed to the surveyor was destroyed. All staff was re-in serviced on most current policy. Section IV Identification and Reporting was re-reviewed by the DON, Administrator, and their designees during their absence. (Attachment R0064-2) 4. As a means to ensure ongoing compliance the administrator or	01/10/2014	

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	<p>verbalize all wants and needs.</p> <p>A "Missing Property Report" dated 8/1/13, indicated Resident #578 had reported to the facility she was missing 7 rings. The "Missing Property Report" indicated the items were unable to be located. The record lacked documentation the findings were reported to the appropriate state agency.</p> <p>During an interview with the Resident Unit Manager on 12/12/13 at 5:35 P.M., she indicated she did not have any documentation, but the investigation report. She indicated, "I'm not sure it was reported to the state."</p> <p>During an interview with the Director of Nursing on 12/13/13 at 9:15 A.M., she indicated the missing items were not reported to the state according to the facility policy.</p> <p>A current facility policy revised on 6/17/11 and titled "Resident Missing Personal Effects" and provided by the Resident Unit Manager on 12/12/13 at 5:35 P.M., indicated, "Purpose: To establish guidelines for investigating all reports of missing effects and to promote resident satisfaction and comfort regarding</p>		<p>their designee will keep a log of resident missing property reports to be reviewed once weekly in the morning stand up until the Quality Assurance committee adjusts actions as warranted. (Attachment R0064- 3)</p>				

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	handling and security of personal property ... 11. Should the Facility determine that resident property has been willfully "misappropriated" then the Indiana State Depart of Health shall be contacted per regulatory guidelines."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 690 S STATE ST FRANKLIN, IN 46131
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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to ensure fire drills were completed according to the facility policy for 2 of 12 fire drill reports reviewed.</p> <p>Findings include:</p> <p>The fire drill records were reviewed on 12/12/13 at 10:00 A.M. The last quarter of 2012 (October, November, and December) fire drill reports</p>	R000092	R092 Administration and Management The facility must maintain a written fire and disaster preparedness. 1. No resident was negatively affected. 2. All residents have the potential to be affected. 3. Maintenance shall be in charge of scheduling and monitoring all unannounced fire drills that will consist of a drill quarterly on each shift. It is the policy of the Indiana Masonic Home to conduct quarterly fire drills in each building, on all three shifts to	01/10/2014

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	<p>lacked documentation of a night shift fire drill. The 3rd quarter of 2013 (July, August, and September) fire drill reports lacked documentation of a night shift fire drill.</p> <p>During an interview with the Residential Unit Manager on 12/12/13 at 3:30 P.M., she indicated no further documentation could be found for fire drills completed on the night shift.</p> <p>A current undated facility policy titled "Indiana Masonic Home Fire and Disaster Manual" provided by the Residential Unit Manager indicated, "... 2. Each shift will have a fire drill four times annually ..."</p>		<p>insure that the current undated facility policy titled "Indiana Masonic Home Fire and Disaster Manual" which states, "Each shift will have a fire drill four times annually ..." is followed. The current policy was reviewed and is appropriate. As a means to ensure ongoing compliance the Director of Facilities will monthly audit the Fire Drill record. (Attachment R0092-1) 4. We will put electronic reminders on the computers of the Director of Facilities, the Director of Human Resources, and the Administrator, since some of these persons are in separate buildings, to insure that these key administrative positions will be aware of the quarterly time frame in which to have fire drills completed on the night shift, day shift, and evening shift. By 1/10/14 we will also complete staff training for the Facilities Departments of all buildings so managers of the department can update their calendars as well. Fire drills will be scheduled at the beginning of the year for the entire year. The dates of those will only be shared with the Department Heads and Administration. This will be monitored quarterly and reported at the quarterly CQI meeting by: Director of Facilities, Director of Environmental Services, Director of Human Resources, and the Administrator.</p>		